# CHAPTER IV
# COVERED SERVICES AND LIMITATIONS

**CHAPTER IV**
**TABLE OF CONTENTS**

# CHAPTER IV
# COVERED SERVICES AND LIMITATIONS

## INTRODUCTION

The Department of Medical Assistance Services (DMAS) administers the Medicaid fee-for-service limited benefit family planning program, **Plan First**. The purpose of Plan First is to prevent unintended pregnancies through coverage of family planning services for eligible men and women.

## ELIGIBILITY AND ENROLLMENT

Eligible individuals include men and women who meet the following criteria:

- Meet income requirements within 200 percent of the federal poverty level;
- Meet citizenship and identity requirements;
- Be a Virginia resident; and
- Not be eligible for a full-benefit Medicaid or FAMIS covered group.

Individuals must complete an application for Medical Assistance and opt in to Plan First to be evaluated for this covered group, regardless of age.

Individuals enrolled in Plan First are entitled to retroactive coverage of up to three months prior to the date the application was filed, if they meet all the requirements in the retroactive period. Individuals with other insurance coverage can be enrolled in Plan First; Medicaid is the payer of last resort. Individuals who have had a hysterectomy or sterilization procedure will not be prohibited from enrolling in Plan First. Please note that even though sterilizations are a covered service through Plan First, most individuals who have had a sterilization procedure will not have the need to access family planning services. However, there are instances when back-up contraception and follow up visits are needed to ensure that the sterilization procedure was a success.

Note: Members of Plan First are excluded from enrollment in a managed care organization (MCO).

Effective March 1, 2016, members enrolled in Plan First will receive a green and white Plan First ID card in the mail. If the member has a blue and white Commonwealth of Virginia Medicaid ID card, that card is no longer valid. Individuals previously enrolled in a Medicaid or FAMIS MCO may not continue to use any previously issued MCO card and must use the green and white Plan First ID card.

## BENEFIT AND COVERAGE LIMITATIONS

Plan First services are provided by enrolled DMAS (Medicaid) providers. DMAS currently reimburses enrolled providers for limited family planning services provided to eligible Plan First members. The services are reimbursed on a fee-for-service basis and are provided under the same administrative structure as Medicaid state plan benefits except with limited family planning covered services. Eligibility should always be verified prior to rendering services to any Medicaid member so the provider is aware of which program the member is enrolled.

The following services are covered under Plan First only when provided in accordance with the limitations and requirements specified.

Plan First covers **routine and periodic family planning office visits** including:

- Annual physical exams for family planning (birth control) purposes only, including exams for men and women;
- Cervical cancer screening for women;
- Laboratory services for family planning and Sexually Transmitted Infection (STI) testing;
- Family planning education and counseling;
- Sterilization procedures*;
- Most Food and Drug Administration (FDA) approved birth control methods provided by a clinician or obtained with a prescription** (such as contraceptive implants, ring, patch, IUDs, birth control pills, diaphragms, Depo Provera, and condoms); and
- Non-Emergency Transportation, if needed, which is limited to travel to and from a family planning service or pharmacy to obtain prescribed contraception. Please contact the Non-Emergency Medical Transportation Broker at 866-386-8331 to set up transportation or gas reimbursement to Plan First appointments.
-

*A completed sterilization consent form, in accordance with the requirements of 42 CFR Part 441, Subpart F, must be submitted with all claims for payment for sterilization procedures. See section on sterilization requirements in Chapter IV of the Physician/Practitioner Medicaid Provider Manual.

**Please refer to the DMAS Pharmacy Provider manual for specific coverage of DMAS fee-for-service pharmaceuticals, including supply limits and the Preferred Drug List (PDL).

If the Plan First member needs follow up care or treatment services pursuant to a family planning visit or any other medically necessary service not covered through Plan First, the Plan First provider may initiate a referral to a primary care provider. Note: The Plan First member will not have Medicaid coverage for services not listed on the approved billing code list available online at https://www.dmas.virginia.gov/for-providers/plan-first/ under Plan First - Family Planning Services Program.

Family planning office visits require the establishment of medical records, an in-depth evaluation of an individual including a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted infection prevention counseling, and issuance of supplies or prescription. Counseling in the family planning setting is interactive and includes education.

Family planning office visits are generally performed annually; however, may be more frequent depending on the method of contraception (e.g. Depo-Provera injections, either intramuscular every 11 to 13 weeks, or subcutaneously every 11 to 14 weeks). Laboratory tests are generally performed or recommended during an initial family planning visit and may be processed by an outside laboratory as needed as long as the claim for the outside lab includes the approved Plan First ICD diagnosis code. Additional screening tests are often performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Subsequent routine/periodic family planning visits generally include a cervical cancer screening and other screening laboratory tests depending on the method of contraception and the established protocol.

Service Limits

DMAS will only reimburse for service and supply codes approved for coverage through Plan First. The service and supply codes must be accompanied with an approved Plan First ICD diagnosis code. Please visit https://www.dmas.virginia.gov/for-providers/plan-first for a list of approved codes and specific billing information for Plan First.

Services must be performed in an office or clinic setting, except for sterilization procedures which can be covered in an outpatient or inpatient setting.

Services Not Covered

- Treatment for medical problems (including STIs or other reproductive health problem);
- Non-family planning prescription drugs;
- Performance of, counseling for, or recommendations of abortions;
- Infertility treatments;
- Performance of a hysterectomy or partial hysterectomy;
- Medical services outside scope of pregnancy prevention;
- Repeat cervical cancer screens or diagnostic tests/exams due to abnormal results or Pap tests for women who do not need birth control;
- Mammograms;
- Vaccinations (except for COVID-19 vaccines, as discussed above);
- Exams for women/men who no longer need or want pregnancy prevention services;
- Emergency transportation or ambulance coverage – ground or air; and Medical complications resulting from a family planning, contraception or sterilization service are not reimbursable under Plan First. Examples of such complications would be a perforated uterus or overwhelming uterine infection due to an intrauterine device or severe menstrual bleeding caused by an implant or contraceptive injection requiring a dilation and curettage.

Even though sterilizations are a covered service through Plan First, most individuals who have had a sterilization procedure will no longer need to access family planning services. However, Plan First will cover back-up contraception and follow-up visits until the member can confirm with their provider the sterilization procedure was a success.

Plan First does not cover primary care services, such as a diagnostic test/exam needed after an abnormal cervical cancer screening test. Providers for Plan First should refer members to seek appropriate follow up care from a primary care provider, free clinic, or Federal Qualified Health Center (FQHC). A list of community health centers to which members may be referred for treatment of conditions and services not covered through Plan First can be found through the Health Resources and Services Administration website: http://findahealthcenter.hrsa.gov. These clinics provide services on a sliding payment scale.

## CONTRACEPTIVE MEDICATIONS

Pharmacy Point of Sale Transactions

Routine contraceptives may be covered for up to a 12-month supply. Other medications will not be covered for members who are in Plan First. Plan First utilizes the same policy of contraceptive coverage as fee-for-service Medicaid. Please refer to the DMAS Pharmacy Provider Manual for additional information. A copy of the Pharmacy Provider Manual is available on the DMAS website at www.virginiamedicaid.dmas.virginia.gov, under Provider Services. Please note that there are specific National Drug Codes (NDCs) which are covered through point of sale pharmacy and may change on a regular basis. For more information about Medicaid covered NDCs please follow up with a local pharmacist.

Physician Administered Medications

For contraceptive injections that are administered in an office or outpatient setting, the physician must purchase the device and should use the Healthcare Common Procedure Coding System (HCPCS) code for these types of contraceptives when submitting the claim on a CMS-1500 form so that the drug can be covered by Plan First. DMAS will reimburse the provider their actual invoice cost for the contraception. Please note that any prescribed FDA approved contraception may be covered through Plan First when billing the appropriate HCPCS code and dispensed by a clinician.

## STERILIZATIONS

Providers must follow the guidelines for sterilizations as detailed in Chapter IV, “Covered Services and Limitations”, of the DMAS Physician/Practitioner Provider Manual. The “Sterilization” section of this chapter contains information on the conditions for coverage, informed consent process, the sterilization consent document and instructions for completion and claims information. A copy of the manual is located on the DMAS website at www.virginiamedicaid.dmas.virginia.gov.

## COMMUNITY RESOURCES AND REFERRALS

Primary Care Services

At a minimum, the primary family planning office visit will include oral counseling to the Plan First member addressing how he or she may access primary care services, as well as information on how to locate medical providers. This may be provided to the member

via the Plan First program brochure which is available on the DMAS website at www.planfirst.org.

Community Health Centers

Community Health Centers (CHCs) are nonprofit organizations located in medically underserved areas that provide comprehensive primary health care to anyone seeking care. In addition to treating individual members, a health center emphasizes health promotion and disease prevention for entire communities. A CHC does not deny anyone primary health care services - all community residents have equal access regardless of ability to pay, geographic location, culture, age, sex, or religion. As Federally Qualified Health Centers (FQHC), CHCs provide a wide range of services to their members. Among the core services are:

- Physician care
- X-Ray services
- Laboratory services
- Preventive services (mammography, well-child, etc.)
- Immunizations
- Transportation for health services
- Case management
- Specialty referrals

Area clinics may be located through the Health Resources and Services Administration website at: http://findahealthcenter.hrsa.gov.

Every Woman's Life

Plan First provides an annual family planning physical exam, cervical cancer screening test, lab services, contraceptives and family planning education and counseling services to women through the family planning office visit. Women with an abnormal cervical cancer screening test or breast exam do not have follow up coverage through Plan First. These women should be referred to a provider, such as the Every Woman's Life (EWL) program for further testing. Women eligible for the EWL program must be age 18 to 64, under-or uninsured, have an income at or less than 200% of the Federal Poverty Level, and reside in Virginia. Women enrolled in EWL and diagnosed with breast and cervical cancer (including pre-cancerous conditions) and certified as needing treatment may be eligible for payment of medical services under the Breast and Cervical Cancer Prevention

and Treatment Act (BCCPTA). EWL staff will refer these cases to their local Department of Social Services for a Medicaid eligibility determination. Women enrolled in the BCCPTA, a full coverage Medicaid program, will be disenrolled from Plan First. Once cancer treatment is completed and the woman is no longer eligible for services under the BCCPTA; the woman must apply for Plan First coverage to be reenrolled in the Plan First program. Women diagnosed with cancer by a provider who is not operating under the EWL program are not eligible for the BCCPTA.

If you have questions about EWL, or would like to make a referral, call the Virginia Department of Health's EWL toll-free line at 1-866-395-4968.

Virginia Department of Health Family Planning Clinics

The Virginia Family Planning Program provides women and men with the ability to decide if they want to have children and if so, how many and how far apart they want to space them. The Family Planning Clinics provide a broad range of acceptable and effective family planning birth control methods and services. All services are confidential. The Family Planning Clinics are providers for Plan First and may also offer additional services which are affordable and provided at low or no cost based on an individual's income. A Family Planning Clinic is available in many city and county health department in the state. For more information about Family Planning Clinics or to locate a local clinic, please visit the Virginia Department of Health website at http://www.vdh.virginia.gov/lhd.

## DOCUMENTATION REQUIREMENTS

The provider agreement requires that the medical records fully disclose the extent of services provided to members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and must be legible and clear in the description of the services rendered. Individual providers must follow documentation requirements as outlined in the appropriate DMAS Provider Manual for the provider's profession (i.e., Physicians must follow the documentation requirements outlined in the DMAS Physician/Practitioner Provider Manual, laboratory providers must follow the documentation requirements outlined in the DMAS Independent Laboratory Provider Manual, etc.).