BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Reimbursement Policy

Family Planning, Sterilization and Abortion Services

Policy Number: 4.115
Version Number: 14
Version Effective Date: 01/01/2022

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☒ MassHealth MCO ☒ MassHealth ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered family planning, sterilization and abortion items and services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

For information specific to genetic testing please reference the medical policies: Genetic Testing Guidelines and Pharmacogenetics, OCA 3.727, and Preimplantation Genetic Testing (Preimplantation Genetic Diagnosis and Pregenetic Testing), OCA 3.726.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Provider Reimbursement

Abortion Services

- The Plan provides coverage for abortion services.
- Payment for an abortion service represents full compensation for these services, including the preoperative evaluation and counseling, laboratory and radiology services, surgery, and postoperative care.

Family Planning Services

- The Plan will reimburse for medical services, laboratory services and drugs related to family planning services when provided to an eligible member in a facility licensed as a clinic or a hospital and under the supervision of a physician.
- Family Planning Services also may be provided at freestanding clinics, community health centers, hospital outpatient departments, hospital-licensed health centers or physician offices. Members may self-refer to any network family planning provider.
- Covered family planning services include, but are not limited to, contraceptives, family planning counseling service, follow-up service, genetic counseling, and laboratory services related to family planning.
- A family planning agency will be reimbursed for each type of visit performed. Payment for such visits will include all administrative and operational overhead required of the facility, except for laboratory, supplies, and drugs.

Sterilization Services

- The Plan covers sterilization services only if the member is at least 18 years of age and is mentally competent.
- Reversal of voluntary sterilization is not a covered service.
- Payment for a sterilization service represents full compensation for these services, including the preoperative evaluation and counseling, laboratory and radiology services, surgery, and postoperative care.

Medication Reimbursement

- The Plan will reimburse providers for medications administered as a component of care in a family planning clinic.
- In addition to injectable medications, family planning providers may administer and be paid for prescription medications ordinarily covered only through the pharmacy benefit by attaching modifier FP to the applicable HCPCS code (i.e. J codes). Such medications are limited to those covered drugs that are related to a member's course of treatment by the family planning agency. Any other covered medication required must be filled according to the Plan's pharmacy benefit.
- The Plan will not reimburse for any of the defined visits if the sole purpose is for replenishing a member's supply of contraceptives. When this occurs, the provider will be reimbursed for the contraceptive only.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Modifiers for Abortion and Family Planning Services

The following HCPCS modifiers are recognized by the Plan for billing abortion and family planning related services.

- FP – Services provided as a part of a Medicaid family planning program
- TF – Intermediate level of care
- TG – Complex/High tech level of care

CPT/HCPCS for Abortion, Sterilization and Family Planning Services

Please note, for Payable Laboratory Services, please reference MassHealth Family Planning Agency Manual Subchapter 6.

Code	Description
11976	Removal, implantable contraceptive capsules
11981	Insertion, drug delivery implan (ie, bioresorbable, biodegradable, non-biodegradable)t
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance
49084	Peritoneal lavage, including imaging guidance, when performed
54050	Destruction of lesions(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	Biopsy of vulva or perineum (Separate Procedure.); 1 lesion
57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

Code	Description
57100	Biopsy of vaginal mucosa; simple (separate procedure.)
57420	Colposcopy of the entire vagina, with cervix if present
57421	Colposcopy of the entire vagina, with cervix if present; with biopsy(ies) of vagina/cervix
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57455	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57456	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505	Endocervical curettage (not done as part of a dilation and curettage)
57510	Cautery of cervix; electro or thermal
57511	Cautery of cervix; cryocautery, initial or repeat
57513	Cautery of cervix; laser ablation
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
57800	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; Dilation of cervical canal, instrumental (separate procedure)
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58340	Catherization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58555	Hysteroscopy, diagnostic (separate procedure)
58562	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C with removal of impacted foreign body

Code	Description
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral approach
58670	Laparoscopy, surgical, with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g. band, clip or Falope ring)
59200	Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)
59812	Treatment of incomplete abortion, any trimester, completed surgically
59820	Treatment of missed abortion, completed surgically, first trimester (includes physician's charges and clinic services)
59821	Treatment of missed abortion, completed surgically; second trimester
59840	Induced abortion, by dilation and curettage (includes physician's charges and clinic services with either intravenous sedation or general anesthesia; CPA-2 form required)
59840 TF	Induced abortion, by dilation and curettage includes physician's charges and clinic services with either intravenous sedation or general anesthesia; CPA-2 form required)
59840 TG	Induced abortion by dilation and curettage includes physician's charges and clinic services with either intravenous sedation or general anesthesia and insertion of cervical dilator, e.g., laminaria; CPA-2 form required)
59841	Induced abortion, by dilation and evacuation (includes physician's charges and clinic services; CPA-2 form required)
59841 TF	Induced abortion, by dilation and evacuation includes physician's charges and clinic services with either intravenous sedation or general anesthesia; CPA-2 form required)
59841 TG	Induced abortion, by dilation and evacuation includes physician's charges and clinic services with either intravenous sedation or general anesthesia, and insertion of cervical dilator, e.g., laminaria; CPA-2 form required)
59870	Uterine evacuation and curettage for hydatidiform mole
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days, transabdominal approach; single or first gestation
76802	Each additional gestation, list separately in addition to code 76801
76805	Ultrasound, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)
76810	Each additional gestation, list in addition to code 76805

Code	Description
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Each additional gestation, use in addition to code 76811
76815	Ultrasound, pregnant uterus, B-scan and/or real time with image documentation; limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76830	Ultrasound, transvaginal (For obstetrical transvaginal ultrasound, use 76817)
76857	Ultrasound, pelvic (nonobstetrical), real time with image documentation; limited or follow-up (eg, for follicles)
90385	Rho(D) immune globulin (Rhlg), human, mini-dose, for intramuscular use
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 3 dose schedule, for intramuscular use
96127	Brief emotional/behavorial assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - straightforward medical decision making
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity

Code	Description
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity
99211	Office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician or other qualified health-care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - a problem-focused history; - a problem-focused examination; - straightforward medical decision making
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - an expanded problem-focused history; - an expanded problem-focused examination; - medical decision making of low complexity (limited service)
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - a detailed history; - a detailed examination; - medical decision making of moderate complexity
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - a comprehensive history; - a comprehensive examination; - medical decision making of high complexity (comprehensive service)
99384	Initial comprehensive preventive medicine evaluation and management of new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of a new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of a new patient; 40-64 years
99394	Periodic comprehensive preventive medicine reevaluation and management of an established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an established patient; 40-64 years

Code	Description
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individual (separate procedure); approximately 15 minutes. (HIV pre- and post-test counseling only; 2 visits per day; maximum eight visits per year)
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individual (separate procedure); approximately 30 minutes. (HIV pre- and post-test counseling only; 2 visits per day; maximum eight visits per year)
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
A4261	Cervical cap for contraceptive use
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system
A4266	Diaphragm for contraceptive use (includes applicator and contraceptive cream or jelly)
A4267	Contraceptive Supply, condom, male, each
A4268	Contraceptive Supply, condom, female, each
A4269	Contraceptive Supply, spermicide (e.g., foam, gel), each (per tube or package) (includes contraceptive sponges)
J0461	Injection, atropine sulfate, 0.01 mg
J0696	Injection, ceftriaxone sodium, per 250 mg
J1050	Injection, medroxyprogesterone acetate, 1 mg
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
J2210	Injection, methylergonovine maleate, up to 0.2 mg
J2790	Injection, Rho D immune globulin, human, full dose, 300 mcg (1500 i.u.) Use this code for RhoGam, HypRho SD. (When required only, reimbursed at the actual wholesale cost of the serum. A copy of the purchase invoice must be submitted with the claim form)
J3490- FP	Unclassified Drugs (service provided as part of a Medicaid family planning program) (may be used by other governmental purchasers of family planning services)
J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg

Code	Description
J7300	Intrauterine copper contraceptive (use for Paragard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg
J7304	Contraceptive supply, hormone containing patch, each
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies. Use this code for Implanon.
S0190	Mifepristone, Oral, 200MG
S0191	Misoprostol, Oral, 200MCG
S0199	Medically induced abortion Note: Includes all associated office visits, ultrasounds, labs, anesthesia, and counseling.
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies.
S4993	Oral contraceptives (birth control pills) actual cost up to maximum cost of $10.00 per cycle.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/01/2006	01/01/2012	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
10/03/2007	Format revisions and modification of “Responsibilities” to include members, providers, and the Plan. Added Family Planning Counseling code.	10/03/2007	Payment Policy Committee
10/10/2011	Updated formatting; added modifier requirements; removed definitions and responsibility and accountability; updated formatting	10/10/2011	Payment Policy Committee
02/02/2012	Updated coding	02/02/2012	Payment Policy Committee
12/02/2013	Updated template, product applicability section, and references for BMC HealthNet Plan	12/02/2013	Payment Policy Committee

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/01/2006	01/01/2012	Payment Policy	Payment Policy Committee

Policy Revisions History			
	Qualified Health Plans, including ConnectorCare		
12/17/2014	Annual review, updated coding and template.	01/01/2015	Payment Policy Committee
12/15/2015	Updated coding	01/01/2016	Payment Policy Committee
12/12/2016	Updated coding	01/01/2017	Payment Policy Committee
06/13/2017	Added CPT Q9984 to code table	07/01/2017	Payment Policy Committee
12/08/2017	Removed Q9984 and replace with J7296. Added J1726 and J1729 new codes, and removed deleted code 55450	01/01/2018	Payment Policy Committee
06/19/2019	Added new codes, new product applicability box, updated coding table	07/01/2019	Payment Policy Committee
03/08/2021	Removed code 99201	01/01/2021	Payment Policy Committee
10/19/2021	Removed deleted code J7303 and added J7295	11/01/2021	Payment Policy Committee
12/14/2021	Updated description of 11981 per 1/1/2022 code load	01/01/2022	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies:

- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Inpatient Hospital, 4.110
- Outpatient Hospital, 4.17
- Physician and Non-Physician Practitioner Services, 4.608
- Modifiers, 4.23

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Medical Policies:

- Genetic Testing Guidelines and Pharmacogenetics, OCA 3.727
- Preimplantation Genetic Testing (Preimplantation Genetic Diagnosis and Pregenetic Testing), OCA 3.726

References

- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- MassHealth Regulation 101CMR 313.00 – Rates for Freestanding Clinics Providing Abortion and Sterilization Services
- MassHealth Regulation 101 CMR 312.00 – Family Planning Services
- MassHealth Regulation 101 CMR 316.00 – Surgery and Anesthesia
- MassHealth Regulation 101 CMR 317.00 – Medicine
- MassHealth Regulation 101 CMR 318.00 – Radiology
- MassHealth Regulation 130 CMR 484.00, 130 CMR 485.00 and 130 CMR 421.00
- Abortion Clinic (ABR) Manual, Sterilization Clinic (STR) Manual and Family Planning (FPA) Mnual, Subchapters 1 through 6
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.