

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 07/01/06</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Family Planning (Non-Waiver)</b>	<b>Section: 70.01</b>	
	<b>Pages: 1</b>	
<b>Subject: Introduction</b>	<b>Cross Reference:</b>	

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1905 (a)(4)(C) of the Act requires States to provide family planning services and supplies (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments and providers may **not** bill beneficiaries for these services.

The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

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	<b>Pages: 1</b>	
<b>Subject: Freedom of Choice</b>	<b>Cross Reference:</b>	

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required."

Beneficiaries have freedom of choice in deciding to receive or reject family planning services. Beneficiaries have the freedom to choose family planning providers. Beneficiaries may choose any method of birth control including sterilization. Providers must ensure that information is given in such a way as to encourage and support free choice.

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	<b>Pages: 1</b>	
<b>Subject: Beneficiary Cost Sharing</b>	<b>Cross Reference:</b>	
	<b>Beneficiary Information 3.08</b>	

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services.

Family planning services are exempt from co-pay requirements. Claims must be filed with the appropriate exception code. Otherwise, co-payment will be deducted from the claim payment amount.

Beneficiaries may be subject to co-pay requirements when receiving services other than family planning. Refer to Beneficiary Information, Section 3.08.

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<b>Section: Family Planning (Non-Waiver)</b>	<b>Section: 70.04</b>	
<b>Subject: Covered Services</b>	<b>Pages: 2</b>	
	<b>Cross Reference:</b>	
	<b>Pharmacy 31</b>	
	<b>Hospital Inpatient 25.29</b>	
	<b>General Medical Policy 53.19</b>	

Family planning services are services provided to eligible beneficiaries who voluntarily choose to prevent pregnancy, plan the number of pregnancies, or plan the spacing between pregnancies.

Family planning services are provided, with limitations, in the following general categories:

- Visits
- Contraceptive drugs
- Contraceptive devices
- Voluntary sterilization
- Infertility assessment
- Laboratory procedures

### Visits

Counseling and education are considered part of the family planning visit and may not be billed separately. Providers must bill using the Evaluation and Management CPT Code appropriate for the level of service.

### Contraceptive Drugs

- Insertion and removal of contraceptive implants are covered. The implant devices may be billed as a separate charge.
- Contraceptive injections administered in the provider's office are covered. An administration fee may be billed separate from a visit code.
- Prescription contraceptives are available through the pharmacy program. Refer to Pharmacy, Section 31 of this manual.

### Contraceptive Devices

- Insertion and removal of contraceptive intrauterine devices are covered. The device may be billed as a separate charge.
- Diaphragm or cervical cap fitting with instructions. The device may **not** be billed as a separate charge.
- Over-the-counter contraceptive devices such as condoms, spermicides and sponges are **not** covered.

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### **Voluntary Sterilization**

Vasectomy and tubal ligation procedures, including tubal ligation by hysteroscopy, are covered if they meet Medicaid criteria for sterilization. Refer to Hospital Inpatient, Section 25.29 of this manual.

In the event a second sterilization procedure is required due to failure of the first procedure, coverage for a second covered 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 procedure failure. Refer to General Medical Policy, Section 53.19 of this manual.

### **Infertility Assessment**

Infertility assessment is limited to the office visit and laboratory studies.

### **Laboratory Procedures**

Pap smears, infertility tests, and screening for sexually transmitted diseases are covered services.

### **Codes/Modifiers**

**Claims for family planning services must be submitted with the FP modifier.**

A complete list of covered family planning codes may be found by accessing the DOM website at [www.dom.state.ms.us](http://www.dom.state.ms.us). Click on Maternal and Child Health Services link.

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	<b>Pages: 1</b>	
<b>Subject: Program Exclusions</b>	<b>Cross Reference:</b>	

Services and items that are **not considered family planning services** include, but are not limited to, the following:

- Facilitating services such as parking and child care while family planning services are being obtained
- Indirect services such as telephone contacts/consultations
- Drugs used to promote fertility
- Emergency contraceptives and related services
- Over-the-counter drugs and supplies including, but not limited to, pregnancy tests, condoms, and spermicides
- Procedures to enhance fertility including, but not limited to, sterilization reversal, in vitro fertilization, artificial or intrauterine insemination, and all related services
- Abortions and related services
- Hysterectomy and related services
- Menopausal/post menopausal treatment and related services
- Removal of an implanted device if the beneficiary is not Medicaid eligible when it is time for the device to be removed
- Natural Family Planning services
- Mammograms
- Ultrasound and radiology
- All services provided for the **treatment of medical conditions** including medical complications of a family planning service
- Cancer screening services except for pap smears
- Services to a beneficiary whose age or physical condition precludes reproduction
- Services to a beneficiary known to be pregnant
- Services outside the scope/and or authority of the provider's specialty and/or area of practice

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	<b>Pages: 2</b>	
<b>Subject: Documentation/Record Maintenance</b>	<b>Cross Reference:</b>	

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, Family Planning documentation must include the following on each beneficiary:

- Signed and dated consent for treatment, if applicable
- Signed and dated consent for sterilization, if applicable
- Date of service
- Demographic information (name, address, Medicaid number, date of birth, sex, marital status, etc.)
- Medical history (past and current)
- Family history when appropriate
- Allergies (type, reaction, and treatment)
- Specific name/type of all diagnostic studies (example: laboratory) and the result/finding of the studies
- Treatments/procedures rendered
- Physical findings
- Medications (Documentation must reflect all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples, etc. Documentation must include the name of the medication, strength, dose, and route. The method of administration and site must be included for all injectable medications. Documentation must reflect whether prescriptions were issued in writing or by telephone.)
- Contraceptive supplies (record all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples, etc.)
- Contraceptive devices
- Contraception counseling
- Date, time, and signature for all entries in the beneficiary record
- Order (including time, date, and signature) for all medications, treatments, and procedures rendered

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DOM, the Utilization Management and Quality Improvement Organization (UM/QIO), and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the family planning provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.