Washington State Health Care Authority

Washington Apple Health (Medicaid)

Family Planning Billing Guide

Including:

Reproductive Health Services and Family Planning Only program

January 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effect **January 1, 2025**, and supersedes earlier billing guides to this program.

This billing guide includes billing information for the following programs:

- Reproductive Health Services
- Family Planning Only

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

Refer also to HCA's ProviderOne Billing and Resource Guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

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[1] This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
What reproductive health services are covered? What services are covered under the Family Planning Only program? Coverage table – Social determinants of health risk screening	Added a social determinants of health risk screening during qualifying visits	Policy change. Beginning January 1, 2025, HCA pays for a social determinants of health risk screening during specific, qualifying visits. (This change arises from section 211(103)(b), chapter 376, Laws of 2024 (ESSB 5950).)
Contraceptives coverage table - Prescription contraceptives - Pills, Ring, and Patch	For HCPCS codes J7295 (monthly contraceptive ring) and J7304 (contraceptive hormone patch), added additional billing instructions regarding the use of two separate service lines	Not a policy change. The purpose of the additional, clarifying billing instruction is to prevent claim denials for continuous use contraceptive rings and patches.

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Resources Available

Topic	Resource
Information about reproductive health services and the Family Planning Only program	Contact the Billers, providers, and partners "Contact us" webpage. Contact the Family Planning Program at: hcafamilyplanning@hca.wa.gov.
For additional billing guidance	See the ProviderOne Billing and Resource Guide and the following billing guides: • Outpatient Hospital Billing Guide • Physician-Related/Professional Services Billing Guide • Professional Administered Drugs Fee Schedule
Family Planning Only application form, HCA 13-781 (8/20) (for clients)	See Where can I download HCA forms?
Information about sterilization	See HCA's Sterilization Supplement Billing Guide and WAC 182-531-1550.
Pharmacy information	See HCA's Pharmacy Information and the Prescription Drug Program Billing Guide.
Additional HCA resources	See HCA's Billers, providers, and partners webpage or contact Medical Assistance Customer Service Center

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

340B dispensing fee – HCA'S established fee paid to a registered and Medicaid-participating 340B drug program provider under the public health service (PHS) act for expenses involved in acquiring, storing, and dispensing prescription drugs or drug-containing devices (see WAC 182-530-7900). A dispensing fee is not paid for nondrug items, devices, or supplies (see WAC 182-530-7050).

Applicant – A person applying for Family Planning Only services.

Comprehensive preventive family planning visit – A comprehensive, preventive, contraceptive visit that includes evaluation and management of an individual, such as: age-appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and laboratory and diagnostic procedures that are covered under the client's respective HCA program.

Contraception – Prevention of pregnancy using contraceptive methods.

Contraceptive – Food and Drug Administration (FDA)-approved prescription and nonprescription methods, including devices, drugs, products, methods, or surgical interventions used to prevent pregnancy, as described in WAC 182-530-2000.

Family planning clinic – A clinic that is designated by HCA to provide family planning services to eligible people as described in this guide. Other types of providers may offer family planning services within their scope of practice.

Family Planning Only program - The program that covers family planning only services for eligible clients for 12 months from the date HCA determines eligibility.

Family planning services – Medically safe and effective medical care, educational services, and contraceptives that enable individuals to plan and space the number of children they have and avoid unintended pregnancies.

Informed consent – When an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the client's diagnosis
- Offered the client an opportunity to ask questions about the procedure and request information in writing
- Given the client a copy of the consent form
- Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257

- Given the client oral information about all the following:
    - The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure
    - Alternatives to the procedure including potential risks, benefits, and consequences
    - The procedure itself, including potential risks, benefits, and consequences

(WAC 182-531-0050)

Natural family planning (also known as fertility awareness method) – Methods to identify the fertile days of the menstrual cycle and avoid unintended pregnancies, such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle.

Over-the-counter (OTC) – Drugs, devices, and products that do not require a prescription to be sold or dispensed (see WAC 182-531-0050).

Public Health Service Act (PHS) – The federal act governing the 340B program administered through the Office of Pharmacy Affairs. Per Washington Administrative Code (WAC), any drugs or items purchased, dispensed, or administered by a PHS-qualified covered entity participating in the 340B program must be billed at the actual acquisition cost (see WAC 182-530-7900).

Reproductive health - The prevention and treatment of illness, disease, and disability related to the function of reproductive systems during all stages of life, and includes:

- Related, appropriate, and medically necessary care
- Education of clients in medically safe and effective methods of family planning
- Pregnancy and reproductive health care

Reproductive health care services - Any medical services or treatments, including pharmaceutical and preventive care services or treatments, directly involved in the reproductive system and its processes, functions, and organs involved in reproduction, in all stages of life. Reproductive health care services do not include infertility treatment.

Reproductive system - Includes, but is not limited to: Genitals, gonads, the uterus, ovaries, fallopian tubes, and breasts.

Sexually Transmitted Infection (STI) –A disease or infection acquired as a result of sexual contact.

U.S. Citizenship and Immigration Services (USCIS) – Refer to USCIS for a definition.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).

- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MCO enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's **Apply for or renew coverage webpage**.

Client's options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to **Washington Healthplanfinder website**.

- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care** webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment or have an option to enroll in fee-for-service. These clients are eligible for physical health services under the fee-for-service program. In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted health plan. For more information, visit Apple Health Expansion.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services,

including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Provider Requirements

Confidentiality, consent, and release of information

When providing family planning services, providers must do all the following:

- Follow federal **Health Insurance Portability and Accountability Act (HIPAA)** requirements in safeguarding the confidentiality of clients' records. These safeguards must do the following:
  - Allow for timely sharing of information with appropriate professionals and agencies on the client's behalf
  - Ensure that confidentiality of disseminated information is protected

  (See **chapter 70.02 RCW** for more details.)
- Ensure that all necessary forms are accurately and fully completed:
  - Informed consent as defined in **WAC 182-531-0050** and as required by **WAC 182-531-1550**, as necessary
  - The federal Consent for Sterilization form **HHS-687** must be attached to a sterilization claim. See the **Sterilization Supplemental Billing Guide** for requirements and instructions. See also **Where can I download HCA forms**?
  - Authorization from clients for release of information
- Ensure the proper release of client information:
  - To transfer information to another provider when a client changes providers or when the provider is unable to provide services (in a timely manner)
  - To transfer information to a primary care provider when a client needs non-family planning related services
  - To conform to all applicable state and federal laws

Nationally recognized clinical guidelines

Providers must follow nationally recognized clinical guidelines when providing services, such as guidelines from:

- Centers for Disease Control and Prevention (CDC)
- U.S. Preventive Services Task Force (USPSTF)
- U.S. Office of Population Affairs
- American College of Obstetrics and Gynecology (ACOG)
- American Cancer Society (ACS)
- American Society for Colposcopy and Cervical Pathology (ASCCP)

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners** webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange (EDI)** webpage.

How do providers bill for managed care services?

Family planning providers under contract with an HCA-contracted managed care organization (MCO) must directly bill the MCO for family planning or sexually transmitted infection (STI) services received by clients enrolled in the MCO.

Family planning providers not under contract with an HCA-contracted MCO must bill using fee-for-service when providing services to managed care clients who self-refer outside their plans.

Family planning providers or HCA-contracted local health department STI clinics who are contracted with an HCA-contracted managed care organization (MCO) must follow their contract regarding laboratory services for MCO clients.

Family planning providers or HCA-contracted local health department STI clinics not under contract with an HCA-contracted MCO must pay a laboratory directly for services provided to clients who self-refer outside of their MCO. Providers then must bill HCA for payment for laboratory services.

- Laboratories must be certified through the Clinical Laboratory Improvements Act (CLIA).
- Documentation of current CLIA certification must be kept on file.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment before providing the service. Providers may bill clients only in very limited situations as described in **WAC 182-502-0160**.

How do providers who participate in the 340B drug pricing program bill for drugs and dispensing fees?

Bill HCA the actual acquisition cost (AAC) for all drugs purchased under the 340B Drug Pricing Program. HCA may require providers to submit an invoice to substantiate the AAC. The invoice must be dated within twelve months prior to the date of service and substantiate the dose of the drug dispensed and its cost and quantity.

The provider NPI used for 340B drugs must be listed on the federal Office of Pharmacy Affairs Medicaid Exclusion File. To receive the 340B dispensing fee, the provider must be enrolled and participating in the 340B Drug Pricing Program and listed on the Medicaid Exclusion file as a 318-entity type (STD clinic). HCA pays the 340B dispensing fee only for HCA-designated hormonal contraceptives that are purchased through the 340B program of the Public Health Service Act. (See **chapter 182-530 WAC**.)

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Sexual and Reproductive Health Program (SRHP) Fee Schedule

Effective October 1, 2021, Apple Health pays an enhanced rate to contracted providers in the Department of Health's (DOH) SRHP for designated procedure codes. Refer to the **SRHP fee schedule**. For information on how to enroll in the SRHP, visit the **Department of Health website**. SRHP was formerly known as the Washington Title X Family Planning Program.

> **Note**: SRHP fee schedule rates are payable only to billing provider NPIs for SRHP contracted providers. It is the responsibility of each SRHP-contracted provider to ensure Apple Health has a complete, updated list of billing provider NPIs. If you are an SRHP contracted provider, please contact **hcafamilyplanning@hca.wa.gov** to verify or update your billing provider NPIs. HCA will verify current SRHP contract status with DOH. If HCA does not have the billing providers NPIs identified in the ProviderOne system, HCA will pay at the regular fee schedule rates.

SRHP fee schedule requirements

To be paid, SRHP contracted providers must bill using the KX modifier according to the SRHP fee schedule.

Clients with Family Planning Only medical coverage are not eligible for all service codes on the SRHP fee schedule. Refer to **What services are covered under the Family Planning Only program**?

SRHP contracted providers are eligible for the SRHP fee schedule rates even when the care provided is not related to family planning. For example, an SRHP contracted provider may bill an E/M code with the KX modifier for a visit focused on gender-affirming care.

Federally Qualified Health Center (FQHC) SRHP Billing

FQHCs providing SRHP services do not receive the enhanced SRHP fee schedule rates and must not bill with the KX modifier on the same day an FQHC encounter eligible service is performed. SRHP services performed on the same day as an eligible encounter must be bundled with the encounter.

For FQHC SRHP services that are not performed on the same day as an encounter eligible service, FQHCs must bill with the KX modifier to receive the enhanced rate. This FQHC SRHP billing guidance applies to both fee-for-service and managed care claims.

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Reproductive Health Services

What are reproductive health services?

HCA defines reproductive health services as those services that:

- Assist clients in avoiding illness, disease, and disability related to reproductive health.
- Provide related, appropriate, and medically necessary care when needed.
- Assist clients in making informed decisions about using medically safe and effective methods of family planning.

Who is eligible for reproductive health services?

HCA covers medically necessary reproductive health services, as described in this guide, for clients covered by one of the Washington Apple Health programs as listed in the table in WAC 182-501-0060.

Managed care clients

For clients enrolled in one of the HCA-contracted managed care organizations (MCOs), managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

Clients enrolled in an HCA-contracted MCO must obtain services through their MCO, unless otherwise noted.

> **Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from both the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Self-referral for managed care clients

A client enrolled in an HCA-contracted MCO may self-refer outside their MCO for reproductive health care services including, but not limited to:

- Family planning
- Abortion
- Sexually transmitted infection (STI) services

A client may seek services from any HCA-approved provider. A client who is age 21 or older may not self-refer outside their MCO for sterilization.

Limited coverage

Family Planning Only program

Family Planning Only clients are eligible to receive limited reproductive health services which includes only family planning and specified family planning-related services. See the program guidelines in this guide.

Alien Emergency Medical

Under WAC 182-507-0115, HCA covers reproductive health services under Alien Emergency Medical programs only when the services are directly related to an emergency medical condition.

Where can Washington Apple Health clients receive reproductive health services?

Reproductive health services can be provided by any licensed, HCA-contracted provider whose scope of practice includes reproductive health or the ancillary services associated with a reproductive health procedure or treatment (e.g., pathology, anesthesia, facility, etc.). See chapter 182-502 WAC for requirements of HCA-contracted providers.

What are the requirements for providers?

To be paid by HCA for reproductive health services provided to eligible clients, providers, including licensed midwives, must:

- Meet the requirements in chapters 182-501, 182-502, and 182-532 WAC.
- Provide only those services that are within the scope of their licenses.
- Bill HCA according to this guide and other applicable HCA billing guides.
- Educate clients on Food and Drug Administration (FDA)-approved contraceptive methods and over-the-counter (OTC) contraceptive drugs, devices, and products, as well as related medical services.
- Provide medical services related to FDA-approved contraceptive methods and OTC contraceptive drugs, devices, and products upon request.
- Supply or prescribe FDA-approved contraceptive methods and OTC contraceptive drugs, devices, and products upon request.

How do providers bill for reproductive health services for transgender clients?

HCA covers reproductive health services based on medical necessity, not the client's gender identity.

Use one of the following gender dysphoria diagnoses as secondary on the claim to prevent claim denial due to gender mismatch:

- F64.0
- F64.1

- F64.2
- F64.9

For example, oral contraceptives and emergency contraception are covered for a transmasculine client with a uterus.

> **Note**: Family Planning Only clients who are transgender or gender non-conforming are eligible to receive only the limited benefit provided by this program. Services such as gender-affirming treatment are not included in the Family Planning Only benefit package.

What reproductive health services are covered?

In addition to the services listed in WAC 182-531-0100, HCA covers all the following reproductive health services:

- For a client capable of reproducing, one **comprehensive preventive family planning visit** every 365 days, based on nationally recognized clinical guidelines. This visit must have a primary focus and diagnosis of family planning and include the following:
  - Counseling
  - Education
  - Risk reduction
  - Initiation or management of contraceptive methods

> **Note:** Clients who are sterilized or otherwise not at risk for pregnancy do not qualify for a comprehensive family planning prevention visit. They do qualify for all other services.

- Contraception, including all the following:
  - Food and Drug Administration (FDA)-approved contraceptive methods (see the **Prescription Drug Program Billing Guide**)
  - Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence (see the **Contraceptives Coverage Table)**
  - Sterilization procedures, as described in WAC 182-531-1550 and the Sterilization Supplemental Provider Guide
- Cervical, breast, and prostate cancer screenings, according to nationally recognized clinical guidelines (see the **Physician-Related Services/Health Care Professional Services Billing Guide**)
- STI screening, testing, and treatment, according to nationally recognized clinical guidelines

- Hepatitis B and C testing, according to nationally recognized clinical guidelines
- HIV testing, according to nationally recognized clinical guidelines
- Immunizations for human papillomavirus (HPV) and hepatitis B administered according to the recommended guidelines and schedule published by the Centers for Disease Control and Prevention (CDC)
- Diagnostic services, follow-up visits, imaging, and laboratory services related to the services listed in this section
- Social determinants of health risk screening during qualifying visits. See HCA's **Physician-Related Services/Health Care Professional Services Billing Guide** for the complete policy and a list of qualified visits.
- Pregnancy-related services including:
    - Maternity-related services, as described under "Maternity Care and Services" in the **Physician-Related Services/Health Care Professional Services Billing Guide**
    - Abortion (see **Physician-Related Services/Health Care Professional Services Billing Guide**)

What reproductive health services are not covered?

Noncovered reproductive health services are described in HCA's **Physician-Related Services/Health Care Professional Services Billing Guide** and WACs **182-501-0070** and **182-531-0150**.

> **Note**: HCA reviews requests for noncovered services under **WAC 182-501-0160**.

What fees does HCA pay?

For clients on Apple Health, HCA pays for:

- Covered reproductive health services using HCA's **Family Planning Fee Schedule.**
- Family planning pharmacy services, family planning laboratory services, immunizations, and sterilization services using HCA's published fee schedules.
- A professional dispensing fee only for hormonal contraceptive drugs purchased through the 340B program of the Public Health Service Act.

For clients on Family Planning Only, HCA pays for:

- Family planning and family planning-related services as described in this billing guide.
- Pharmacy services, laboratory services, immunizations, and sterilization services listed on the HCA Family Planning fee schedule.

- A professional dispensing fee only for hormonal contraceptive drugs purchased through the 340B program of the Public Health Service Act.

HCA requires providers to seek timely reimbursement from a third party when a client has available third-party resources, as described under WAC 182-501-0200. See Billing for third-party liability and "good cause" for exceptions.

Billing for third-party liability and "good cause"

HCA requires a provider under WAC 182-501-0200 to seek timely reimbursement from a third party when a client has available third-party resources, except when "good cause" exists.

"Good cause" means that use of the third-party coverage would violate a client's confidentiality because the third party:

- Routinely sends written, verbal, or electronic communications, as defined in RCW 48.43.505, to the third-party subscriber and that subscriber is someone other than the applicant.
- Requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to the subscriber.

Clients may request an exemption from the requirement to bill third-party insurance due to "good cause" if they are either of the following:

- Age 18 or younger and seeking services in confidence
- Domestic violence victims and seeking services in confidence

A client desiring a "good cause" exemption from third-party billing can request this by contacting the Medical Assistance Customer Service Center.

If a client applies for Family Planning Only and qualifies for a "good cause" exemption due to age or domestic violence, the applicant is considered for Family Planning Only coverage without regard to the available third-party insurance. At the time of a Family Planning Only application, providers must make a determination about "good cause" on a case-by-case basis.

> **Note**: To preserve confidentiality when billing for family planning services for either exception above, do not indicate on the claim that the client has other insurance.

What services are not covered under Family Planning Only?

HCA does not pay for inpatient services under the Family Planning Only program, except for complications arising from covered family planning services.

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Family Planning Only Program

What is the purpose of the Family Planning Only program?

The purpose of the Family Planning Only program is to provide family planning services to:

- Improve access to family planning and family planning-related services.
- Reduce unintended pregnancies.
- Promote healthy intervals between pregnancies and births.

Who is eligible for the Family Planning Only program?

To be eligible for the Family Planning Only program, a client must meet all the following:

- Provide a valid Social Security number (SSN), unless ineligible to receive one, or meet good cause criteria listed in WAC 182-503-0515
- Be a Washington state resident, as described in WAC 182-503-0520
- Have an income at or below 260% of the federal poverty level, as described in WAC 182-505-0100
- Need family planning services
- Have been denied Apple Health coverage within the last 30 days, unless the applicant meets any of the following:
    - Has made an informed choice to not apply for full-scope coverage, including family planning
    - Is age 18 or younger and seeking services in confidence
    - Is a domestic violence victim who is seeking services in confidence
    - Has an income of 150% to 260% of the federal poverty level, as described in WAC 182-505-0100.

A client is not eligible for Family Planning Only medical if the client is any of the following:

- Pregnant
- Sterilized
- Covered under another Apple Health program that includes family planning services
- Covered by concurrent creditable coverage, as defined in RCW 48.66.020, unless the client meets any of the following:
    - Is age 18 and younger and seeking services in confidence
    - Is a domestic violence victim who is seeking services in confidence

A client may reapply for coverage under the Family Planning Only program up to 60 days before the expiration of the 12-month coverage period. HCA does not limit the number of times a client may reapply for coverage.

> **Note:** Always check ProviderOne to make sure that a client's one-year eligibility for the Family Planning Only program is still valid, or that the client is not on another HCA program that covers family planning services. **The client must be referred to the Washington Healthplanfinder's website or call 1-855-923-4633 first to determine if the client qualifies for medical services under another program.**

What services are covered under the Family Planning Only program?

HCA covers all the following services:

- One comprehensive preventive family planning visit every 365 days, based on nationally recognized clinical guidelines. This visit must have a primary focus and diagnosis of family planning and include the following:
  - Counseling
  - Education
  - Risk reduction
  - Initiation or management of contraceptive methods
- Assessment and management of family planning or contraceptive problems, when medically necessary
- Contraception, including all the following:
  - FDA-approved contraceptive methods, as described under WAC 182-530-2000, including, but not limited to, the following items:
    - Prescription and over-the-counter oral hormonal contraceptives (pills)
    - Transdermal hormonal contraceptives (patch)
    - Monthly intravaginal contraceptive ring
    - Yearly intravaginal contraceptive ring
    - Injectable hormonal contraceptives
    - Implantable hormonal contraceptives
    - Intrauterine devices (IUDs)
    - Diaphragm, cervical cap, and cervical sponge
    - External and internal condoms
    - Spermicides (foam, gel, suppositories, and cream)

    - Emergency contraception
  - Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence
  - Sterilization procedures, as described under WAC 182-531-1550.

Note: For more details on contraceptives HCA covers, see What contraceptives does HCA cover? and the Contraceptives Coverage Table.

- When clinically appropriate or provided according to nationally recognized guidelines:
  - Pregnancy testing
  - Cervical cancer screening
  - Gonorrhea and chlamydia screening and treatment
  - Syphilis screening and treatment
  - Sexually transmitted infection (STI) screening, testing, and treatment, when medically indicated by symptoms or report of exposure, and medically necessary for the client's safe and effective use of their chosen contraceptive method.
  - HIV testing, including rapid tests
  - Testing for hepatitis B, or hepatitis C, or both
  - Hepatitis B vaccines and hepatitis A/B combination vaccines
  - Human papillomavirus (HPV) vaccines
  - Social determinants of health risk screening during qualifying family planning or STI-related visits. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for the complete policy and a list of qualified visits.

Note: Pregnancy-related services, including abortions, are not covered under the Family Planning Only program. Refer clients who become pregnant while on one of the Family Planning Only programs the Washington Healthplanfinder's website to enroll for coverage. People may also wish to contact Within Reach for further assistance.

Complications from contraceptive methods

HCA covers inpatient, outpatient, and professional costs when they result from a complication arising from covered Family Planning Only program services.

Example of a minor contraceptive complication

A client is unable to find the intrauterine device (IUD) string, it is not visualized on the speculum exam, and an ultrasound is needed to determine its location.

Example of a serious contraceptive complication

An IUD has migrated out of the uterus and needs to be removed by laparoscopy.

For HCA to consider payment when complications occur, providers of Family Planning Only program-related inpatient, outpatient, or professional services must submit to HCA a claim with a complete report of the circumstances and conditions that caused the need for the additional services (see WAC 182-501-0160 and WAC 182-532-540).

A complete report includes all the following:

- Letter of explanation (a short description of the clinical situation and medical necessity for the visit, procedure, testing, or surgery)
- Inpatient discharge summary or outpatient chart notes
- Operative report (if applicable)

> **Note**: For information on how to submit a claim with attachments, see the ProviderOne Resource and Billing Guide. For complications due to a birth control method, write "birth control complication" in the *Claim Note* section of the electronic claim. Claims are subject to post-payment review.

What drugs and supplies are covered under the Family Planning Only program?

See the guidelines regarding contraceptive prescribing and dispensing in What contraceptives does HCA cover?

See the Contraceptives coverage table section in this guide for contraceptive products and procedures covered under the Family Planning Only program.

See the Coverage table in this guide for additional procedures, drugs, and tests covered under the Family Planning Only program.

See the Sterilization Supplemental Billing Guide for drugs related to sterilization procedures.

The following categories of drugs are covered:

- Prescription contraceptives
- Antibiotics and antifungals for the treatment of STIs
- Adjunctive to a sterilization procedure

Over-the-counter contraceptive drugs and supplies (for example: daily oral contraceptive pill), emergency contraception, condoms, spermicidal foam, cream, and gel), with or without a prescription, may be obtained through a pharmacy or a family planning clinic using a Services Card.

HCA does not pay for noncontraceptive take-home drugs dispensed at a family planning clinic.

Coverage table

See the appropriate family planning fee schedule for fees related to covered procedures and visits.

For instructions on billing for office, professionally administered drugs, imaging, and laboratory codes listed below, see the **Physician-Related Services/Health Care Professional Services Billing Guide**.

> **Note:** Due to its licensing agreement with the American Medical Association, HCA publishes only the official, short CPT® code descriptions. To view the full descriptions, refer to a current CPT book.

Office visits for family planning or family planning-related visits

HCPCS/CPT® Code	Short Description	Comments
99202	Office o/p new sf 15-29 min	
99203	Office o/p new low 30-44 min	
99204	Office o/p new mod 45-59 min	
99211	Office o/p est minimal prob	
99212	Office o/p est sf 10-19 min	
99213	Office o/p est low 20-29 min	
99214	Office o/p est mod 30-39 min	

HCPCS/CPT® Code	Short Description	Comments
G0101	CA screen; pelvic/breast exam	As indicated by nationally recognized clinical guidelines.

Comprehensive prevention family planning visit

CPT® Code	Modifier	Short Description	Comments
99384	FP	Prev visit new age 12-17	New patient with uterus and ability to become pregnant. Once every 365 days.
99385	FP	Prev visit new age 18-39	New patient with uterus and ability to become pregnant. Once every 365 days.
99386	FP	Prev visit new age 40-64	New patient with uterus and ability to become pregnant. Once every 365 days.
99394	FP	Prev visit est age 12-17	Established patient, with uterus and ability to become pregnant. Once every 365 days.
99395	FP	Prev visit est age 18-39	Established patient, with uterus and ability to become pregnant. Once every 365 days.
99396	FP	Prev visit est age 40-64	Established patient, with uterus and ability to become pregnant. Once every 365 days.
99401	FP	Preventive counseling, individ	Use for contraceptive counseling in clients with penis and ability to impregnate. Once every 365 days.

Contraceptives

See the Contraceptives Coverage Table.

Sterilization

For sterilization procedure codes, see the Sterilization Supplemental Billing Guide.

Radiology services

Radiology services are covered only when medically necessary due to a family planning complication. See **Complications from contraceptive methods** for how to bill when a family planning complication occurs. See the **Physician-Related Professional Services Fee Schedule** for payment rates for procedures related to a complication.

Immunizations

The Family Planning Only program covers vaccines administered according to the current Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) immunization schedule for adults and children/minors in the United States.

For Family Planning Only clients under age 19, refer to the **EPSDT Billing Guide** for billing instructions and the **Enhanced Pediatric Fee Schedule** for current rates.

For Family Planning Only clients age 19 and older, refer to the **Physician-Related/Professional Services Billing Guide** for billing instructions, the **Professional Administered Drug Fee Schedule** for current vaccine rates, and the **Physician-Related/Professional Services Fee Schedule** for current administration code rates.

CPT® Code/HCPCs Code	Diagnosis	Short Description	Comments
90471	Z23	Immunization admin	Clients age 19 and older only.
90472	Z23	Immunization admin each add	Clients age 19 and older only.
90636	Z23	Hep a/hep B vacc adult im	Clients age 18 and younger, use SL modifier. Clients age 19 and older, do not use a modifier.
90651	Z23	9vhpv vaccine 2/3 dose im	Clients age 18 and younger, use SL modifier. Clients age 19 and older, do not use a modifier.
90739	Z23	Hepb vacc 2/4 dose adult im	Clients age 18 and younger, use SL modifier. Clients age 19 and older, do not use a modifier.
90746	Z23	Hepb vaccine, 3 dose adult im	Clients age 18 and younger, use SL modifier. Clients age 19 and older, do not use a modifier.

Laboratory services

Laboratory services are covered when clinically appropriate and/or according to nationally recognized guidelines. Covered services include:

- Pregnancy testing
- Cervical cancer tests
- Gonorrhea tests
- Chlamydia tests
- Syphilis tests
- HIV tests
- Hepatitis B tests
- Hepatitis C tests

Laboratory testing in conjunction with a sterilization procedure or family planning complication is covered. See the **Physician-Related Professional Services Fee Schedule** for payment rates for laboratory services related to a sterilization or family planning complication.

CPT® Code	Short Description	Comments
36415	Routine venipuncture	Drawing blood venous. Payment limited to one draw per day.
36416	Collj capillary blood spec	
81025	Urine pregnancy test	
84703	Chorionic gonadotropin assay	
86592	Syphilis test non-trep qual	
86593	Syphilis test non-trep quant	
86631	Chlamydia antibody	
86632	Chlamydia igm antibody	
86701	HIV-1 antibody	
86702	HIV-2 antibody	
86703	HIV-1/HIV-2 1 result antibody	
86706	Hepatitis b surface antibody	

CPT® Code	Short Description	Comments
86803	Hepatitis c ab test	
87110	Chlamydia culture	
87210	Smear wet mount saline/ink	
87270	Chlamydia trachomatis ag if	
87320	Chylmd trach ag ia	
87340	Hepatitis b surface ag ia	
87389	Hiv-1 ag w/hiv-1&-2 ab ag ia	
87490	Chylmd trach dna dir probe	
87491	Chylmd trach dna amp probe	
87590	N.gonorrhoeae dna dir prob	
87591	N.gonorrhoeae dna amp prob	
87624	HPV high-risk types	
87625	HPV types 16 & 18 only	Includes type 45, if performed
87800	Detect agnt mult dna direc	
87806	Hiv ag w/hiv1&2 antb w/optic	
87810	Chylmd trach assay w/optic	
88141	Cytopath, c/v interpret	
88142	Cytopath, c/v thin layer	
88143	Cytopath, c/v thin layer redo	
88147	Cytopath, c/v automated	
88148	Cytopath, c/v auto rescreen	
88150	Cytopath, c/v manual	
88152	Cytopath, c/v auto redo	

CPT® Code	Short Description	Comments
88153	Cytopath, c/v redo	
88164	Cytopath tbs c/v manual	
88165	Cytopath tbs c/v redo	
88166	Cytopath tbs c/v auto redo	
88167	Cytopath tbs c/v select	
88174	Cytopath c/v auto in fluid	
88175	Cytopath c/v auto fluid redo	

Sexually transmitted infection (STI) treatment

Providers must follow CDC guidelines for treatment of STIs. Single dose drugs recommended to be directly observed are covered when administered in an office or clinic. All other covered drugs must be prescribed by the provider and then obtained from and billed by a pharmacy.

The Family Planning Only program covers limited treatment for STIs. Treatment for HIV, hepatitis B, and hepatitis C are not covered under the Family Planning Only program. If a client tests positive for HIV, hepatitis B, and/or hepatitis C, refer to the Department of Health Office of Infectious Disease (OID). OID provides services related to HIV/AIDS and viral hepatitis. OID also manages the HIV Client Services Early Intervention Program, which pays for medications, insurance premiums, and limited health care services for eligible HIV-positive individuals.

HCPCS/CPT® Codes	Short Description	Comments
96372	Ther/proph/diag inj sc/im	May not be billed with an office visit. (Specify substance or drug)
J0558	Peng benzathine/procaine inj	
J0561	Penicillin g benzathine inj	
J0696	Ceftriaxone sodium inj	250 mg
J1580	Garamycin gentamicin inj	80 mg. Alternative regimen*
Q0144	Azithromycin dehydrate, oral	1 g. Alternative regimen*

HCPCS/CPT® Codes	Short Description	Comments
By prescription only	Doxycycline 100 mg PO	Includes coverage for postexposure prophylaxis (PEP) for bacterial STIs
By prescription only	Cefixime 400 capsules mg PO	Alternative regimen*
By prescription only	Levofloxacin 500 mg	Alternative regimen*
By prescription only	Metronidazole 500 mg po	
By prescription only	Clotrimazole 1% cream vaginal	
By prescription only	Clotrimazole 2% cream vaginal	
By prescription only	Miconazole 2% cream vaginal	
By prescription only	Miconazole 200 mg vaginal suppository	
By prescription only	Butoconazole 2% cream vaginal	
By prescription only	Terconazole 0.4% cream vaginal	
By prescription only	Terconazole 0.8% cream vaginal	
By prescription only	Terconazole 80 mg vaginal suppository	

*Alternative regimens can be considered in instances of substantial drug allergy or other contraindications.

Social determinants of health risk screening

HCA considers a social determinants of health risk screening (HCPCS code G0136) medically necessary when billed with specific qualifying visits. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for the complete policy and a list of qualified visits.

HCPCS/CPT® Codes	Short Description	Comments
G0136	Adm of soc dtr assess 5-15 m	For Family Planning Only clients, G0136 may be billed with the following qualifying visits: • CPT® codes 99384, 99385, 99386 – Comprehensive prevention family planning visits for new patients • CPT® codes 99394, 99395, 99396 – Comprehensive prevention family planning visits for established patients • CPT® codes 99204, 99214 – Office visits for family planning or family planning-related visits

What are the requirements for providing services to Family Planning Only program clients?

To be paid for services provided to clients eligible for the Family Planning Only program, providers must meet the requirements in chapters 182-501, 182-502, and 182-532 WAC. Refer to WAC 182-532-520 for comprehensive details on Family Planning Only provider requirements.

Providers must also meet the documentation requirements in WAC 182-502-0020 and WAC 182-532-560.

Providers must participate in the research and evaluation component of the Family Planning Only program if requested by HCA. Some services related to research and evaluation may be contracted and billed separately. Providers must also ensure they have a way of reaching the client in a confidential manner if the client requests confidentiality regarding the use of family planning services.

As of 2019, FPO clients are not limited to family-planning specialty providers or clinics and can be served by any Apple Health provider that provides family planning services.

> **Note**: It is important for the client to have easy and immediate access to the Apple Health provider or pharmacy of their choice. A client may enroll in the Family Planning Only program at one provider's office and receive services at a different provider's office. Providers must help all potentially eligible clients enroll in the program, regardless of where they choose to receive services.

For additional information, visit the HCA Family Planning Only webpage.

What contraceptives does HCA cover?

Prescription hormonal contraceptives

HCA generally requires oral, transdermal, injectable, and intra-vaginal hormonal contraceptives to be dispensed as a one-time 12-month supply according to the chart below, including daily over-the-counter contraception pills.

Providers and clinics may dispense for a lesser amount if any of the following are true:

- The client does not want a 12-month supply all at once.
- There is a clinical reason, as documented on the prescription, for the client to receive a smaller supply.
- The pharmacy or clinic does not have enough supply to fill for 12 months.

This requirement applies to clients in both fee-for-service and managed care.

See the Prescription Drug Program Billing Guide or the expedited authorization code from the Apple Health EA list for more details.

Contraceptive type	Quantity required for 12 months to be dispensed	Cycles/Packs
Oral contraceptives, including daily over-the-counter, e.g. pills	364 tablets	13
Continuous oral contraceptives	504 tablets when dispensed as 28-day packs	18
Continuous oral contraceptives	378 tablets when dispensed as 21-day packs	13
Transdermal contraceptives, e.g., patch	39 transdermal patches	13
Transdermal contraceptives, e.g., patch	52 transdermal patches	18
Monthly intra-vaginal contraceptives, e.g., Nuvaring	13 intra-vaginal rings	13
Monthly intra-vaginal contraceptives, e.g., Nuvaring	18 intra-vaginal rings	18
Quarterly injectable contraceptives, e.g., Depo-SubQ Provera 104	4 prefilled syringes	4

Prescription hormonal contraceptives dispensed from a family planning clinic

340B dispensing fee

A 340B dispensing fee may be billed only for designated prescription hormonal contraceptives, which must be purchased and dispensed by a family planning clinic participating with Medicaid in the 318-drug program under the Public Health Service (PHS) Act. The clinic is listed on the Medicaid Exclusion File as a 318 entity (STD clinic). The 340B drugs must be billed at actual acquisition cost. See WAC 182-530-7900.

The 340B dispensing fee may be billed with the following HCPCS codes **only**:

- S4993 (prescription hormonal contraceptives only)
- J7295

- J7294
- J7304
- J1050 (Depo-SubQ Provera 104 only).

The number of billed units for S9430 must always equal the number of units dispensed by the provider for codes S4993, J7295, J7294, and/or J7304 and be billed on the same day of service and on the same claim. For J1050 (Depo-SubQ Provera 104 only), the number of billed units for S9430 must equal the number of syringes dispensed by the provider and be billed on the same day of service and on the same claim.

These requirements apply to clients in both fee-for-service and managed care.

> **Note**: HCA does not reimburse for any drug provided free of charge (for example, samples obtained through special manufacturer agreements). A dispensing fee in these cases is not reimbursable.
>
> HCA requires providers to list the 11-digit National Drug Code (NDC) number in the appropriate field of the claim when billing for all drugs administered in or dispensed from their office or clinic.

Immediate postpartum Long-Acting Reversible Contraceptive (LARC) insertion

HCA reimburses professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure.

HCA does not reimburse facility services for the immediate postpartum IUD or contraceptive implant insertion procedure. These inpatient services may not be unbundled on the hospital's facility claim.

HCA reimburses for the IUD or contraceptive implant device in one of the following ways:

- Through the facility's pharmacy point of sale system
- As a separate professional claim submitted by the facility when the facility supplies the device. (ProviderOne does not require a servicing provider NPI on a device-only claim.)
- As part of the professional claim when the device is supplied by the provider performing the insertion

> **Note**: When billing for an IUD or contraceptive implant device, the provider must use the appropriate HCPCS code and NDC.

Contraceptives coverage table

Prescription contraceptives

Pills, Ring, and Patch

HCPCS Code	Short Description	Comments
S4993	Contraceptive pills for bc	1 unit = each 21 or 28-day pack. (Seasonale should be billed as 3 units.) Participating 340B provider: may bill with S9430.
J7295	Monthly contraceptive ring, each (Nuvaring)	Participating 340B providers may bill with S9430. For continuous use rings, bill J7295 on two separate service lines with no more than 13 units per line. The sum of units on the two service lines for J7295 must equal the total number of rings dispensed.
J7294	Yearly contraceptive ring, each (Annovera)	Participating 340B providers may bill with S9430.
J7304	Contraceptive hormone patch	Each (Ortho-Evra). Participating 340B provider may bill with S9430. For continuous use patches, bill J7304 on two separate service lines with no more than 39 units per line. The sum of units on the two service lines for J7304 must equal the total number of patches dispensed.

HCPCS Code	Short Description	Comments
S9430	Pharmacy comp/disp serv	A dispensing fee for participating 340B providers. May bill only with S4993 (birth control pills, and emergency contraception pills), J7295 (monthly contraceptive rings), J7294 (yearly contraceptive ring), J7304 (contraceptive patches), J1050 (Depo-SubQ Provera 104). For birth control pills, emergency contraceptive pills, contraceptive rings, and contraceptive patches: Units of dispensing fee must match units of contraceptive. For Depo-SubQ Provera 104: S9430 is payable once per syringe, rather than per unit of medication.

Emergency Contraception

HCPCS Code	Short Description	Comments
S4993	Contraceptive pills for bc	Unclassified drug Used for: Ulipristal acetate 30 mg Ulipristal is a prescription for all ages. Each 1 unit equals one course of treatment. Participating 340B provider may bill with S9430. Dispense the quantity requested by the client

Injectable

HCPCS Code	Short Description	Comments
J1050	Medroxyprogesterone acetate	**Injection 1 mg (Depo-Provera)** **Depo-Provera IM:** • No 340B dispensing fee allowed. • May be billed with injection administration code 96372 only when not in conjunction with an office visit. **Depo-SubQ Provera 104:** • Participating 340B provider may bill with S9430 for up to four doses. S9430 is payable once per syringe, rather than per unit of medication. • For in-clinic injection, may be billed with injection administration code 96372 only when not in conjunction with an office visit. • Bill all units of Depo-SubQ Provera 104 on a single service line within the claim, whether doses administered or dispensed. Do not separate into more than one service line.

Intrauterine Device (IUD)

HCPCS Code	Short Description	Comments
J7297	Liletta, 52 mg	Levonorgestrel-releasing IUD. No 340B dispensing fee allowed.
J7298	Mirena, 52 mg	Levonorgestrel-releasing IUD. No 340B dispensing fee allowed.
J7300	Intraut copper contraceptive	Paragard. No 340B dispensing fee allowed
J7301	Skyla, 13.5 mg	Levonorgestrel-releasing IUD. No 340B dispensing fee allowed

HCPCS Code	Short Description	Comments
J7296	Kyleena, 19.5 mg	Levonorgestrel-releasing IUD. No 340B dispensing fee allowed
58300	Insert intrauterine device	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate.
58301	Remove intrauterine device	

Implant

HCPCS/CPT® Code	Short Description	Comments
J7307	Etonogestrel implant system	Contraceptive (Nexplanon). No 340B dispensing fee allowed.
11981	Insert drug implant device	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate. Must be billed with FP modifier.
11982	Remove drug implant device	Must be billed with FP modifier.
11983	Remove/insert drug implant	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate. Must be billed with FP modifier.
11976	Remove contraceptive capsule	Norplant only

Cervical Cap/Diaphragm

HCPCS/CPT® Code	Short Description	Comments
A4261	Cervical cap contraceptive	No 340B dispensing fee allowed
A4266	Diaphragm	No 340B dispensing fee allowed
57170	Fitting of diaphragm/cap	

Nonprescription over-the-counter (OTC) contraceptives

Nonprescription OTC contraceptives may be obtained with a Services Card through a pharmacy or HCA-designated family planning clinic.

HCPCS Code	Short Description	Comments
A4267	External Condom, each	No 340B dispensing fee allowed.
A4268	Internal Condom, each	No 340B dispensing fee allowed.
A4269	Spermicide	Includes gel, cream, foam, vaginal film, and contraceptive sponge. No 340B dispensing fee allowed.

OTC daily contraceptive pill

HCPCS Code	Short Description	Comments
S4993	Contraceptive pills for bc	Unclassified drug Used for: Norgestrel 0.75 mg (Opill) Norgestrel is over-the-counter for clients of all ages per the FDA. No 340B dispensing fee allowed.

Emergency contraception

HCPCS Code	Short Description	Comments
S4993	Contraceptive pills for bc	Unclassified drug Used for: Levonorgestrel 1.5 mg Levonorgestrel is over-the-counter for clients of all ages per the FDA. Each 1 unit equals one course of treatment. No 340B dispensing fee allowed. Dispense the quantity requested by the client

Nondrug contraceptive supplies (natural family planning)

HCPCS/CPT® Code	Modifier	Short Description	Comments
T5999	FP	Supply nos	Use for cycle beads only. Each 1 unit equals one set of cycle beads.
99071	FP	Patient education materials	Use for natural family planning booklet only. Each 1 unit equals one booklet.
A4931	FP	Reusable oral thermometer	Use for basal thermometer only. Each 1 unit equals one thermometer.

Telemedicine

Telemedicine is covered for family planning services, according to HCA guidance on telemedicine and audio-only procedures. See HCA's **Provider billing guides and fee schedules** webpage, under *Telehealth*, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

For COVID PHE telemedicine/telehealth policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth and Clinical policy and billing for COVID-19*.

Effective October 1, 2023

Effective for claims with dates on and after October 1, 2023, HCA pays for the following procedure codes via telemedicine/telehealth:

Family planning services

CPT® Code	Short description
99202	Office o/p new sf 15-29 min
99203	Office o/p new low 30-44 min
99204	Office o/p new mod 45-59 min
99211	Off/op est may x req phy/qhp
99212	Office o/p est sf 10-19 min
99213	Office o/p est low 20-29 min
99214	Office o/p est mod 30-39 min

Comprehensive prevention family planning visits

CPT® Code	Short description	Modifier	Limitations
99384	Prev visit new age 12-17	FP	Limited to once every 365 days
99385	Prev visit new age 18-39	FP	Limited to once every 365 days
99386	Prev visit new age 40-64	FP	Limited to once every 365 days
99394	Prev visit est age 12-17	FP	Limited to once every 365 days
99395	Prev visit est age 18-39	FP	Limited to once every 365 days
99396	Prev visit est age 30-64	FP	Limited to once every 365 days
99401	Preventive counseling indiv	FP	Limited to once every 365 days

Appendix A - Frequently Asked Questions

If a client changes from Family Planning Only program coverage to full scope Medicaid coverage, are they covered under the Family Planning Only program?

No. The client now is eligible for Reproductive Health Services. (See Reproductive Health Services.)

Are prostate cancer screenings, digital rectal examinations, and prostate-specific antigen tests (PSA) covered under reproductive health services and the Family Planning Only program?

Prostate cancer screenings are covered under Reproductive Health Services with the following procedure codes and diagnoses:

- Individuals with a prostate are covered for HCPCS procedure code G0103 for prostate–specific antigen test (PSA) with diagnosis code Z12.5 (encounter for screening for malignant neoplasm of the prostate).
- A digital rectal exam (HCPCS procedure code G0102) is bundled into the reimbursement for the office visit.

These prostate cancer screenings *are not* covered under the Family Planning Only program.

Are mammograms covered under reproductive health services and the Family Planning Only program?

Mammograms are covered for clients under Reproductive Health Services. For more information, refer to the Physician-Related Professional Services Billing Guide. Mammograms *are not* covered under the Family Planning Only program.

Are abortions covered under reproductive health services and the Family Planning Only program?

Abortions are covered for clients under Reproductive Health Services. Bill HCA for these services with a medical taxonomy.

Abortions *are not* covered under the Family Planning Only program.

> **Note**: If a Family Planning Only program client becomes pregnant, refer the client to the Washington Healthplanfinder's website or call 1-855-923-4633 to determine if the client qualifies for medical services under another program.