519.15 REPRODUCTIVE HEALTH SERVICES

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BACKGROUND

The West Virginia Bureau for Medical Services (BMS) covers reproductive health services for West Virginia Medicaid members when provided by an enrolled physician, physician assistant (PA), or advanced practice registered nurse (APRN) acting within the scope of his/her license. Services include but are not limited to family planning and sterilization services. This section lays out the conditions under which these reproductive health services are covered under Medicaid.

POLICY

519.15.1 Family Planning Services

West Virginia Medicaid covers family planning services for both male and female members and may be provided as part of a practitioner's routine care. Federal Regulation 42 CFR § 441.20 provides that each member must be free from coercion and free to choose the method of family planning to be used. The purpose of family planning is to reduce unintended pregnancies. Medicaid family planning services must be documented in the member's medical record.

In addition to family planning services provided by West Virginia Medicaid, the West Virginia Department of Health's Office of Maternal Child and Family Health (OMCFH) Family Planning Program also provides services under the Title X Family Planning program.

519.15.2 Long Acting Reversible Contractive (LARC)

Long-Acting Reversible Contraception (LARC) methods, including intrauterine devices (IUDs) and the contraceptive implant, are highly effective forms of contraception and are over 99% effective in preventing pregnancy for three to 10 years depending on the device. Providing women with easy access to LARC methods, including immediately postpartum, greatly reduces the risk of unplanned pregnancies, and improves the health of newborns and mothers by facilitating healthy spacing between pregnancies.

LARCs are covered in an outpatient setting in the physician's office and in the hospital. Practitioners should inform members, verbally and in writing, of all available forms of contraception and maintain documentation in the member's record.

LARC reimbursement by setting:

SETTING	DEVICE	INSERTION
Inpatient Hospital	When insertion is during any inpatient stay, hospitals will be reimbursed for the device in addition to the Diagnostic Related Group (DRG). A separate claim specific to the LARC must be submitted. • A LARC device from hospital inpatient pharmacy stock must be billed on the Uniform Billing (UB) form using Bill Type 0111.	The qualified attending provider performing the procedure will be reimbursed based on the ICD-10 Surgical Professional Service Code and corresponding Medicaid fee schedule, in addition to any postpartum inpatient services performed.

	• A LARC device from hospital out-patient pharmacy stock must be billed on the UB form with a Bill Type 0131.	Practitioners may bill for the professional service associated with the insertion of the LARC device on a separate Center for Medicare and Medicaid Services (CMS) 1500 claim, using the appropriate Current Procedural Terminology (CPT) code and place of service 21.
Office	Practitioners performing the insertion of a LARC in an office setting may bill for the device with the appropriate CPT code on a separate CMS 1500 claim with place of service 11.	Practitioners may bill for the professional service associated with insertion of the LARC device using the appropriate CPT code on a separate CMS 1500 claim with place of service 11.
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)	Practitioners performing the insertion of a LARC in a FQHC or RHC may bill for the device in addition to the encounter rate, using the appropriate HCPCS code that represents the device, along with the ICD-10 Surgical Code and ICD-10 Diagnosis Code that best describes the services delivered.	The qualified practitioner performing the insertion of the LARC device may bill for the associated professional service in addition to the encounter rate, using the appropriate CPT code on a separate CMS 1500 claim.

Covered Contraceptive Systems/Implants: The following list of codes is provided as a reference. This list may not be all inclusive and is subject to updates:

- 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
- J7300 Intrauterine copper contraceptive (ParaGard®)
- J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla®) 13.5 mg
- J7307 Etonogestrel contractive implant system, including implant and supplies (Nexplanon®)

519.15.3 Emergency Contraceptives

The morning-after pill, a type of emergency birth control that contains the hormone levonorgestrel, a progestin, (Plan B One-Step®, Next Choice®) or ulipristal acetate, a progesterone agonist-antagonist, (Ella®), is covered by Medicaid as a pharmacy benefit.

West Virginia Medicaid also requires a prescription for over the counter (OTC) emergency contraception if Medicaid is to be the payer. This includes all West Virginia Medicaid women of reproductive potential.

519.15.4 Sterilization

Sterilizations are covered for both male and female members in accordance with the Federal Social

Security Act, as implemented in regulation 42 CFR 441, Subpart F – Sterilizations, §441.253, §441.254, §441.257, and §441.258 and WV Code Section 9-5-12(e) (SB716). All of the following conditions must be met:

- The member must be at least 21 years of age at the time consent is obtained;
- The member must not be a mentally incompetent individual; and
- The member must have voluntarily given informed consent in accordance with all the requirements prescribed in §441.257 and §441.258 and WV Code Section 9-5-12(e) (SB716)

The West Virginia-specific Consent for Sterilization form must be completed in its entirety. The form must be kept in the member record and may be requested at any time.

To differentiate between claims with more than 30 days between informed consent and less than 30 days between informed consent, modifiers will be required. The following modifiers must be added to the professional claim form for reimbursement. This will also determine where the claim will be sent for reimbursement.

- If **less than** 30 days have passed between the date of the member's signature on the sterilization consent form and the date the sterilization, append modifier - SE to the current CPT code. The claim should be forwarded to the fee-for-service (FFS) fiscal agent for payment.
- If **at least** 30 days have passed between the member's signature on the sterilization form and the date of the sterilization, append modifier - FP to the CPT code. The claim should be forwarded to the fiscal agent (managed care organization (MCO) or FFS) that the member is assigned to.

Exception: If less than 30 days, but more than 72 hours after the date of the member's signature on the consent form and the date the sterilization was performed because of premature delivery or emergency abdominal surgery, append modifier - FP and forward the claim assigned fiscal agent (MCO or FFS) the member is enrolled in.

If no modifier has been added, the claim will be denied.

519.15.5 Non-Covered Services

Family planning services do not include procreative management or fertility services. Non-covered services are not eligible for the West Virginia Department of Human Service's Fair Hearings or Desk/Document Review. See 42 § 431.220 When a hearing is required for more information.

REFERENCES

West Virginia State Plan Sections 3.1(e), 3.1-A(4)(c), 3.1-B reference family planning services. West Virginia State Plan Section 3.4 references Sterilization services.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

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CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Reproductive Health Services	January 15, 2016
Entire Chapter	Added 519.15.2 LARC and moved 519.15.3 Emergency Contraceptives from 519.19 Women's Health Services.	November 1, 2019
Section 519.15.4 Sterilization	In accordance with Senate Bill 716, effective July 1, 2020, removes 30-day waiting period for tubal ligations and changes billing method to fee-for-service (FFS) for both FFS and MCO members.	July 1, 2020
Section 519.15.4 Sterilization	Add link to sterilization form and billing instructions for modifiers with instructions of when to send to MCO and when to FFS.	January 1, 2025