Family Planning Services

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. FAMILY PLANNING CLINICS ELIGIBLE TO PARTICIPATE

Family planning clinics that are under the oversight and monitored by a state or federal family planning program and are under the direction of a physician are eligible to participate in the Medicaid program.

B. COVERAGE OF SERVICES

Covered services include counseling, medical examinations, laboratory tests, and drugs and supplies furnished by the clinic in connection with family planning. Family planning services include the following:

- Examination and tests which are necessary before prescribing family planning services.
- Contraceptive services. (Sterilization procedures must meet the informed consent requirements as outlined in this manual.)
- Supplies for family planning, including such items as an intrauterine device (IUD), implant, or a basal thermometer.
- Family planning related services are also covered. Family planning related services include the following:
  - Drugs and follow-up visits for the treatment of sexually transmitted infections when the STI is identified during a routine family planning visit.
  - Drugs and follow-up visits for the treatment of lower genital tract and genital skin infections when the infection is identified during a routine family planning visit.
  - Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to a family planning service such as vaccinations to prevent cervical cancer.

1. 340B Drugs

Any provider filling prescriptions for Medicaid members with drugs acquired through the 340B Program are required to bill Medicaid their actual acquisition cost (AAC) plus the dispensing fee.

If the Medicaid carve-out option is chosen, drugs shall be billed in accordance with existing state Medicaid reimbursement methodologies, allowing rebates to be collected. 42 USC 256b(a)(5)(A)(i) prohibits duplicate discounts; that is, manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. This is reviewed through a post-payment review. Overbillings are subject to recoupment.

a. Using the UD Modifier

340B providers must use the "UD" modifier for any separately reportable and payable physician-administered drugs billed with "J" codes.

- For providers billing through a CMS-1500 claim form, indicate the modifier in box 24D.
- For providers billing through a UB-04 claim form, indicate the modifier in box 44.

NOTE: The "UD" modifier should only be used for "J" code drugs actually acquired through the 340B discount program. It should **not** be used for any "J" code drugs acquired through other non-340B sources. The J code should be submitted with the actual 340B cost of the drug and should not include a dispensing fee.

Provisions of the information described above will enable the IME to assure that rebates are not improperly claimed for 340B drugs. As with all aspects of the Medicaid program, please be aware that compliance with this requirement is subject to IME review. Providers who fail to attest to their status in this regard may face penalties or sanctions related to any such non-compliance.

For questions, please contact IME Provider Services at (800) 338-7909, or locally in Des Moines at (515) 256-4609, or by email at imeproviderservices@dhs.state.ia.us.

b. Adjustments to 340B Claims

Manufacturers periodically adjust Average Manufacturer Price (AMP) and Best Price (BP) values previously submitted to the Centers for Medicare and Medicaid Services (CMS) for certain quarters for specific products. In connection with that recalculation, the manufacturer also recalculates the 340B ceiling prices for the affected products for the associated quarters.

Based on these recalculations, the manufacturer communicates with and issues refunds to 340B Covered Entities (CEs) where the data demonstrates a difference between the original and recalculated 340B ceiling prices paid during impacted quarters by such CEs for the impacted products.

Providers are required to adjust their 340B claims submitted to Medicaid to reflect any price reductions received through this process. Claims are considered overpaid if the cost of the 340B drug is reduced after Medicaid makes payment for the 340B drug. Pursuant to 441 IAC 79.2(10), providers are required to return an overpayment within 60 days of identification of the overpayment.

2. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

3. Sterilizations

Federal regulations provide that payment shall not be made through the Medicaid program for sterilization of a member under the age of 21 at the time of consent or who is legally mentally incompetent or institutionalized.

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual incapable of reproducing and which is not:

- A necessary part of the treatment of an existing illness; or
- Medically indicated as an accompaniment to an operation of the genital urinary tract.

For purpose of this definition, mental illness or intellectual disability is not considered an illness or injury.

A "legally mentally incompetent" person is one who has been declared mentally incompetent by a federal, state or local court for any purpose, unless the court declares the person competent for purposes which include the ability to consent to sterilization.

An "institutionalized" person is a person who is:

- Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- Confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

The same revision of federal regulations provide that payment may be made through the Medicaid program for the sterilization of a member aged 21 or over when the consent form is signed, who is mentally competent and not institutionalized in accordance with the above definitions under certain conditions.

a. Requirements

The following conditions must be met:

- The member to be sterilized must voluntarily request the services.
- The member to be sterilized must be advised that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing the member's future care or loss of other project or program benefits to which the member might otherwise be entitled.
- The member to be sterilized must be given an explanation of the procedures to be performed by a knowledgeable informant upon which the member can base the consent for sterilization. An "informed consent" is required.

  "Informed consent" means the voluntary knowing assent from the member on whom the sterilization is to be performed after the member has been given a complete explanation of what is involved and has signed a written document to that effect.

  If the member is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The member to be sterilized may be accompanied by a witness of the member's choice.

The informed consent shall not be obtained while the member to be sterilized is:

- In labor or childbirth,
- Seeking to obtain or obtaining an abortion, or
- Under the influence of alcohol or other substance that affects the member's state of awareness.

The elements of explanation which must be provided are:

- A thorough explanation of the procedures to be followed and the benefits to be expected.
- A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- Counseling concerning alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure.
- An offer to answer any questions concerning the proposed procedure.

The member must give "informed consent" at least 30 days, but not more than 180 days, before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs.

For an exception to be approved when emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent was obtained.

For an exception to be approved when a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained. Documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed.

b. Consent for Sterilization, Form 470-0835 or 470-0835S

The "informed consent" shall be obtained on form 470-0835, *Consent for Sterilization*, or the Spanish version, form 470-0835S, *Formularo de Consentimiento Requerido*. The individual must be 21 years of age or older at the time of consent. An equivalent Medicaid form from another state is acceptable.

Click here to view the English consent form online.

Click here to view the Spanish consent form online.

Consent forms may be requested by contacting IME Provider Services at (800) 338-7909 or locally in Des Moines at (515) 256-4609. To request forms by mail, complete the *Iowa Medicaid Provider Form Request*, form 470-4166, and send to the following address:

Iowa Medicaid Enterprise
Form Requests
PO Box 36450
Des Moines, IA 50315

Click here to view the form online.

The physician's copy of the consent must be completely executed in all aspects (no substitute form is accepted) according to the above directions and attached to the claim in order to receive payment.

When a claim for physician's services for sterilization is denied either due to the failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided, or failure to use the official consent form, 470-0835 or 470-0835S, any claim submitted by the ambulatory surgical center, hospital, anesthesiologists, assistant surgeon, or associated providers for the same operation or procedure will also be denied.

It is the responsibility of the ambulatory surgical center, hospital, and other providers associated with the sterilization services to obtain a photocopy of the completed consent form which must be attached to their claim when submitted to the IME for payment.

All names, signatures, and dates on the consent form must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:

- The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the member to be sterilized.
- The information requested pertaining to race ethnicity designation is to be supplied voluntarily on the part of the member, but is not required.

It is the responsibility of the provider obtaining the consent form to verify that the member requesting the sterilization is at least 21 years of age on the date that the member signs the form. If there is any question pertaining to the true age of the patient, the patient's birthdate must be verified.

The "Statement of Person Obtaining Consent" may be completed by any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control which are available to the member.

The "Physician's Statement" must be completed fully and signed by the **physician performing the sterilization** and dated when signed. It is important that one of the paragraphs at the bottom of this statement which is not used, be crossed out as per instructions.

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization for which a claim will be submitted; i.e., ambulatory surgical center, hospital, anesthetist, assistant surgeons, etc.

It is the responsibility of all other providers associated with the sterilization to obtain a photocopy of the fully completed consent form from the physician performing the sterilization, to be attached to the provider claim which is submitted to Iowa Medicaid Enterprise for payment.

The only signatures which should be on the completed consent form are those of the member, interpreter (if interpreter services were provided), the provider obtaining the consent form, and the physician performing the sterilization.

C. BASIS OF PAYMENT

Payment for services rendered by family planning services is based on a fee schedule. The fee schedule amount is the maximum payment allowed.

Click here to view the fee schedule for Family Planning Services.

D. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes are divided into three levels. Level 1 is the current CPT-4 codes. Levels 2 and 3 are specifically designed regional and local codes (five-digit codes beginning with alphabetical characters A or B). Level 3 also includes codes beginning with alphabetical characters from W-Z (local).

Providers who do not have Internet access can obtain a copy upon request from the Iowa Medicaid Enterprise (IME).

It is the provider's responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

Immunizations

Providers must provide immunizations under the Vaccines for Children Program (VFC). When a member receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement. Click here to be redirected to the VFC website, or call (800) 831-6293.

For VFC vaccine, the charges in box 24F should be "0" for the vaccine. Charge the usual and customary charge for the administration of the vaccine.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Family Planning Services are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf.