

CODING & BILLING GUIDANCE DOCUMENT REVIEW

Family Planning

This webinar content will follow the Coding & Billing Guidance Document, version 6 September 2017, pages 60-84, in addition to resources provided by the WHB-Family Planning Section and DMA Clinical Coverage Policies.

Annual Exam Date (AED)

- N.C. Division of Medical Assistance (DMA) requires that the Annual Exam Date (AED) be placed in the “initial treatment date” area on the claim form for the initial annual exam and accompanying laboratory procedures and all inter-periodic visits, except pregnancy tests.
- DMA is now allowing beneficiaries, transitioning to the “Be Smart” program from other Medicaid programs, to use the comprehensive annual, physical or postpartum exams received under these programs to meet the “Be Smart” AED requirement

Annual/Inter-Periodic exam and IUD

- **Annual exam & IUD:** If during an annual exam, the beneficiary requests an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), or during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and the IUD insertion or IUD removal. An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

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Annual/Inter-Periodic exam and IUD

Inter-Periodic Visit & IUD: If the only reason that the beneficiary is seen in the office is to request an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), providers should not bill a separate inter-periodic office visit. An office visit component is included in the reimbursement for CPT procedure codes 58300 and 58301.

Family Planning & STD services

Q- if a patient comes in for STD treatment (to STD clinic) and then is seen for depo shot and patient is FPW how should that be billed since you have use the 99211.

A#1 – The agency renders and documents the STD treatment within the STD program. There is no charge to the patient, and Be Smart cannot be billed for STD program encounters. The agency renders and documents the contraceptive injection (Depo) services within the Family Planning program. The agency bills Be Smart for these Family Planning program services, including a 99211, if applicable.

A#2 – The agency renders and documents both the STD treatment and the contraceptive injection (Depo) services within the Family Planning program. The agency bills Be Smart for these Family Planning services, including a 99211, if applicable.

340B stock Emergency Contraception

- 340B stock Emergency Contraception may only be prescribed/dispensed/ administered via the Family Planning clinic.

and

- If it is appropriate to offer Emergency Contraception, then a Family Planning encounter must be opened before prescribing/ dispensing/administering the Emergency Contraception from 340B stock.

Billing scenario for client with insurance and Medicaid with device purchased with 340b funds

- Jane has both BCBS and Medicaid. Her family planning appointment includes an IUD that costs \$300 at 340B/acquisition cost. That same IUD costs \$600 at the usual and customary cost. The agency bills BCBS \$600, and BCBS reimburses the agency \$200. The agency then bills Medicaid \$100 in the hopes of being reimbursed for \$300 total – the 340B acquisition cost.
- Advice is that it's okay to bill Medicaid the remainder of the 340B/acquisition cost if private insurance reimburses an amount that's less than the 340B/acquisition cost.
- If, however, the device was **purchased privately (NOT via 340B pricing)**, you would bill Medicaid the \$400.00 difference between the billed price (**\$600**) and what BCBS paid (**\$200**).

Billing for client with Insurance with device purchased with 340b funds

Q: If an agency has a client with commercial insurance, and the agency is not contracted with that commercial insurance but bills for a device, and the reimbursement is less than the fee, what happens to the rest of the charge?

Billing for client with Insurance with device purchased with 340b funds

A: The agency may set two fees for Family Planning devices/medications:

1. The 340B/acquisition fee, which is also the fee billed to Medicaid. This is the lower of the two allowable fees.
 2. The usual and customary fee. This is the higher of the two allowable fees.
- The fee for Medicaid-insured clients must be set at the acquisition cost.
 - The fee for uninsured, self-pay clients may be set EITHER at the acquisition cost or at the usual and customary fee.
 - The fee for commercially-insured clients may be set at EITHER the acquisition cost or at the usual and customary fee.

Billing Scenario 1 (Insurance & IUD)

- The agency decides to set the two fees for Family Planning devices/medications and to charge commercially-insured clients the usual and customary fees. Client Beth has BCBS, and comes to the agency's family planning clinic requesting an IUD. Beth is informed that her visit may cost less with an in-network provider, since the agency is not contracted with BCBS. Beth makes an informed decision to be seen at the agency. The provider inserts a Liletta IUD. The agency purchased the Liletta IUD at the \$50 340B/acquisition fee. The agency bills BCBS their usual and customary Liletta IUD fee of \$600. BCBS reimburses the agency \$300. The agency then bills Beth the remaining \$300 on the SFS. Since Beth falls at 20% on the SFS, her charge for the Liletta device is \$60.

Pro = Agency receives higher reimbursement from commercial insurance

Con = Client is charged higher fee

Billing Scenario 2 (Insurance & IUD)

- The agency decides to only set one fee for Family Planning devices/medications – the 340B/acquisition fee. Client Beth has BCBS, and comes to the agency's family planning clinic requesting an IUD. The provider inserts a Liletta IUD. The agency bills BCBS the \$50 340B/acquisition fee for Liletta. BCBS reimburses the agency \$25. The agency then bills Beth the remaining \$25 on the SFS. Since Beth falls at 20% on the SFS, her charge for the Liletta device is \$5.

Pro = Client is charged lower fee

Con = Agency receives lower reimbursement from commercial insurance

New Code for Kyleena

- We have received clarification, and want to share that, while regular Medicaid does cover the Kyleena IUD, Be Smart does not cover the Kyleena IUD at this time. Because there are other similar, less expensive devices available, Kyleena has not been included on the current BeSmart formulary.
- When billing DMA for Kyleena devices inserted for regular Medicaid recipients, please use **HCPCS code Q9984**. J3490 was discontinued for Kyleena effective July 1, 2017.

Billing Depo with an E&M/Preventive visit

- It is permissible to bill 96372 (injection fee) for contraceptive injections (Depo) with an ***E&M visit code*** (99212-99215) or with a ***preventive visit code*** when:
 - 1) a provider or an RN is onsite, **and**
 - 2) the RN clearly documents that he/she administered the injection.
A-25 modifier is required, and should be appended to the office visit code.

Additional Depo Billing information

- For *nurse-only visits* at which patients receive Depo injections, agencies may opt to bill in one of the following two ways for regular Medicaid, Be Smart Family Planning Medicaid, self-pay and commercial insurance:
 - Bill a 99211 FP and a J1050 FP UD
 - *Note: the FP modifier is not needed with 99211 for self-pay patients.*
 - Bill a 96372 FP and a J1050 FP UD
 - For patients with Be Smart Family Planning Medicaid:
 - Please note that when billing 96372 it **does not** count toward the patient's annual limit of six inter-periodic office visits, while 99211 **does** count toward this limit.
 - In deciding how your agency will bill, please be aware of the different reimbursement rates for 99211 (\$34.16) and 96372 (\$17.04).

New guidance on billing for STI services in Family Planning

- If an established Family Planning patient needs an appointment for STI testing or treatment, the agency may see the patient in the Family Planning clinic and bill the respective payer source, including Be Smart Family Planning Medicaid.

New guidance on billing for STI services in Family Planning

- Previous guidance was to see the patient in STD/Adult Health instead of in Family Planning, especially if the patient was using the Depo injection for contraception. However, since updated Be Smart Family Planning Medicaid guidance states that agencies may opt to bill 96372 instead of 99211 for Depo injections without depleting one of the six inter-periodic visits, there is no longer significant concern about depleting inter-periodic visits by seeing these patients in Family Planning for STI testing/treatment.

General Billing Information

- Sliding Fee Scale 101-250% must be used for all Family Planning services (except Medicaid)
- Family planning diagnosis (DX) codes Z30.0 –Z30.9 (except Z30.8) must be the 1st Dx for all Medicaid clients when family planning services are provided (except postpartum exams); you may use Z01.41 Gynecological exam for private insurance.
- If a local health department has not been approved to offer pregnancy testing under “Other Services” using a flat fee, and if they offer pregnancy testing in General Clinic and/or Family Planning clinic, then they must offer pregnancy testing on the Sliding Fee Scale

General Billing Information

For Family Planning clients you may only charge the client for services provided.

You may not charge for:

- Returned check fees
- Credit Card fees
- Late charges

