



MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid Provider Reference Guide

For Part 221

Family Planning and Family Planning Related Services

*This is a companion document to the
Mississippi Administrative Code Title 23 and
must be utilized as a reference only.*

Mississippi Medicaid Provider Reference Guide

Part 221 Family Planning Services

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CO-PAYMENTS

Family planning and family planning related services are exempt from co-pay requirements. The beneficiary is not required to share the cost of receiving family planning services.

ELIGIBILITY

Beneficiaries enrolled in the Family Planning Waiver Program receive a yellow Medicaid Identification Card. The yellow Identification Card signifies that the beneficiary is eligible for family planning waiver services only. Providers are responsible for verification of covered services and beneficiary eligibility at each visit. Covered services under the Family Planning Waiver Program are identified on the Division of Medicaid's website at <http://www.medicaid.ms.gov>. Click on Programs and Family Planning Waiver links. Beneficiary eligibility may be verified by calling the Automated Voice Response System (AVRS) of the fiscal agent or using the Division of Medicaid's web portal at <https://www.ms-medicaid.com/msenvision/> on the day the service is rendered. Refer to the Administrative Code Part 200, Chapter 3 for Verification of Eligibility policy.

APPLICATION FOR SERVICES

Women and men interested in family planning and family planning related services who are not eligible for another Medicaid program, may apply for services under the Waiver. The application form may be obtained from a Medicaid eligibility site, a Mississippi State Health Department Clinic or the Division of Medicaid's web site at <http://www.medicaid.ms.gov>. Click on Programs and Family Planning Waiver link.

The applicant must:

- Complete the Application for Family Planning Services,
- Sign and date the Application for Family Planning,
- Attach a copy and not the original of the:
 - For an initial application only:
 - Birth Certificate,
 - Government issued photo identification such as a driver's license or student identification, and
 - Social Security Card
 - For each renewal application which occurs every twelve (12) months:

- The last paycheck stub(s) for the last month (four weeks) of employment. The paycheck stub(s) must be dated no more than one (1) month prior to application.
- Return the completed, signed and dated application with the required attachments by mail, fax, email or hand delivery as directed on the application or on the Division of Medicaid's website.

COVERED SERVICES

Counseling and education must be included as part of each family planning and family planning related visit. Counseling and education must contain the following:

- Breast self-exam or testicular self-exam,
- Full range of contraceptive methods available and individualized to the beneficiary,
- Informing of the risks, benefits and side effects of the contraceptive methods, and
- Prevention of Sexually Transmitted Illness/Sexually Transmitted Disease (STI/STD) including Human Immunodeficiency Virus (HIV).

PRESCRIPTION DRUG PHARMACY BENEFITS

Prescription contraceptives such as oral contraceptive agents, topical patches, self-inserted contraceptive products or injectable contraceptives are available through the pharmacy program.

Covered Family Planning Waiver medications can be located on the Division of Medicaid's website at www.medicaid.ms.gov/providers/pharmacy/pharmacy-resources/ under 'Family Planning Drugs'.

PHYSICIAN ADMINISTERED DRUGS

The human papillomavirus (HPV) vaccine is covered when administered in the provider's office. Female and male condoms are covered when prescribed, supplied and billed by the provider.

CONTRACEPTIVE DEVICES

Insertion, removal and removal with reinsertion of subdermal implants are covered. The subdermal implant must be billed as a separate charge. The duration of action of contraceptive

implants is thirty-six (36) months. If a contraceptive subdermal implant must be removed prior to the thirty-fourth (34th) month, the provider must clearly document the necessity for removal in the beneficiary's medical record. Providers billing more than one (1) contraceptive subdermal implant in thirty-four (34) months must document the medical necessity for the repeat subdermal implant in the beneficiary's medical record.

The Division of Medicaid does not provide separate reimbursement for most Evaluation and Management (E&M) services when a substantial diagnostic or therapeutic procedure is performed.

VOLUNTARY STERILIZATION

In the event a second sterilization procedure is required due to failure of the first sterilization procedure, coverage for the second covered sterilization procedure will be provided. A second sterilization consent form must be completed. Documentation in the beneficiary's medical record must include the date of the first sterilization and the reason for the sterilization procedure failure.

LABORATORY

A list of laboratory services and codes may be found on the Division of Medicaid website at <http://www.medicaid.ms.gov> under Programs and then under the Family Planning Waiver link.

QUALITY ASSURANCE

Providers selected for quality assurance reviews are determined through a random selection. To be eligible for review, the provider must have provided family planning and family planning related services to a minimum of twenty-five (25) beneficiaries during the past year. A minimum of fifteen (15) and a maximum of thirty-five (35) of a provider's medical records are reviewed by a Division of Medicaid Program Nurse. Additional medical records above the maximum of thirty-five (35) may be reviewed if deemed necessary by the Division of Medicaid Program Nurse.

Program areas that may require a written plan of correction (POC) and/or a follow-up on-site review include medical documentation, health education, primary care referral, lab, and contraceptive choices. The necessity for a POC and/or follow-up on-site visits are as follows:

- 98% and above-no written plan of correction necessary,
 - 95% to 97.9%-written plan of correction, but no follow-up on-site review, or
 - 94.9% and below-written plan of correction and a six (6) month follow-up on-site review.
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At the conclusion of the on-site review, the Division of Medicaid Program Nurse will conduct an exit interview with the appropriate staff. The findings of the review will be discussed. Written findings will include both strengths and weaknesses and will be submitted to the provider within twenty-one (21) calendar days of the completion date of the review.

The Division of Medicaid will perform tracking and trending analyses of complaints. When indicated, the information obtained will be integrated into quality improvement activities.

BILLING REQUIREMENTS

The 'FP' modifier must be appended to claims when billing for family planning or family planning related services.

LARC REIMBURSEMENT

Effective July 1, 2016, reimbursement for Long Acting Reversible Contraceptive (LARC) devices in the inpatient and outpatient setting is as follows:

Inpatient LARC placement postpartum (supplied by HOSPITAL and prior to discharge)

- The hospital may submit an outpatient claim for LARC devices placed during the postpartum inpatient stay, listing only the date of the insertion as the date of service.
- The claim should include only the LARC device and insertion billed under the applicable Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.
- Any professional claims submitted should not duplicatively include a LARC device.

Inpatient LARC placement postpartum (supplied by PHYSICIAN and prior to discharge)

- The hospital will not be reimbursed for the LARC device when it is provided by the physician during the postpartum inpatient stay.
 - All other services provided by the hospital must be billed on the inpatient hospital claim and reimbursement will be calculated at the appropriate APR-DRG rate.
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- The physician will submit a CMS1500 professional claim for services provided and include the appropriate device HCPCS code, and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.

Outpatient LARC placement (supplied by the HOSPITAL)

- The hospital may submit an outpatient claim for all services provided and include the LARC device billed under the appropriate Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- Any professional claims submitted should not duplicatively include a LARC device.

Outpatient LARC placement (supplied by the PHYSICIAN)

- The hospital will not be reimbursed for the LARC device when it is provided by the physician.
- All other services provided by the hospital must be billed on the outpatient hospital claim and will be reimbursed at the outpatient hospital rate for the date of service billed.
- The physician will submit a CMS-1500 professional claim for services provided and include the appropriate device HCPCS code and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.