

**Affected Programs:** BadgerCare Plus, Medicaid  
**To:** Family Planning Clinics, HMOs and Other Managed Care Programs

## Changes to Billing Policy for Family Planning Clinics

This *ForwardHealth Update* announces upcoming changes to billing policy for family planning clinics, effective for dates of service on and after April 1, 2017.

This *ForwardHealth Update* announces changes to billing policy for family planning clinics, effective for dates of service (DOS) on and after April 1, 2017.

### Claims

Currently, family planning providers may submit claims to ForwardHealth for family planning drugs and supplies with either Healthcare Common Procedure Coding System (HCPCS) procedure codes and National Drug Codes (NDCs) or NDCs only, with the exception of claims for emergency contraception, which currently must be submitted using NDCs only.

Effective for DOS on and after April 1, 2017, family planning providers will be required to indicate HCPCS procedure codes for family planning drugs and supplies on professional claims. Family planning providers will no longer be able to submit pharmacy claims with NDCs for family planning drugs and supplies. In addition, family planning providers are required to continue to comply with the federal Deficit Reduction Act of 2005 and submit NDCs with HCPCS procedure codes on all professional claims for drugs, regardless of whether or not the drug is acquired under the federal 340B Drug Pricing Program (340B Program) (i.e., Section 340B of the Public Health Service Act). Providers

should not submit claims with an unlisted, unspecified, unclassified, not otherwise classified, or not otherwise specified procedure code when there is another procedure code that better describes the drug. In circumstances when an unlisted, unspecified, unclassified, not otherwise classified, or not otherwise specified procedure code must be used, the NDC is still required. Attachment 1 of this *Update* lists allowable HCPCS procedure codes for covered family planning drugs and supplies.

Providers may refer to the Procedure Codes topic (topic #2661) in the Codes chapter of the Covered and Noncovered Services section of the Family Planning service area of the ForwardHealth Online Handbook for a list of all allowable family planning procedure codes.

Providers should refer to the Family Planning Online Handbook for additional information regarding claim submission and covered and noncovered services.

### ***New Procedure Codes for Family Planning Related Drugs Used to Treat Sexually Transmitted Infections***

#### *Sexually Transmitted Disease/Sexually Transmitted Infection Treatment*

Effective for DOS on and after April 1, 2017, ForwardHealth will cover the following additional HCPCS

procedure codes to be used on family planning clinics claims for drugs used to treat sexually transmitted infections:

- J3490 (Unclassified drugs) — Use this procedure code for gels and creams (e.g., metronidazole vaginal gel and miconazole nitrate cream). The HCPCS units billed for the detail must match the NDC units. For instance, if the NDC unit is one, indicate a quantity of one for the HCPCS unit on the claim detail.
- J8499 (Prescription drug, oral, non chemotherapeutic, NOS) — Use this procedure code for oral tablets and capsules that do not have an identified HCPCS procedure code (e.g., metronidazole 500 mg tablets). The HCPCS units billed for the detail must match the NDC units. For instance, if the NDC units are seven, indicate a quantity of seven for the HCPCS units on the claim detail.
- Q0144 (Azithromycin dehydrate, oral, capsules/powder, 1 gm) — Use this procedure code as described (e.g., azithromycin 250 mg tablet). The HCPCS units billed for this detail are defined by the procedure code; one unit equals 1 gm. For example, if four 250 mg tablets are dispensed, bill a quantity of 1 (i.e., 4 x 250 mg = 1000 mg and 1000 mg = 1 gm, which is the unit for this code).

Providers should refer to the following Online Handbook topics for policy and reimbursement requirements related to the procedure codes listed above:

- Unlisted Procedure Codes topic (topic #643) in the Codes chapter of the Covered and Noncovered Services section
- Not Otherwise Classified Procedure Codes topic (topic #5677) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section
- Documenting and Billing the Appropriate National Drug Code topic (topic #15957) in the Submission chapter of the Claims section
- Provider-Administered Drugs topic (topic #4382) in the Submission chapter of the Claims section

## **340B Drug Pricing Program**

### *Definition of the 340B Drug Pricing Program*

The 340B Program is a federal program that requires drug manufacturers to provide outpatient drugs to eligible covered entities at significantly reduced prices. Section 340B(a)(4) of the Public Health Services Act specifies which covered entities are eligible to participate in the 340B Program. The 340B Program enables covered entities to fully utilize federal resources, reaching more eligible patients and providing more comprehensive services.

Providers may determine if they are an eligible organization/covered entity to participate in the 340B Program and, if so, may register with the 340B Program through the Health Resources & Services Administration (HRSA) website at <http://www.hrsa.gov/opa/index.html>. Upon enrollment in the 340B Program, covered entities must determine whether they will use drugs purchased through the 340B Program for their Medicaid members (carve-in) or whether they will purchase drugs for their Medicaid members through other mechanisms (carve-out). Covered entities who carve-in must be listed on the HRSA 340B Medicaid Exclusion File (MEF), which is used to assist states and manufacturers in determining which drugs are not subject to Medicaid rebates.

### *Claim and Billing Requirements for Drugs Purchased Through the 340B Drug Pricing Program*

Providers who submit professional claims to ForwardHealth for drugs purchased through the 340B Program for DOS on and after April 1, 2017, are required to comply with revised billing instructions. ForwardHealth will require a modifier on professional claims to identify claims for drugs purchased through the 340B Program. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth will rely solely on the UD modifier to identify professional claims for drugs purchased through the 340B Program. If modifier UD is present, then the claims will be excluded from the drug rebate invoicing process. It is the responsibility of the 340B covered entity to indicate the

actual acquisition cost (AAC), and to correctly report claims filled with 340B inventory for 340B-eligible patients to ensure rebates are not collected for these drugs. If a rebate is received by ForwardHealth for a drug purchased through the 340B Program due to incorrect claim level identifiers, the 340B covered entity will be responsible for reimbursing the 340B discount to the manufacturer.

Covered entity providers who carve-in are required to submit their AAC when they dispense drugs purchased through the 340B Program to ForwardHealth members. ForwardHealth defines AAC as the calculated 340B ceiling price for the drug. The calculated 340B ceiling price refers to the maximum amount a manufacturer can charge a covered entity for the purchase of a covered outpatient drug through the 340B Program. Providers should contact HRSA directly with questions regarding drug ceiling price. Providers who dispense 340B inventory to ForwardHealth members will be reimbursed at AAC. Providers are required to bill their usual and customary fee for drugs not purchased through the 340B Program that they dispensed. The ForwardHealth reimbursement for drugs not purchased through the 340B Program will be the lesser of the billed amount or the Medicaid maximum allowable fee.

Providers may continue to bill a professional service procedure code with the drug or supply, as appropriate. For example, providers may bill *Current Procedural Terminology* (CPT) procedure code 11981 (Insertion, non-biodegradable drug delivery implant) or 58300 (Insertion of intrauterine device [IUD]) in addition to billing the procedure code for the implant or intrauterine device (IUD).

### ***New Modifiers for All Family Planning Drugs and Supplies***

Effective for DOS on and after April 1, 2017, ForwardHealth is adding the following new modifiers for all family planning drug and supply claims:

- Modifier UD — Family planning providers will be required to use modifier UD when dispensing drugs acquired under the 340B Program. Refer to the previous 340B Drug Pricing Program section of this *Update* for additional information about claims for drugs purchased

through the 340B Program. Do not add modifier UD to the professional service procedure code. For example, add modifier UD to procedure code Q0144 (Azithromycin dehydrate, oral, capsules/powder, 1 gm), but do not add modifier UD to procedure code H1010 (Non-medical family planning education, per session).

- Modifier GD — Providers will be required to use modifier GD with procedure code S4993 for **emergency contraception**. Both procedure codes S4993-GD (Contraceptive pills for birth control — emergency contraception) and S4993 (Contraceptive pills for birth control) are reimbursable on the same DOS. The maximum allowable fee for procedure code S4993-GD is established at a higher rate than for procedure code S4993. Providers should add other modifiers, as appropriate; however, they are required to list modifier GD first if more than one modifier is used.

### ***Coverage Changes***

Effective for DOS on and after April 1, 2017, ForwardHealth will remove quantity limits from all contraceptive implants and IUDs.

Effective for DOS on and after April 1, 2017, ForwardHealth will no longer accept procedure codes G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and G0123 (Screening cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision). These services should be submitted with the applicable CPT procedure codes.

### ***New Non-Medical Family Planning Education Procedure Code***

Effective for DOS on and after April 1, 2017, ForwardHealth will reimburse family planning clinics for procedure code H1010 (Non-medical family planning education, per session) for the non-medical family planning education clinics provide with nearly all drugs and supplies they dispense.

Providers may submit claims with procedure code H1010 when a health care professional or paraprofessional, including a clinic aide, provides education with the dispensing of a drug and/or supply. Since family planning education is included in a preventive medicine visit (i.e., procedure codes 99384–99387 and 99394–99397) providers may not bill procedure code H1010 with a preventive medicine visit. Procedure code H1010 is allowable once per member (i.e., one unit), per DOS, per provider. Family planning education is covered only when provided one-on-one, in a face-to-face session between the provider and the member. Providers will be required to retain documentation in accordance with Wis. Admin. Code § DHS 106.02(9).

### **Terms of Reimbursement**

Effective for DOS on and after April 1, 2017, ForwardHealth has revised the Family Planning Clinic Terms of Reimbursement, P-01654 (04/2017), to reflect the policy changes in this *Update*. The conditions outlined in the revised terms of reimbursement will automatically take effect; providers do not need to resubmit enrollment materials.

Refer to Attachment 2 for the revised Family Planning Clinic Terms of Reimbursement. This document will be available on the Terms of Reimbursement Provider Enrollment page of the Portal on and after April 3, 2017.

### **Documentation Retention**

As a reminder, providers are required to retain relevant documentation supporting adherence to the program requirements outlined in the Online Handbook and Wisconsin Administrative Code and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet program requirements.

### **Information Regarding Managed Care Organizations**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to

provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services, the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

P-1250

This *Update* was issued on 03/29/2017 and information contained in this *Update* was incorporated into the Online Handbook on 04/12/2017.

# ATTACHMENT 1

## Allowable Family Planning Drugs and Supplies

The following table contains a list of Healthcare Common Procedure Coding System (HCPCS) procedure codes for drugs and supplies that are allowable for Family Planning Clinics by ForwardHealth for dates of services on and after April 1, 2017. The table also indicates which procedure codes require a National Drug Code. Refer to the ForwardHealth Online Handbook for the complete listing of allowable procedure codes.

Procedure Code	Description	National Drug Code Required
A4261	Cervical cap for contraceptive use	No*
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	No*
A4266	Diaphragm for contraceptive use	No*
A4267	Contraceptive supply, condom, male, each	No*
A4268	Contraceptive supply, condom, female, each	No*
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each	No*
H1010	Non-medical family planning education, per session	No*
J0561	Injection, penicillin G benzathine, 100,000 units	Yes
J0696	Injection, ceftriaxone sodium, per 250 mg	Yes
J1050	Injection, medroxyprogesterone acetate, 1 mg	Yes
J3490**	Unclassified drugs	Yes
J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg	Yes
J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg	Yes
J7300	Intrauterine copper contraceptive	Yes
J7301	Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg	Yes
J7303	Contraceptive supply, hormone containing vaginal ring, each	Yes
J7304	Contraceptive supply, hormone containing patch, each	Yes
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	Yes
J8499**	Prescription drug, oral, non chemotherapeutic, NOS	Yes
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gm	Yes
S4993	Contraceptive pills for birth control	Yes
S4993-GD	Contraceptive pills for birth control — emergency contraception	Yes

\* Considered family planning supply without a drug component.

\*\* The HCPCS quantity in the detail field must match the NDC quantity reported for the detail. Providers are required to report the same quantity for both the National Drug Code (NDC) units billed and the HCPCS units billed for HCPCS procedure codes J3490 and J8499.

# **ATTACHMENT 2**

## **Revised Family Planning Clinic Terms of Reimbursement**

(A copy of the “Family Planning Clinic Terms of Reimbursement” is located on the following page.)

## **FAMILY PLANNING CLINIC TERMS OF REIMBURSEMENT**

The Wisconsin Department of Health Services (DHS) will establish maximum allowable fees for all covered family planning services provided to Wisconsin Medicaid members eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees for immunizations and laboratory procedures may reflect the maximum allowable fees for similar services provided by physicians. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients. For each covered service, DHS shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by DHS.

Providers participating in the federal 340B Drug Pricing Program (340B Program) are required to bill no more than the actual acquisition cost (AAC) for drugs purchased under the 340B Program. The AAC is defined as the calculated 340B ceiling price for the drug. For each covered drug purchased through the 340B Program, DHS will pay the provider-submitted 340B AAC.

Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department of Health Services will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to Wis. Stat. ch. 49.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Wis. Stat. § 49.46(2)(c).

In accordance with federal regulations contained in 42 C.F.R. § 447.205, DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

P-01654 (04/2017)



Wisconsin  
Department of Health Services