Arkansas Department
Of Health and Human Services
Division of Medical Services

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OFFICIAL NOTICE

DMS-2006-A-4 DMS-2006-O-3 DMS-2006-X-1 DMS-2006-II-4
DMS-2006-L-4 DMS-2006-SS-3 DMS-2006-KK-4 DMS-2006-R-4
DMS-2006-OO-3

TO: **Health Care Provider – Ambulatory Surgical Center; Certified Nurse-Midwife; Family Planning; Federally Qualified Health Center (FQHC); Hospital; Independent Lab; Nurse Practitioner; Physician; Rural Health Clinic (RHC) and Arkansas Division of Health**

DATE: **June 20, 2006**

SUBJECT: **Family Planning Services**

I. Introduction

The purpose of this Official Notice is to inform providers of changes required by the Centers for Medicare and Medicaid Services (CMS) to be implemented **June 28, 2006**. Arkansas Medicaid covers family planning services for beneficiaries in full-coverage aid categories ("regular Medicaid") and covers many family planning services for women of child-bearing age who are Medicaid-eligible only in aid category 69 and who participate in the Arkansas Women's Health Program, a research and demonstration project approved by CMS.

NOTE: Currently, the system is unable to process claims with the newly added family planning procedure codes included in this notice. Providers will be notified when the necessary system changes are complete.

Please hold affected claims until further notice.

II. Non-Payable Family Planning Procedure Codes

A. Women's Health Program

Effective for dates of service on and after June 28, 2006, the procedure codes listed below are no longer payable for Women's Health Waiver (Aid category 69) beneficiaries.

58605 58611 58661 58700 S0612

B. Regular Medicaid

Effective for dates of service on and after June 28, 2006, procedure code **S0612** is no longer covered as a family planning service.

S0612 is covered for annual gynecological examinations for beneficiaries of regular Medicaid services with a diagnosis other than family planning service. Paper claims require type of service code **"1"**.

III. Continued Coverage of Services for Regular Medicaid Beneficiaries

Procedure codes **58605**, **58611**, **58661** and **58700** remain payable as family planning services for beneficiaries of regular Medicaid.

A. Providers of professional services must use modifier **FP** for procedure codes **58605**, **58611**, **58661** and **58700**. Paper claims require type of service code **"A"**, modifier **FP**, a primary detail diagnosis of family planning and form DMS-615.

B. Claims for facility charges for **58605** must be billed as an inpatient claim with required consent form DMS-615.

Facility charges for procedure codes **58611**, **58661** and **58700** remain payable as family planning services for beneficiaries of regular Medicaid. Claims for these services require a primary diagnosis of family planning. Claims must be filed on paper with the required form DMS-615.

IV. Procedures Relating to **58565** – Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (Essure)

A. Effective for dates of service on and after February 1, 2006, conscious sedation (procedure codes **99144** and **99145)** may be covered as a family planning service only when it is administered in conjunction with the Essure procedure (**58565**).

1. To file electronic claims for these professional services, use modifier **FP.** On paper claims, use type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

   Claims filed for these professional services when provided in an outpatient hospital clinic do not require modifiers if filed electronically. If billing on paper, type of service **"J"** is required. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis.

2. Facility fees for **99144** and **99145** are included in the facility fee for **58565**.

B. Effective for dates of service on and after February 1, 2006, procedure codes **58340**, **58345**, **72190**, **74740** and **74742** are only payable as family planning services within the 6 months after the Essure procedure's date of service. The following billing instructions apply.

1. Professional claims for procedure codes **58340** and **58345** must be filed with modifier **FP**. Paper claims require a type of service code **"A"** and modifier **FP**. Whether billing on paper or electronically, the primary detail diagnosis code for each procedure must be a family planning diagnosis code.

   The following instructions apply when procedures **58340** and **58345** are performed in an outpatient clinic associated with a hospital.

   Claims for professional services provided in an outpatient clinic associated with a hospital must be filed with a type of service code **"J"**. Whether billing on paper or electronically, a family planning diagnosis code must be listed as primary on the claim detail.

   When filing facility claims for **58340** and **58345**, a primary diagnosis of family planning is required.

2. Professional claims for procedures **72190**, **74740** and **74742** must be filed with modifier **FP**. Paper claims require a type of service code **"A"** and modifier **FP**. Whether billing paper or electronic claims, each detail requires a family planning diagnosis code.

   When these radiology procedures are performed as family planning services in an outpatient hospital clinic, bill Medicaid in accordance with the following instructions.

   Claims for the professional component of procedure codes **72190**, **74740** and **74742** require type of service code **"J"** on paper claims. No modifier is necessary on electronic or paper claims. Whether billing on paper or electronically, a family planning diagnosis code must be listed as primary on each detail.

   Facility (outpatient hospital clinic) claims for procedure code **72190** require a family planning diagnosis code as the primary diagnosis.

C. Procedure codes **J1055**, **11976** and **58301**, are currently payable family planning services. Effective for dates of service on and after February 1, 2006, these procedures are also covered up to six months as necessary for follow-up services to the Essure procedure. When provided for post-Essure follow-up care, billing protocol is unchanged for **J1055**, **11976** and **58301** for all providers.

All visits related to post-Essure services during the 6 months following the Essure procedure are included in the fee allowed for **58565**.

V. Laboratory Procedures

Effective for dates of service on and after February 1, 2006, laboratory procedure codes **87491** and **87591** are covered as family planning services.

Professional claims for procedure codes **87491** and **87591** must include modifier **FP**. Paper claims require a type of service code **"A"** and modifier **FP**. Whether a claim is paper or electronic, a family planning diagnosis code must be listed as primary on each detail.

Facilities billing for **87491** and **87591** as family planning services must have a primary diagnosis of family planning on the claim, whether billing electronically or on paper.

Thank you for your participation in the Arkansas Medicaid Program.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 TDD.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals, official notices and remittance advice (RA) ages are available for downloading from the Arkansas Medicaid website: ***www.medicaid.state.ar.us*****.**

Roy Jeffus, Director