# 519.15 Reproductive Health Services

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## Disclaimer

This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.
BACKGROUND

Reproductive health services are covered for West Virginia Medicaid members when provided by enrolled physicians, physician assistants (PAs), or advanced practice registered nurses (APRNs) 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 provided 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 and Human Resources’ (DHHR) Office of Maternal Child and Family Health (OMCFH) also provides services under the Title X Family Planning program.

519.15.2 Long Acting Reversible Contraceptive (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 percent effective in preventing pregnancy. 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 as part of the postpartum stay. 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:

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| 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.  
Practitioners may bill for the professional service associated with the |
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- A LARC device from hospital outpatient pharmacy stock must be billed on the UB form with a Bill Type 0131.

- 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 CMS1500 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 CMS1500 claim with place of service 11.

Federally Qualified Health Center (FQHC)/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 CMS1500 claim.

Covered Contraceptive Systems/Implants: The following list of codes are 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) 52mg
- J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena) 52mg
- J7300 Intrauterine copper contraceptive (ParaGard)
- J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla) 13.5mg
- J7307 Etongestrel 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 progestosterone 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...
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Effective Date TBD

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Security Act, as implemented in regulation 42 CFR 441, Subpart F – Sterilizations, §441.253, §441.254, §441.257, and §441.258. The requirements are as follows:

- The member is at least 21 years of age at the time consent is obtained;
- The member is not a mentally incompetent individual;
- The member has voluntarily given informed consent in accordance with all the requirements prescribed in §441.257 and §441.258; and
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and date of the sterilization, except in the case of premature delivery or emergent abdominal surgery. The member may consent to be sterilized at the time of a premature delivery or emergent abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

The sterilization consent form must be complete in its entirety and attached to the claim for payment consideration. If any portion of the consent form is incomplete, inaccurate, or illegible, the claim will be denied. The BMS fiscal agent will not return the consent form for correction, changes, or additions. The consent form must include, but is not limited to:

- The Date of Surgery form must list the specific date the surgery was performed; “to be scheduled” and “after delivery” is not acceptable.
- The Physician’s Statement section must be fully completed by the physician.
- The Date of Physician’s Signature must occur within one day of the date of surgery.
- The interpreter’s statement, if applicable. The statement must be completed only if the member does not understand the language on the consent form or the language used by the person obtaining consent, and needs an interpreter. If this section is used, the interpreter must sign and date the consent form, using the date informed consent was given.

In order to establish the 72-hour period, the specific time of the signing of the consent form is necessary. If premature delivery is indicated on the consent form, the member’s expected delivery date must be indicated. If emergent abdominal surgery is indicated, the circumstances of the emergency must be explained. In both cases, the field for the condition that does not occur must be crossed out.

Informed consent is the voluntary assent from a member that he/she has been informed orally of, and given the opportunity to question and receive satisfactory answers concerning sterilization. Informed consent may not be obtained while the member is in any one of the following conditions:

- In labor or childbirth;
- Seeking or obtaining a pregnancy termination;
- Under the influence of alcohol or other substance that affects the individual’s awareness; and/or
- Under anesthesia.

The United States Department of Health and Human Services (DHHS) consent form must be used for sterilization, and must be signed and dated by the:

- Member who wants to be sterilized;
- Interpreter, if applicable;
- Person who obtained the consent; and
- Physician who performed the sterilization procedure.
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Photocopy, facsimile, or electronic format is acceptable.

519.15.5 Non-Covered Services

Family planning services do not cover procreative management or fertility services.

Non-covered services are not eligible for a West Virginia Department of Health and Human Resources (DHHR) Fair Hearing. See 42 CFR § 431.220 (when a hearing is required) for more information.

GLOSSARY

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

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.

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<td>Added 519.15.2 LARC and moved 519.15.3 Emergency Contraceptives from 519.19 Women’s Health Services</td>
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