To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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This clinical coverage policy has an effective date of April 1, 2023; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect.

Related Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related clinical coverage policies listed below:

1E-3*, Sterilization Procedures*
1E-5*, Obstetrical Services*
1D-4*, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*
1A-38*, Special Services: After Hours*
1S-3 *Laboratory Services*
9*, Outpatient Pharmacy*
1E-2, *Therapeutic and Non-therapeutic Abortions*
1-H, *Telehealth, Virtual Communications and Remote Patient Monitoring*

1.0 Description of the Procedure, Product, or Service

Medicaid Family Planning services are provided to an eligible Medicaid beneficiary of childbearing age to temporarily or permanently prevent or delay pregnancy. Medicaid Family Planning is designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina.

1.1 Definitions

1.1.1 Traditional Medicaid Family Planning

Traditional Medicaid family planning services consist of:

a. Consultation;
b. Examination;
c. treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision;
d. laboratory examinations and tests; and
e. Food and Drug Administration(FDA) approved family planning supplies and devices to prevent conception.

1.1.2 Family Planning Medicaid (FP Medicaid)

FP Medicaid serves eligible beneficiaries regardless of age or gender. FP Medicaid provides limited coverage to beneficiaries with MAFDN eligibility. These beneficiaries are only eligible for family planning and family planning-related services, as described in this policy. Family Planning Medicaid beneficiaries needing non-family planning services shall be referred to their primary care or a safety net provider. Beneficiaries with MAFDN eligibility are not eligible for any other Medicaid program or categories of service.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*)
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

a. Medicaid

A traditional Medicaid, FP Medicaid beneficiary **may be eligible** for family planning and family planning-related services when the beneficiary meets **ALL** the following eligibility criteria:

1. is a North Carolina resident; is a U.S. citizen or qualified alien;
2. is childbearing age;
3. is not pregnant; and
4. is not incarcerated.

FP Medicaid shall cover an individual who meets the above criteria and the income eligibility requirements defined in 42 CFR 435.214.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the

needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.2.2 Undocumented Aliens

Undocumented aliens are eligible for emergency medical services as found in 42 CFR 440.255(c).

2.2.5 Retroactive Eligibility

Retroactive eligibility applies to FP Medicaid.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover procedures, products, and services related to this policy when they are medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: *Telehealth, Virtual Communications, and Remote Patient Monitoring.*

3.2 Specific Criteria Covered

Family Planning Services must adhere to 42 CFR §441.20, "For beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used."

3.2.1 Specific criteria covered by both Medicaid

Medicaid shall cover family planning services for a beneficiary consisting of consultation, examination, laboratory tests, FDA approved contraceptive methods, supplies, and devices to prevent conception, as documented in this policy.

Traditional Medicaid, FP Medicaid shall cover the following when the eligibility criteria in **Section 2.0** are met:

a. The "fitting" of diaphragms;
b. Birth control pills (up to a 12-month supply);
c. Insertion of Intrauterine Devices (IUD's) (Mirena, Paragard, Liletta, Kyleena and Skyla);
d. Removal of IUD's outside of the office, i.e. Local Health Department (LHD), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) setting;
e. Contraceptive injections (Depo-Provera);
f. Implantable contraceptive devices (Nexplanon);
g. Contraceptive patch (norelgestromin and ethinyl estradiol transdermal system); available from the pharmacy with a prescription;
h. Contraceptive vaginal rings available from the pharmacy with a prescription;
i. Emergency Contraception (Plan B, One Step and Ella) available from the pharmacist with a prescription;

j. Screening, early detection and education for Sexually Transmitted Infections (STIs), including HIV and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis B and Hepatitis C;

k. Treatment for most STIs (refer to Attachment C for specific FP Medicaid coverage);

l. Lab services (refer to **Attachment A, C1** for specific FP Medicaid coverage);

m. Ultrasounds when the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are also covered to locate stringless IUDs. Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion; and

n. Human Papillomavirus (HPV) Gardasil 9 Vaccine.

Note: The contraceptive methods named above are not all inclusive for Traditional Medicaid beneficiaries.

3.2.2 Medicaid Additional Criteria Covered

In addition to the **Specific Criteria** covered in **Section 3.2.1**, traditional Medicaid and FP Medicaid shall cover the following Family Planning Services:

a. Sterilization procedures for male and female beneficiaries. Refer to Clinical Policy *1E-3, Sterilization Procedures* on the NC Medicaid website at https://medicaid.ncdhhs.gov for requirements related to sterilization procedures; and

b. Non-emergency medical transportation, as needed, to and from family planning appointments.

3.3 United States Preventive Services Task Force (USPSTF) Recommendations

NC Medicaid encourages screening for the following United States Preventative Services Task Force (USPSTF) recommendations in all Family Planning Medicaid beneficiaries:

a. Increased blood pressure in adults aged 18 years or older and obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment. Beneficiaries with elevated blood pressure should be referred for follow up.

b. BRCA risk assessment: clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (*BRCA1/2)* gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should be referred for genetic counseling and, if indicated after counseling, genetic testing. Women with Family Planning Medicaid should be referred to their primary care or a safety net provider.

c. Cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing). Women with Family Planning Medicaid should be referred to their primary care or a safety net provider for non-family planning services.

d. Chlamydia and Gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
e. HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.
f. Screening and referral for preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
g. Hepatitis B Virus (HBV) screening among high-risk populations, which include persons from countries with a high prevalence of HBV infection, HIV-positive persons, injection drug users, household contact of persons with HBV infection, and men who have sex with men.
h. Hepatitis C Virus (HCV) screening in all asymptomatic adults (including pregnant beneficiaries) aged 18 to 79 years without known liver disease. Most adults need to be screened only once. A beneficiary with continued risk for HCV infection should be screened periodically.
i. Intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.
j. Obesity: Offer and refer adults and adolescents with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions through their primary care or a safety net provider.
k. Postpartum depression: referring persons who are at increased risk of postpartum depression for counseling interventions through their primary care or a safety net provider.
l. Sexually transmitted infections: education and referral for intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
m. Syphilis infection in persons who are at increased risk for infection.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover procedures, products, and services related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Traditional Medicaid, FP Medicaid

Traditional Medicaid, FP Medicaid shall not cover the following:

a. Infertility services and related procedures;
b. Reversals of sterilizations;
c. Diaphragms;
d. Contraceptives that can be purchased without a prescription or do not require the services of a physician for fitting or insertion; and
e. Ultrasounds for MAFDN beneficiaries; unless performed to verify that the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are not covered for the purpose of routine checking of placement after IUD insertion.

4.2.2 Medicaid Additional Criteria Not Covered by FP Medicaid (MAFDN)

a. In addition to the specific criteria not covered in Subsection 4.2.1 of this policy, FP Medicaid (MAFDN) shall not cover medical conditions unrelated to family planning or family planning-related services. MAFDN eligible beneficiaries are ONLY eligible for services described in **Subsection 3.2.1**. If a medical condition unrelated to family planning or family planning-related services occurs, or the beneficiary has no need for family planning services, the provider shall refer the beneficiary to a primary care or safety net provider.

   MAFDN beneficiaries may request services not described in **Subsection 3.2.1**, but they would be responsible for the cost of those services.

b. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, FP Medicaid (MAFDN) shall not cover the following:
   1. Abortions;
   2. Ambulance Services;
   3. Hospital Emergency room or emergency department services;
   4. Inpatient hospital services;
   5. Surgical procedures or hospital services requiring outpatient beneficiary registration other than sterilizations.
   6. Treatment for HIV or AIDS;
   7. Treatment for Hepatitis B;
   8. Treatment for Hepatitis C;
   9. Treatment for cancer;
   10. Services provided to manage or treat medical conditions (Not including STIs):
      A. Discovered during the screening;
      B. Caused by or following a family planning procedure (including urinary tract infections, diabetes, hypertension, breast lumps);
      C. Complications of women's health care problems, including heavy bleeding or infertility; and

D. Hysterectomy.

11. Services for beneficiaries who have been sterilized or no longer have a need for family planning services; and
12. Any specialty health care services not related to family planning services (including dental, mammography, cardiology, physical therapy, neurology, radiology, behavior health services).

Note: The cost of any service(s) provided in a hospital setting is the responsibility of the beneficiary, except for a beneficiary who has been referred to the hospital for an outpatient sterilization procedure.

Note: EPSDT does not apply to 42 CFR §441.253 (a) Sterilization of a mentally competent individual aged 21 or older. Federal financial participation (FFP) is available in expenditures for the sterilization of an individual only if the individual is at least 21 years old at the time consent is obtained.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Traditional Medicaid, FP Medicaid, shall not require prior approval for family planning services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

FP Medicaid beneficiaries are subject to the following limitations and requirements:

a. FP Medicaid beneficiaries are limited to one comprehensive preventive medicine examination per 365 calendar days.
b. FP Medicaid beneficiaries are required to receive an annual office visit assessment to determine the beneficiary's need for services related to preventing or achieving pregnancy before rendering any other family planning or family planning-related services. This annual assessment is not required to be a comprehensive preventive medicine exam.
c. FP Medicaid beneficiaries are limited to a total of six inter-periodic visits per 365 calendar days in addition to the annual assessment or comprehensive preventive medicine exam.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

6.3 Provider Billing of beneficiaries

The provider shall comply with 10A NCAC 22J.0106, Provider Billing of Patients Who Are Medicaid Recipients.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: January 1, 1974

History:

Date	Section Revised	Change
10/01/2014	All sections and attachment(s)	New policy documenting current Medicaid FP and NCHC coverage. Family Planning Waiver (FPW) demonstration project began operation October 1, 2005. Information incorporated throughout this policy referred to as the "Be Smart" program was approved by CMS on **June 7, 2013** to convert the FPW project to a State Plan Amendment (SPA) under the Affordable Care Act (ACA) legislation.
05/01/2015	Attachment A	Added updated CPT codes 87623, 87624, and 87625 to replace CPT code 87621
05/01/2015	Attachment A	Added Revenue Codes 0301 and 0302
05/01/2015	Attachment B	Added sections "Billing the Beneficiary" and "Emergency Departments and Emergency Room Services" to further clarify program services and non-covered services
05/01/2015	Attachment B Section E (4)	Repeat Pap for Insufficient Cells information added
05/01/2015	Attachment B Section F	Pharmacy –Post operative medications for sterilization information added
05/01/2015	Attachment B Section I	Clarified "Miscellaneous Billing Instructions" for contraceptive methods and devices.
05/01/2015	Attachment B Section J (5)	Specific billing instruction for Private Providers added
05/01/2015	Attachment B Section K (8)	Specific billing instructions for FQHCs and RHCs added
05/01/2015	Attachment B Section L (6)	Specific billing instructions to LHDs added
05/01/2015	Attachment B Section M (6)	Specific billing instructions to Outpatient Hospitals added
05/01/2015	Attachment B Section N (6)	Specific billing instructions to Outpatient only Pharmacies added
05/01/2015	Attachment C	Added "Be Smart" Family Planning Program Billing Codes
05/01/2015	Attachment D	Added "Be Smart" STI Medications
05/01/2015	Attachment E	Added Postoperative Sterilization Medications list
05/01/2015	Attachment F	Added Primary Care "Safety Net" Providers
08/01/2015	Attachment D	Added additional medications to the list of "Be Smart" STI Medications to reflect current provider practice
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
11/15/2015	Attachment C	Changed, "Providers must include the **ICD-10-CM Diagnosis 042** as the secondary diagnosis on the appropriate claim," to "Providers must include the **ICD-10-CM Diagnosis B20** as the secondary diagnosis on the appropriate claim." This amendment is clarification of information from ICD-10 transition.

02/01/2016	Attachments A	Consolidated "Be Smart" comprehensive list of ICD-10-CM diagnosis codes from Attachment B with the list in Attachment A.
02/01/2016	Attachments B	Deleted "Be Smart" comprehensive list of ICD-10-CM diagnosis codes in Attachment B.
02/10/2015	Attachment A	Corrected code Z00.89 to Z01.89
04/01/2016	Attachments A	Added Z11.4 to list of MAFDN ICD-10-CM diagnosis codes.
04/01/2016	Attachments A	Added J7297 and J7298 to list of MAFDN HCPCS codes, already in NCTracks for MAFDN, but omitted from the Family Planning Services policy. Deleted code J7302.
04/01/2016	Attachment C	Replaced diagnosis code B20 with diagnosis code Z11.4
04/01/2016	Attachment C	Added J7297 and J7298 to list of codes for IUDs. Deleted code J7302 from this list.
04/01/2016	Attachment C	Added J7297 and J7298 to list of codes for Family Planning Supplies and Devices. Deleted duplicate code J7301 and deleted code J7302 from this list.
04/21/2016	Attachment A	Removed Revenue Code "RC0302" which was inadvertently left in during revision process
11/1/18	All Sections and Attachments	Replaced Medicaid FP and "Be Smart" with FP Medicaid. Replaced regular Medicaid with traditional Medicaid. Removed claim submission instructions. Removed Revenue Code and ICD-10 PCS Procedure code lists. "Should" changed to "shall."
11/1/18	Section 1.0	Clarified the description and removed statute 42 U.S.C. 1396d(a)(4)(C).
11/1/18	Subsection 1.1.1	Clarified language. Removed, "Family Planning (Medicaid FP)."
11/1/18	Subsection 1.1.2	Clarified the language defining "Be Smart" Family Planning Medicaid.
11/1/18	Subsection 2.1.2	Clarified the eligibility criteria. Removed, "not sterilized," per CMS guidance. Removed unnecessary language.
11/1/18	Subsection 2.2.4	Updated 10A NCAC 21B.0302 and replaced with 10A NCAC 23E.0102. Clarified language.
11/1/18	Subsection 2.2.5	Removed Presumptive Eligibility related information.
11/1/18	Subsection 3.2	Clarified language.
11/1/18	Subsection 3.2.1	Clarified language. Liletta was added to section 3.2.1 but was already covered device. Updated Plan B to Plan B One Step. Updated Attachment A to C. Added ultrasounds as a covered service for MAFDN beneficiaries.
11/1/18	Subsection 3.2.2	Clarified language and removed unnecessary language.
11/1/18	Subsection 4.2.1	Clarified language. Ultrasounds are covered for MAFDN beneficiaries if there is concern that the IUD is malpositioned.
11/1/18	Subsection 4.2.2	Clarified language regarding referral for services not covered by FP Medicaid. Clarified language.
11/1/18	Subsection 4.2.3	Clarified language.
11/1/18	Subsection 5.1, 5.2.1 and 5.2.2	Clarified language.

11/1/18	Subsection 5.3, 5.4 and 5.5	Clarified language regarding limitations and removed unnecessary language.
11/1/18	Section 6.0	Removed unnecessary language. Clarified language regarding billing a Medicaid beneficiary.
11/1/18	Subsection 7.1	Removed unnecessary language.
11/1/18	Attachment A	(B1) Clarified language. Added diagnosis codes T83.32XA, Z00.01, Z01.411, Z01.419, Z30.015, Z30.016, Z30.017, Z30.44, Z30.45, Z30.46, Z31.69, Z32.01, Z32.02, N76.0, N76.1, N76.2, N76.3. Removed diagnosis codes T83.32XD, T83.32XS. Removed ICD-10 PCS Code list. Clarified that providers and beneficiaries should refer to Clinical Policy 1E-3 Sterilization Procedures guidance on sterilization procedures. NCHC beneficiaries are not eligible for sterilization procedures." (C) HCPCS Q0111 removed from this section, as it is a duplicate procedure of CPT 87210. Removed unnecessary language. (C1) Clarified language and clarified that providers and beneficiaries should refer to Clinical Policy 1E-3 Sterilization Procedures guidance on sterilization procedures. NCHC beneficiaries are not eligible for sterilization procedures." (D)Removed unnecessary language. (F) (G) (H) Clarified language. (C) Added CPT codes 36415, 87660, 76830, 76856, 76857, 87480, 87510.
11/1/18	Attachment B	Clarified language, removed unnecessary and repetitive language throughout attachment B. Included information regarding when an annual exam is required for beneficiaries that are transitioning between Medicaid programs to FP Medicaid. Included clarifying information on billing for office visits and services that include an office visit component. Clarified that providers and beneficiaries should refer to Clinical Policy 1A-38, Special Services: After Hours. Clarified information for beneficiaries who have been permanently sterilized or no longer have need for family planning services. (D)Added information related to venipuncture. (F) Added Bacterial vaginosis and related CPT codes. (I) Added information related to ultrasounds.
11/1/18	Attachment C	Language in Attachment C was clarified, repetitive language was removed, and the relevant information was moved to appropriate subsections of the policy.
11/1/18	Attachment D	Clarified language and updated medication list. Added gentamicin 240mg IM for the treatment of gonorrhea, added medication for the treatment of Bacterial vaginosis.
11/1/18	Attachment E	Clarified language and updated medication list.
11/1/18	Attachment F	The list of Safety Net providers removed from policy.
01/01/2019	Section 3.2.1 (f)	Removed Ortho Evra and added norelgestromin and ethinyl estradiol transdermal system

01/01/2019	Attachment A	(B1) Added diagnosis A63.0. (C1) Removed CPT codes 58340, 58565 and 74740
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/01/2020	Related Coverage Policies Section	Added *1E-5 Obstetrics, 1E-2, Therapeutic and Non-therapeutic Abortions, and 1-H, Telehealth, Virtual Communications and Remote Patient Monitoring*
12/01/2020	Section 1.1.2	Added referral of beneficiary to primary care or a safety net provider for non-family planning services.
12/01/2020	Section 2.1.2	Changed plural nouns for "individuals" and "beneficiaries" to singular nouns here and throughout policy.
12/01/2020	Section 2.2.4	Removed NC Administrative Code 10A NCAC 23E.0102 - repealed in June 2019.
12/01/2020	Added Subsection 3.1.1	As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.
12/01/2020	Section 3.2.1	Added references to Attachments for specific covered criteria. Added that ultrasounds are covered to locate string less IUDs. Added Kyleena IUD for coverage. Removed repetitive language. Clarified coverage for Emergency Contraception when "available from the pharmacist with or without a prescription."
12/01/2020	Section 3.3	Added section with United States Preventive Services Task Force (USPSTF) Recommendations.
12/01/2020	Section 4.2.1	Added reference back to covered services section 3.2.1h to further clarify coverage for emergency contraception.
12/01/2020	Section 4.2.2	Hepatitis B screening and treatment added as non-covered services. Also added "surgical procedures or hospital services requiring outpatient beneficiary registration other than sterilization" as a noncovered item. Clarified removal of IUDs outside of the office setting as a noncovered service. Reformatted into lists for readability.
12/01/2020	Section 5.4	Removed this section as was duplicate to section 6.0
12/01/2020	Sections 5.5	Removed this section as was exact duplication of Sections 6.1.

12/01/2020	Sections 5.6	Removed this section as was exact duplication of Section 6.2.
12/01/2020	Section 6.0	Moved NC Administrative Code 10A NCAC 22J.0106 reference for Medicaid Billing from Section 5.4 to Section 6.0.
12/01/2020	Attachment A, Letter B1	Added ICD-10-CM diagnosis codes N41.0, N45.1-N45.3, Z72.51-Z72.53 and Z86.19 for coverage related to NAAT testing for Trichomonas Vaginalis. Added ICD-10-CM diagnosis codes A49.3, N72, N73.0, N73.1, and N73.9, R36.0, R36.9 and Z86.19 for NAAT diagnostic testing for Mycoplasma Genitalium. Added ICD-10-CM diagnosis codes Z72.51-Z72.53, and Z72.89 for use with general STI screening. Added clarifying language to reference to sterilization procedures under table in this section. Added ICD-10-CM diagnosis codes B86 and N89.8 for scabies diagnosis and amine vaginitis screening.
12/01/2020	Attachment A, Letter C	Added Reference to Attachment B, Letter J for FQHC and RHC Family Planning billing instructions.
12/01/2020	Attachment A, Letter C1	Removed end dated CPT procedure codes 71010 and 88154. Removed incorrectly entered CPT code 78657 and added correct CPT code 76857. Added new covered CPT codes 58661, 87661, 87563, and 80053. Added new covered HCPCS J7296 to HCPCS code table. Added HIV screening code 87806 that was omitted from policy previously as a covered MAFDN covered service. Also added CPT code 82120 for amines screening for vaginitis and 87220 for KOH test for the diagnosis of scabies to CPT code table. Removed repetitive instruction under table C1 regarding sterilization procedures. Added table for CPT Codes Eligible for Telehealth Services with **Note:** Telehealth eligible services may be provided to established patients by the eligible providers listed within this policy. Added MAFDN approved Revenue Codes back to policy.
12/01/2020	Attachment A, Letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.
12/01/2020	Attachment A, Letter F	Added instruction for Outpatient Place of Service, that "the only surgical procedure or hospital services allowed requiring outpatient beneficiary registration is sterilization". Also added clarification to specified POS "Office." Added FQHC and RHC place of services.

		Added the following language for telehealth services: "Telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth)."
12/01/2020	Attachment A, Letter L	Added Comprehensive Metabolic Panel (CMP) for coverage with guidelines.
12/01/2020	Attachment B, Letter A	Changed "FP Medicaid Program" to "FP Medicaid" for policy consistency in this section and throughout policy attachments. Formatted with lists for readability.
12/01/2020	Attachment B, Letter B	Reformatted into lists for readability. Added the following language requirement for Inter-Periodic visits: Each in-person or telehealth encounter will count as one of a beneficiary's allotted six inter-periodic visits, per 365 days.
12/01/2020	Attachment B, Letter C	Clarified billing language related to after-office hours services.
12/01/2020	Attachment B, Letter D	Removed end dated pap test CPT procedure code 88154. Removed pap test as a requirement only at time of annual exam and clarified that can be offered at time of annual exam or during an inter-periodic visit. Added Comprehensive Metabolic Panel (CMP) for coverage with guidelines.
12/01/2020	Attachment B, Letter F	Created new section for Trichomonas Vaginalis and added coverage for NAAT screening code 87661. Clarified Bacterial Vaginosis (Gardnerella) and Candida screening section. Removed CPT 87660 from this section as this was added to the newly created Trichomonas section. Added coverage for new CPT code 87563 for diagnostic Mycoplasma Genitalium testing. Added referral guidelines for interventions in HIV by prophylactic prescription meds through the Ready, Set PrEP program. Added CPT code 82120 for coverage of amines for vaginitis screening. Added CPT code 87220 for coverage of diagnosis for scabies.
12/01/2020	Attachment B, Letter H	Removed "Ortho Evra" from contraceptive patch. Removed unnecessary wording. Removed "Nuva" and added "vaginal contraceptive" to cover other vaginal rings covered under MAFDN. Added Kyleena IUD for coverage.

12/01/2020	Attachment B, Letter I	Added clarification that no waiting period exists for IUD placement when ultrasound confirms IUD has been expelled. Removed repetitive language.
12/01/2020	Attachment B, Letter J	Added section for FQHC and RHC "Be Smart" Family Planning billing instructions.
12/01/2020	Attachment, B Letter K	Letter J. Miscellaneous Billing Instructions became Letter K.
12/01/2020	Attachment C	Added coverage for Moxifloxacin, 400mg to Approved FP Medicaid STI Medications list.
12/01/2020	Attachment C-Addendum to 11/1/2018 Entry	Remainder of Attachment C was combined with Attachment B to form Attachment B: FP Medicaid (MAFDN eligible) Billing Requirements.
12/01/2020	Attachment D	Specified pharmacy program as "Outpatient" pharmacy drug program.
12/01/2020	Attachment D-Addendum to 11/1/2018 Entry	Attachment D became Attachment C: Approved FP Medicaid STI Medications List
12/01/2020	Attachment E-Addendum to 11/1/2018 Entry	Attachment E became Attachment D: Postoperative Sterilization Medication List.
12/01/2020	Attachment F-Addendum to 11/1/2018 Entry	Attachment F was removed all together from the policy.
12/01/2020	Added beginning of Policy	Added the language "This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect."
05/01/2021	Section 3.2.1 (h)	Removed wording "or without."
05/01/2021	Section 4.2.1 (d)	Removed wording "(for emergency contraception see section 3.2.1 h)."

05/01/2021	Section 3.2.1 (b)	Added "(up to a 12-month supply)" to covered birth control pills.
05/01/2021	Attachment B, Letter E	Changed allowance of birth control pills for beneficiaries from a three-month supply to a twelve- month supply, dispensed by a pharmacy.
05/01/2021	Attachment B, Letter H	Changed allowance of birth control pills for beneficiaries from a 3-month supply to a 12-month supply, dispensed by a pharmacy.
05/01/2021	Section 3.3 (j.)	Added a comma after "Postpartum depression".
05/01/2021	Attachment A, Letter F	Made grammar corrections to include punctuation and changing the word "an" to "a" in front of "FP."
05/01/2021	Attachment B, Letter A	Made grammar corrections changing the word "an" to "a" in front of "MPW."
05/01/2021		Policy Posted 05/06/21 with an amended date of 05/01/2021
02/15/2023	Policy Throughout	Edited policy to remove the requirement for a "comprehensive annual exam" prior to providing family planning and family planning related services. Added requirement for an "annual assessment" prior to performing family planning and family planning services. Defined that an annual assessment is not required to be a comprehensive preventive medicine exam. Annual exam language changed to "comprehensive preventive medicine exam" to align with AMA CPT language. Made distinctions throughout policy between an annual assessment and a comprehensive preventive medicine exam.
02/15/2023	Section 1.0	Updated the description of service.
02/15/2023	Section 3.2	Included law for 42 CFR §441.20.
02/15/2023	Subsection 3.2.1 (c)	Added the text " Insertion of"
02/15/2023	Subsection 3.2.1 (d)	Added text "Removal of IUD's outside of the office. Local Health Department (LHD), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) setting."
02/15/2023	Subsection 3.2.1(g)	Removed specific "Nuvaring" list of contraceptive rings.
02/15/2023	Subsection 3.2.1(i)	Added Hepatitis B and Hepatitis C screening and HPV Vaccine as covered services.
02/15/2023	Subsection 3.2.1(j)	Clarified coverage of treatment for "most" STIs. Clarified reference to Attachment C is for FP Medicaid coverage.
02/15/2023	Subsection 3.2.1	Added coverage for HPV Gardasil 9 Vaccine. Added text that coverage was available for vaginal rings and patches by prescription through a pharmacy.

02/15/2023	Subsection 3.3 (d)	Combined chlamydia and gonorrhea USPSTF recommendations.
02/15/2023	Subsection 3.3 (j)	Changed text to Obesity: Offer and refer adults and adolescents with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions through their primary care or a safety net provider.
02/15/2023	Subsection 3.3(h)(i)	Added United States Preventive Services Task Force (USPSTF) Recommendations for HBV and HCV screening.
02/15/2023	Subsection 4.2.2	Removed list of service providers and edited language to "their primary care or a safety net provider" for consistency throughout policy.
02/15/2023	Subsection 4.2.2(7)	Removed HBV screening as a non-covered service.
02/15/2023	Subsection 4.2.2(8)	Added treatment for Hepatitis C as a non-covered service.
02/15/2023	Subsection 4.2.2 (b)(10)	Removal of IUD's outside of the office.
02/15/2023	Subsection 5.3(a)	Changed the language from "annual periodic examination" to "comprehensive preventive medicine examination."
02/15/2023	Subsection 5.3(b)	Added requirement for annual office visit assessment prior to rendering family planning or family planning related service.
02/15/2023	Subsection 5.3(c)	Changed wording from annual exam to annual assessment or comprehensive preventive medicine exam and clarified language for six inter-periodic visits.
02/15/2023	Section 6.3	Created section "Provider Billing" and moved note regarding 10A NCAC 22J.0106 from Section 6.0 to Section 6.3.
02/15/2023	Attachment A, Letter B1	Text was changed to Providers serving MAFDN beneficiaries must bill using a primary diagnosis of contraception. ICD-10 diagnosis codes in this table were removed so that only primary ICD-10 diagnosis codes of contraception remained.
02/15/2023	Attachment A, Letter C1	Text changed to "Providers are limited to the following services for MAFDN beneficiaries: " Added CPT codes 86704, 86706, 87340, 87516 and 87517 as covered Hepatitis B screening codes. Added CPT codes 86803, 86804, 87520, 87521 and 87522 as covered Hepatitis C screening codes. Removed CPT code 99201 as this code is end-dated by AMA. Removed infrequently used HIV procedure codes 87390, 87391, 87537, 87538, 87539, and 87806. Added HPV Gardasil 9 vaccine code 90651 and vaccine administration codes 90460 and 90471 to CPT code table.
02/15/2023	Attachment A, Letter F	Added Local Health Department (LHD) to Place of Service list.

02/15/2023	Attachment B, Letter A	Removed CPT codes in the text. Changed requirement of an annual exam prior to providing family planning and family planning related services to an annual assessment. Added annual assessment requirements and guidelines for referrals when needed for non-family planning preventive and problem services. Added recommendation that a preventive medicine exam should be offered after initial contraceptive needs are met. Added components of an Annual Assessment based on CMS and OPA recommendations guidance. Added table for annual assessment office visit codes. Removed specific CPT codes from this section.
02/15/2023	Attachment B, Letter A, a.- f.	Removed CPT codes in the policy.
02/15/2023	Attachment B, Letter B	Removed end-dated CPT code 99201 from table of inter-periodic visit codes.
02/15/2023	Attachment B, Letter D	Removed physician as allowed billing provider for pap test.
02/15/2023	Attachment B, Letter E	Clarified that "pharmacy" providers should not distribute brand name drugs when a generic is available.
02/15/2023	Attachment B, Letter F	Removed HIV screening codes that are infrequently billed. Removed text that state providers are required to report an appropriate ICD-10-CM Diagnosis code for HIV Screening and STI screening as the secondary diagnosis code on the claim." Added Hepatitis B and C screening codes and coverage criteria. Added HPV vaccine coverage criteria.
02/15/2023	Attachment B, Letter G	Guidance added that referral options should be made available for beneficiaries that do not have a primary care provider.
02/15/2023	Attachment B, Letter H	Removed the following tables: Birth Control Pills provided by a Local Health Department S4993, Diaphragm Fitting 57170; Injectable Drugs J1050, IUDs J7296, J7297, J7298, J7300, J7301, Implantable Devices J7307, Norplant Removal 11976.
02/15/2023	Attachment B, Letter I	Created new section entitled "Other Covered Screenings and Procedures" and moved table from Pharmacy Section (Letter E) to this section.
02/15/2023	Attachment B, Letter J	Language clarified for referrals due to IUD complications.
02/15/2023	Attachment B, Letter K	Added guidance that FQHC providers should bill the FP modifier on their evaluation and management procedure codes.
02/15/2023	Attachment B, Letter L	Removed referral to DSS in the event a beneficiary doesn't have family planning needs.

4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

B1. Providers serving MAFDN beneficiaries MUST bill using a primary diagnosis of contraception.

ICD-10-CM Codes	
Z30.011	Z30.42
Z30.012	Z30.430
Z30.013	Z30.431
Z30.014	Z30.432
Z30.015	Z30.433
Z30.016	Z30.44
Z30.017	Z30.45
Z30.018	Z30.46
Z30.019	Z30.49
Z30.02	Z30.8
Z30.09	Z30.9
Z30.2	Z31.61
Z30.40	Z31.69
Z30.41	

Male and female beneficiaries with FP Medicaid (MAFDN) are eligible for sterilization procedures. Refer to NC Medicaid Clinical Coverage Policy 1E-3, Sterilization Procedures for CPT codes, ICD-10 procedure codes and diagnosis codes related to sterilization procedures.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Refer to **Attachment B, Letter J** of this policy for information on FQHC and RHC billing FP Medicaid services. Additional information is located in clinical coverage policy 1D-4, *"Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics"* on NC Medicaid's website at https://medicaid.ncdhhs.gov

C1. Providers are limited to the following services for MAFDN beneficiaries:

CPT Code(s)				
00851	81015	87207	87592	93000
00921	81025	87210	87623	93010
00952	82120	87220	87624	96372
11976	84702	87270	87625	99050
11981	84703	87273	87660	99051
11982	85013	87274	87661	99053
11983	85014	87285	87798	99202
17000	85018	87320	87810	99203
36415	85027	87340	87850	99204
54050	86592	87389	88141	99205
56501	86593	87480	88142	99211
57170	86631	87490	88143	99212
58300	86632	87491	88147	99213
58301	86689	87492	88148	99214
58600	86694	87510	88150	99215
58615	86695	87516	88152	99241
58661	86696	87517	88153	99242
58670	86701	87520	88155	99243
58671	86702	87521	88164	99244
76830	86703	87522	88165	99245
76856	86704	87528	88166	99383
76857	86706	87529	88167	99384
80053	86780	87530	88174	99385
81000	86803	87534	88175	99386
81001	86804	87535	88302	99387
81002	87070	87536	89310	99393
81003	87071	87563	90460	99394
81005	87081	87590	90471	99395
81007	87110	87591	90651	99396
				99397

CPT Codes Eligible for Telehealth Services	
99211	99241
99212	99242
99213	99243
99214	99244
99215	99245

Note: Telehealth eligible services may be provided to established beneficiaries by the eligible providers listed within this policy.

HCPCS Code(s)	
J1050	J7300
J7296	J7301
J7297	J7307
J7298	S4993

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Revenue: Institutional provider(s) billing on a UB claim, shall bill one of the following revenue codes (RC). When billing revenue codes for a MAFDN beneficiary, a procedure code is required on the line item. If no procedure code is found on the line item or the procedure code is not covered under the Family Planning Services, the line item shall be denied.

Revenue Code(s)			
RC0250	RC0278	RC0312	RC0371
RC0251	RC0279	RC0314	RC0372
RC0252	RC0300	RC0319	RC0379
RC0254	RC0301	RC0320	RC0490
RC0255	RC0305	RC0324	RC0499
RC0258	RC0306	RC0329	RC0510
RC0259	RC0307	RC0360	RC0519
RC0270	RC0309	RC0361	RC0730
RC0271	RC0310	RC0369	RC0739
RC0272	RC0311	RC0370	

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Non-Telehealth Claims:

Family planning services must be billed with the appropriate code using the FP modifier.

All providers, except ambulatory surgical centers, must append modifier FP to the procedure code for family planning services.

N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.

Telehealth Claims:

Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

Family planning services must be billed with the appropriate code using the FP modifier. All providers, except ambulatory surgical centers, must append modifier FP to the procedure code for family planning services.

N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.

E. Billing Units

The provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Non-Telehealth Claims:

a. Inpatient hospitals (not applicable for a FP Medicaid beneficiary);
b. Outpatient hospital: For a FP Medicaid beneficiary, the only surgical procedure or service allowed requiring outpatient beneficiary registration is sterilization;
c. Office: utilizing offices within places of service 11 (Office), 19 (Off Campus Outpatient) or 22 (On Campus Outpatient);
d. Ambulatory Surgical Centers (applicable for a FP Medicaid beneficiary for a sterilization procedure only);
e. Federally Qualified Health Center (FQHC);
f. Rural Health Clinic (RHC); and
g. Local Health Department (LHD).

Telehealth Claims:

Telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov

Attachment B: FP Medicaid (MAFDN-eligible) Billing Requirements:

A. Annual Assessment

An annual assessment must be performed to determine a FP Medicaid beneficiary's need for services related to preventing or achieving pregnancy prior to the rendering of any other family planning and family planning-related services. Most beneficiaries need no or few examinations or laboratory tests before starting a method of contraception. Men require no physical examination or laboratory tests to receive condoms or contraceptives and reproductive health counseling. If emergent or urgent contraceptive services are needed, a beneficiary is allowed limited office visits prior to their annual assessment.

A family planning service site may be a FP Medicaid beneficiary's only source of health care; therefore, visits must consist of the provision of or referral for other non-family planning preventive or problem health services. If a client does not have another source of primary care, priority must be given to providing related reproductive health services or providing referrals, as needed. Services not covered by Family Planning Medicaid can be provided during the visit if the beneficiary is informed of the cost prior to receiving the services.

A comprehensive preventive medicine examination is encouraged and may be performed if it does not create a barrier to care. This can be offered after an assessment of a FP Medicaid beneficiary's need for services is completed and at their request. A beneficiary who has received an annual assessment or a comprehensive preventive medicine examination within 365 calendar days, prior to transitioning to FP Medicaid, has met the annual assessment requirement for FP Medicaid and is not required to receive another annual assessment.

It is the expectation that a beneficiary with Medicaid for Pregnant Women (MPW) coverage shall receive a postpartum exam by the last day of the month in which the 60th post-delivery day occurs. A MPW beneficiary who received her postpartum exam within 365 calendar days prior to enrolling in FP Medicaid shall not be required to receive another annual assessment to begin receiving services under FP Medicaid.

If the beneficiary has not received an annual assessment or a postpartum examination within 365 calendar days under Medicaid or MPW, they are required to receive an annual assessment under FP Medicaid **prior** to receiving any family planning and family planning-related services. Family planning and family planning-related services can be provided during the same visit as the annual assessment.

If it is determined, during the initial assessment, that a beneficiary doesn't have a need for family planning services and discussions concerning reproductive health, family planning **or** contraceptive use occurred during this visit, then the provider may bill for the initial assessment using diagnosis code Z30.09 (Encounter for other general counseling and advice on contraception). The beneficiary is informed they are no longer eligible for family planning or family planning related services under Family Planning Medicaid and referred to their primary care or other safety net provider for medical concerns discovered during this visit.

The Annual Assessment Date (AAD) or Comprehensive Preventive Medicine Examination Date (AED), containing a valid month, day, and year, is required to be documented on **all claims,** except for:

a. pregnancy tests; and
b. prescriptions for FDA approved and Medicaid covered contraceptive devices and supplies, post-operative medications for sterilization procedures; and additional sterilization services such as anesthesia, x-rays, electrocardiogram, and surgical pathology when provided with a sterilization procedure.

Annual Assessment Clinical Guidance

The following components of the annual assessment are documented according to Family Planning and related preventive health services guidance from the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA) recommendations.

a. Medical History;
b. Reproductive Life Plan;
c. Sexual Health Assessment;
d. Height;
e. Blood Pressure: before initiating the use of combined hormonal contraception (CHC);
f. Weight;
g. Documentation of treatment and counseling related to administration and issuance of contraceptive supplies;
h. Counseling and education, as necessary, related to pregnancy prevention and sexually transmitted diseases; and
i. Lab tests as clinically indicated (including Gonorrhea, Chlamydia screening and others).
j. In addition to the above, the following is documented, if not a barrier to care at the initial visit or at a later preventive health visit:

Females:

a. Physical Exam (including Bimanual exam and cervical inspection as clinically indicated);
b. Breast exam for beneficiaries 20 years of age and older for high-risk beneficiaries and as clinical indicated; and
c. Cervical Cytology for beneficiaries 21 years of age and older according to USPSTF recommendations.

Males:

Genital Exam (if clinically indicated)

Annual Assessment Office Visit Codes	
99202	99212
99203	99213
99204	99214
99205	99215

One (1) comprehensive preventive medicine examination is allowed per 365 calendar days.

Comprehensive Preventive Medicine Examination Codes	
99383	99393
99384	99394
99385	99395
99386	99396
99387	99397

If during an annual assessment or comprehensive preventive medicine exam, the beneficiary requests one of the following services, the provider may bill for the annual assessment or comprehensive preventative medicine exam with the applicable CPT code listed:

a. an IUD insertion;
b. an IUD removal;
c. insertion, non-biodegradable drug delivery implant;
d. removal, non-biodegradable drug delivery implant;
e. removal with reinsertion, non-biodegradable drug delivery implant;
f. diaphragm or cervical cap fitting with instructions; or
g. an IUD insertion if, during the annual visit, the beneficiary decides to switch from using birth control pills.

The provider may bill for the annual assessment or comprehensive preventive medicine exam with the appropriate evaluation and management procedure code. An appropriate modifier must be submitted with the annual assessment or exam procedure code, indicating that the service rendered was a **separately identifiable service provided by the same provider on the same day of service**. The providers documentation must support that the service rendered was a separately identifiable service.

The providers shall not bill a separate inter-periodic office visit for the following procedure codes: 58300, 58301, 57170, 11981, 11982 and 11983. An office visit component is already included in the reimbursement for these CPT procedure codes.

B. Inter-Periodic Visits

Six (6) inter-periodic visits are allowed per 365 calendar days. Each in-person or telehealth encounter will count as one of a beneficiary's allotted six inter-periodic visits, per 365 days.

The purpose of inter-periodic visit is:

a. to evaluate the beneficiary's contraceptive needs;
b. to renew or change the contraceptive prescription;
c. STI screening and treatment;
d. HIV screening; and
e. to provide additional opportunities for counseling as follow-up to the annual assessment or comprehensive preventive medicine examination.

Inter-Periodic Visit	
99202	99211
99203	99212
99204	99213
99205	99214
	99215

C. Office "Special Services: After Hours" Visits

Refer to Clinical Coverage Policy *1A-38, Special Services: After Hours*, for guidelines related to Office "after hours" visits on the NC Medicaid website at https://medicaid.ncdhhs.gov

When billing after-office hours services, providers are required to report an office visit CPT code along with an after-office hours CPT code (99211+99050 =1 visit). An FP modifier must be appended to both the office visit code and the after-office code.

After-office codes are not allowed when the service is provided in a hospital emergency room or emergency department services (Refer to Sub section 4.2.2 (b) of this policy).

Office After-Hours Visit
99050
99051
99053

D. Laboratory Tests

The following laboratory tests are **only allowable for FP Medicaid when performed "in conjunction with" an annual assessment or comprehensive preventive medicine examination**. For the purpose of FP Medicaid "in conjunction with" has been defined as the day of the annual assessment or comprehensive preventive medicine exam or within 30 calendar days after this annual exam.

a. Urinalysis; and
b. blood count.

Providers are allowed one urinalysis and one blood count procedure code per 365 calendar days in conjunction with an annual assessment or comprehensive preventive medicine examination.

Urinalysis	
81000	81003
81001	81005
81002	81007
81003	81015
Blood Count	
85013	85018
85014	85027

Clinical Laboratory Improvement Amendments (CLIA) certified laboratories are allowed to bill for one pap test procedure per 365 calendar days during an annual assessment, comprehensive preventive medicine examination or any of the six inter-periodic visits allowed under

FP Medicaid. **One repeat pap test is allowed due to insufficient cells.** Provider(s) shall perform the repeat pap test within 180 calendar days of the first pap test.

Pap Test	
88141	88155
88142	88164
88143	88165
88147	88166
88148	88167
88150	88174
88152	88175
88153	

Pregnancy tests, sexually transmitted infection (STI), and HIV screening can be performed during an annual assessment, comprehensive preventive medicine examination or any of the six inter-periodic visits allowed under the program.

Pregnancy Tests
81025
84702
84703

Providers are allowed to bill one Comprehensive Metabolic Panel every six months in conjunction with an annual assessment or comprehensive preventive medicine examination or one of the six inter-periodic visits as indicated prior to prescribing oral contraceptives or for HIV prophylactic medications.

Comprehensive Metabolic Panel
80053

Note: Providers billing for a venipuncture should follow guidelines outlined in Clinical Policy *1S-3 Laboratory Services*. Medicaid shall allow venipuncture specimen collection to the provider who extracted the specimen only when it is sent to an independent laboratory for testing and no testing is done in the office.

E. Pharmacy

For a complete list of approved antibiotics and pain medications for FP Medicaid beneficiaries, refer to **Attachment C**.

a. FDA approved and Medicaid-covered pharmaceutical supplies and devices, consisting of oral contraceptive pills, intrauterine devices, implantable contraceptive devices, contraceptive patches, contraceptive rings, emergency contraception and contraceptive injections are covered under FP Medicaid if provided for family planning purposes and provided through a pharmacy. The AED or AAD is not required on claims for approved contraceptive supplies and devices.

b. **There is a six-prescription limit per month with no override capability for FP Medicaid prescriptions.** Pharmacy providers shall not distribute "brand medically necessary" dispense as written (DAW1) drugs if a generic is available. All claims must be submitted via Point of Sale (POS) and must include the approved ICD-10-CM diagnosis code.

c. A beneficiary can receive up to a twelve-month supply of birth control pills. FDA approved contraceptive supplies and devices may also be obtained through a pharmacy for FP Medicaid.

d. All approved antibiotic treatment and pain medications must have the appropriate ICD-10-CM diagnosis written on the prescription.

F. HIV, Hepatitis B and Hepatitis C Screening and STI Prevention, Screening and Treatment

HIV, Hepatitis B, Hepatitis C, and other STI screenings can be performed during the annual assessment, comprehensive preventive medicine examination or any of the six inter-periodic visits allowed under the program, after an annual assessment or comprehensive medicine exam has been performed. (Medical treatment for HIV, Hepatitis B and Hepatitis C is not covered by Family Planning Medicaid).

F1 HIV Screening

FP Medicaid allows screening for HIV during the annual assessment, comprehensive preventive medicine examination or the six inter-periodic visits allowed under the FP Medicaid program.

A beneficiary who meets enrollment requirements for the Ready, Set, PrEP (Pre-Exposure Prophylaxis) program can be referred to participating drug stores, LHDs, an FQHC or other participating clinical practices for interventions in HIV by prophylactic prescription medication.

HIV Screening	
86689	87534
86701	87535
86702	87536
86703	
87389	

F2 Hepatitis B and Hepatitis C Screening

FP Medicaid allows screening for Hepatitis B and Hepatitis C during either the annual assessment, comprehensive preventive medicine examination or one of the six inter-periodic visits allowed under the FP Medicaid program.

Hepatitis B Screening
86704
86706
87340
87516
87517

Hepatitis C Screening
86803
86804
87520
87521
87522

F3 STI Prevention

FP Medicaid allows HPV vaccine during an annual assessment or comprehensive preventive medicine examination. Beneficiaries who did not get vaccinated when they were younger should get vaccinated when possible. Gardasil 9 can be administered to male and female beneficiaries through age 45 years.

CPT code 90651 should be used for Gardasil 9. Professional claims for vaccines must now include correct NDC numbers that correspond to the vaccine administered. Providers may bill vaccine administration CPT codes 90460 for beneficiaries through 18 years of age when the physician or qualified health care professional provides face-to-face counseling during the administration of the vaccine. Providers may bill CPT code 90471 for vaccine administration that is not accompanied by face-to-face physician or qualified health care professional counseling or for the administration of the vaccine to beneficiaries over 18 years of age.

ICD 10 CM diagnosis code Z23 (Encounter for immunization) should be billed on the claim for the HPV vaccine.

F4 STI Screening, Diagnostic Testing and Treatment

FP Medicaid allows STI screenings during the annual assessment, comprehensive preventive medicine examination or the six inter-periodic visits.

FP Medicaid allows a total of six courses of STI antibiotic treatments from the approved list identified in this policy per 365 calendar days. All approved antibiotics must have the appropriate ICD-10-CM on the prescription. The AED or AAD is not required on STI prescriptions.

Other STI Screening CPT codes:

Gonorrhea	
87590	87592
87591	87850

Syphilis
86592
86593

General STI Screening
87081
87210

Chlamydia	
86631	87490
86632	87491
87110	87492
87270	87810
87320	

Herpes	
86694	87274
86695	87528
86696	87529
87207	87530
87273	

Trichomonas Vaginalis
87210
87660
87661

Treponema
86780
87285

Papillomavirus
87623
87624
87625

Bacterial Vaginosis (Gardnerella and Candida)
87210
87480
87510
82120

Scabies
87220
Miscellaneous
87798

F5 Mycoplasma Genitalium Diagnostic Testing

FP Medicaid allows Mycoplasma Genitalium diagnostic testing for diagnoses of urethritis, cervicitis, and Pelvic Inflammatory Disease (PID) during the annual assessment, comprehensive preventive medicine exam or the six inter-periodic visits allowed per 365 days. Providers are required to report an appropriate ICD-10-CM Diagnosis code on the claim.

Mycoplasma Genitalium
87563

G. Sterilization

Beneficiaries with FP Medicaid are eligible for sterilization procedures. Refer to Clinical Policy *1E-3, Sterilization Procedures* on the NC Medicaid website at https://medicaid.ncdhhs.gov for requirements related to sterilization procedures. Once a beneficiary with FP Medicaid has had a permanent sterilization procedure and the necessary post-surgical follow-up has occurred, the beneficiary is no

longer eligible for FP Medicaid program services. If the beneficiary has no need for family planning services, but requires further medical care, the provider shall refer the beneficiary to their primary care or a safety net provider. If the beneficiary does not have a primary care provider, available options are provided.

H. Contraceptive Services, Supplies and Devices

Medicaid covered oral contraceptive pills, intrauterine devices, implantable contraceptive devices, contraceptive patches, contraceptive rings, emergency contraception and contraceptive injections are covered under the FP Medicaid program **if provided for family planning purposes.**

There is no co-payment for beneficiaries in the Family Planning program for Medicaid-covered contraceptive supplies and devices.

All eligible drugs for Family Planning have a family planning indicator on the drug file (including birth control pills, Depo-Provera, contraceptive patches, vaginal contraceptive rings). The dispensing fee is based on traditional Medicaid rules. **There is a six-prescription limit per month with no override capability.** Pharmacy providers shall not distribute "brand medically necessary" (DAW1 (dispense as written)) drugs if a generic is available. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-10-CM code.

Post-operative medications are covered for sterilization procedures. All approved post-operative medications must have the appropriate **ICD-10-CM Diagnosis for sterilization** on the prescription.

The AED or AAD is not required on FP Medicaid program prescriptions.

Emergency Contraceptives

Emergency contraceptives are a covered service. The appropriate office visit code may be billed separately.

Birth Control Pills
Birth control pills may be dispensed through a pharmacy.
A beneficiary may receive up to a 12-month supply.

I. Other Covered Screenings and Procedures

Other Screenings or Procedures	
17000	87071
54050	93000
56501	93010
87070	96372

J. Ultrasounds

During the annual assessment, comprehensive preventive medicine exam or inter-periodic visit, if the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing, providers may check IUD placement by performing an ultrasound. Health record documentation must indicate the reason that the ultrasound was performed. Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion. If it is confirmed by ultrasound that an IUD has been expelled, providers may reinsert a replacement IUD without any waiting period.

If it is determined that additional medical care is necessary due to an IUD complication, the provider shall refer the MAFDN eligible beneficiary to the clinician who can best treat the beneficiary in the following facilities: primary care clinic, local health department, federally qualified health center, community health center, or rural health clinic.

K. FQHC and RHC Billing Instructions for Family Planning Medicaid Beneficiaries

a. All FQHC/RHC providers must bill using the non-core taxonomy qualifier.
b. All FQHC/RHC providers must bill using the UD modifier when billing for 340b purchased drugs.
c. The core service code T1015 is not allowed with Family Planning program services. Evaluation and Management and Preventive Service CPT codes as specified in this policy should be billed with the FP modifier.
d. All FQHC's and RHC's must adhere to all applicable North Carolina Medicaid policies and procedures for the Family Planning program.

Note: Family Planning services other than those provided to (MAFDN) beneficiaries or those specifically listed as non-core are billed as core service.

L. Miscellaneous Instructions

a. If a provider discovers that a beneficiary is pregnant, the provider shall refer the beneficiary to the local Department of Social Services (DSS) to determine eligibility that may be available to the beneficiary.
b. Provider(s) shall include the AED or AAD on all claims for an annual assessment or comprehensive preventive medicine examination and on claims for laboratory procedures, except for the pregnancy test.
c. An ICD-10-CM diagnosis code related to family planning services must be the primary diagnosis on the claim forms.

Attachment C: Approved FP Medicaid STI Medications List

Medications for the FP Medicaid program are only provided by a prescription through the pharmacy drug program. However, birth control pills can be provided in a Local Health Department. **All prescriptions for STI medications must document the appropriate ICD-10-CM code.**

For additional information regarding Sexually Transmitted Diseases (STDs), refer to the Center for Disease Control and Prevention website at https://www.cdc.gov/std

FP Medicaid approved medications	
STI Diagnosis	
Herpes	Acyclovir 200mg, 400mg, 800 mg Famciclovir 125mg, 250mg, 500mg Valacyclovir 500mg, 1.0gm
Chlamydia	Azithromycin, 250mg, 500mg, 1gm Doxycycline 100mg Erythromycin 250mg, 400mg, 500mg, 800mg Ofloxacin 200mg, 300mg, 400mg Levofloxacin 500mg Tetracycline 250mg, 500mg
Syphilis	Azithromycin 1gm Benzathine penicillin G 2.4 million units Ceftriaxone 250mg Ciprofloxacin 500mg Doxycycline 100mg Erythromycin 500mg Tetracycline 500mg
Gonorrhea	Azithromycin 250mg, 500mg, 1gm Cefixime 400mg Ceftriaxone 125 mg, 250mg, 500mg Cefotaxime 500mg Cefoxitin 2gm with probenecid 1gm Ciprofloxacin 250mg, 500mg Cefpodoxime 200 mg Doxycycline 100 mg Gatifloxacin 400mg Levofloxacin 250mg Ofloxacin 400mg Sulfamethoxazole/TMP Gentamicin 240mg IM

Other Sexually Transmitted Infections	Azithromycin 250mg, 500mg, 1gm Doxycycline 100mg Erythromycin 500mg, 800mg Gatifloxacin 400mg Levofloxacin 250mg, 500mg Ofloxacin 200mg, 300mg, 400mg Moxifloxacin 400 mg
Candidiasis	Butoconazole 2% cream Fluconazole 50mg, 100mg, 150mg, 200mg Miconazole 200mg suppository Terconazole 80mg suppository Terconazole cream 0.4%, 0.8%
Trichomoniasis	Metronidazole 250mg, 500mg, 750mg, 2gm Tinidazole 2000mg
Bacterial vaginosis	Metronidazole 250mg, 500mg Metronidazole gel 0.75% Clindamycin cream 2% Clindamycin oral 150mg, 300mg Clindamycin ovules 100mg Tinidazole 2gm, 1 gm, 500mg, 250mg
Pubic Louse	Permethrin 5% cream Lindane 1% shampoo

Attachment D: Postoperative Sterilization Medication List

Medications for sterilization procedures for the FP Medicaid program are provided by prescription through the Outpatient Pharmacy drug program. **All prescriptions for postoperative sterilization medications must contain a sterilization diagnosis.**

Sterilization Procedure (vasectomy and tubal ligation)
Antibiotics for sterilization procedures
Amox TR-K CLV 500-125mg, 1000-62.5 Amoxicillin 250mg, 500mg Cephalexin 250mg, 500mg Ciprofloxacin HCL 250mg, 500mg Doxycycline 100mg Erythromycin ES 400mg Levofloxacin 500mg Metronidazole 500mg Penicillin VK 500mg Sulfamethoxazole/TMP DS Azithromax 250mg
Analgesics for sterilization procedures
Acetaminophen/Cod #2, #3 Hydrocodone/apap-5/325, 5/500, 7.5/325, 7.5/500, 7.5/650, 7.5/750, 10/325, 10/500, 10/650, 10/660, 10/750 Hydrocodone/IBU 2.5/200, 5/200, 7.5/200, 10/200 Ibuprofen 400mg, 600mg, 800mg Ketorolac 10mg Naproxen 500mg Naproxen Sodium 550mg Oxycodone 5mg Oxycodone w/apap 2.5/325, 5/325, 5/325, 7.5/325, 7.5/500, 10/325, 10/650
Antiemetic for sterilization procedures
Promethazine 25mg