

Plan First: Provider Frequently Asked Questions



Billing

What Counts for Reimbursement

Q: *Must annual exams be at least one calendar year apart to be reimbursed?*

A. Yes, if you must perform the annual exam prior to one calendar year from previous exam (date of service), attach medical documentation supporting the need to perform exam sooner.

Q. *Will Plan First pay for a pregnancy test when ordered - before birth control is dispensed?*

A. The pregnancy test will be covered under Plan First as long as the code used is on the list of approved billing codes for Plan First listed at the link below and it uses a diagnosis within the "Encounter for contraceptive management" series.

http://dmasva.dmas.virginia.gov/Content_atchs/mch

Q: *I have a Plan First patient on Depo Provera and her pharmacy won't cover it. Is that right?*

A: Yes. She cannot get Depo Provera through a local pharmacy due to the DMAS Pharmacy policy which only allows 34-day limit at a time as well as requiring physician administered drugs/supplies but be purchased up front by practitioner and billed to DMAS only after administration. Her prescribing provider needs to order it and then can get reimbursed upon administration of the drug (buy and bill policy).

Q: *A patient receives an annual exam but has no plans for birth control. Can this visit be billed under a family planning visit with Plan First?*

A: As long as family planning is discussed at the appointment, the visit can be coded as a Family Planning visit using the "Encounter for contraceptive management" ICD diagnosis series. This does not mean the member has to actively be practicing pregnancy prevention, but it does require its discussion between the health provider and the member.

Q: *Can we bill for a problem identified during a Plan First visit (e.g., yeast infection)?*

A: Plan First will pay for the office visit if within the context of a family planning visit when the problem was identified. Plan First will **not** cover any necessary treatment.

Coding

Q: *Does the ICD "Encounter for contraceptive management" diagnosis code have to be the primary code for reimbursement?*

A: The most appropriate "Encounter for contraceptive management" diagnosis code does not have to be primary but must be listed in one of the diagnosis fields on the claim.

Q: *What code can we use for an ultrasound of the arm when the provider is otherwise unable to locate a contraceptive implant for its removal?*

A: Refer to the list of approved Plan First codes to determine which ultrasound code is most appropriate: http://dmasva.dmas.virginia.gov/Content_atchs/mch

Q: How do we code for lab work covered under Plan First?

A: Refer to the list of approved Plan First codes to determine which lab codes are most appropriate: http://dmasva.dmas.virginia.gov/Content_atchs/mch

When you send labs, you should use the same "Encounter for contraceptive management" diagnosis code that was used by the referring physician for the office visit.

Q: Why was our claim for an annual office visit paid and the PAP smear denied?

A: Use the E&M office visit code that reflects the level of care given during the visit, including the administration of the pap smear. Plan First claims require a "Encounter for contraceptive management" diagnosis code pointing to every appropriate procedure code to be covered under Plan First. Note: Plan First does **not** reimburse claims that use the **preventive** evaluation and management (E&M) CPT codes. Additional guidelines are available in the current CPT manual, "Evaluation and Management (E/M) Services Guidelines."

Q: When a patient receives a depo injection, how can the provider bill for the office visit?

A: The provider would bill for the new injection (96372) and the supply code (J1050). If the practitioner performed a separate and distinct service from the depo injection during that visit, the most appropriate E&M visit code could be billed.

Q: During a visit for a Depo injection, our nurse provided family planning counseling. We billed for it, since it was a distinct and separate service, but the claim was denied. Can you explain why?

A: Nursing time is built into the administration code 96372.

Q: What if the primary insurance requires the preventive codes and won't pay for all? How can we resubmit to Plan First for the balance?

A: Bill the primary insurance with the preventive code. After claim processes with other insurance, the provider can change the code to the most appropriate E&M office visit code and send a letter or simple note written on EOB for other carrier.

Q: What documentation do health departments need to submit with SubQ Depo claim?

A: Health Departments are NOT required to submit an attachment of medical documentation for J Codes, including J8499. Non-Health Department providers have to submit J1050 and adjust for dosage.

Q: How are charges not covered by Plan First separated on the claim form?

A: Use the diagnosis pointer on the claim to match the appropriate procedure code to the appropriate diagnosis code. Only those codes approved for use under Plan First along with the "Encounter for Contraceptive Management" will be reimbursed.

Reimbursement and Patient Payment

Q: Can a Primary Care Provider be reimbursed for family planning counseling?

A: Yes, providers must be enrolled with the Department of Medical Assistance Services.

Q: If a patient has a high deductible on her/his current insurance, will Plan First pay?

A: If the patient is enrolled in Plan First and has other insurance, Plan First is the payor of last resort. So if the deductible doesn't pay for covered services, Plan First will.

Q: Can we bill the patient for amounts not reimbursed by Plan First?

A: Providers may not balance-bill the patient for a Plan First covered service. Providers must accept DMAS payment in full.

Q: Is there a waiver we can have patients sign to ensure that they understand their payment obligations for services not covered under Plan First?

A: DMAS does not have a standard waiver form that the patient signs. The Plan First program does have a Plan First Member Fact Sheet that summarizes basic services covered and not covered (also found on www.PlanFirst.org). We suggest that you provide each new Plan First patient with this handout, review the basic coverage limits with and explain that she/he will be responsible for payment of non-covered services.

Q: A patient was recently enrolled into Plan First. We've already received payment from her for a covered service provided during the 3-month retroactive period. What should we do?

A: DMAS does not require the provider to bill at that point; DMAS can only reimburse providers, not members. If the provider is willing, it can: 1) bill DMAS for the visit using the Plan First approved coding; and 2) upon receipt of reimbursement from DMAS, reimburse the patient.

Q: To what extent does Plan First reimburse for services not covered by a member's private insurance?

A: The rules for Third Party Liability for family planning are the same as with all other programs. Medicaid is the payer of last resort. DMAS will reimburse the difference up to its allowed amount. If the primary carrier's reimbursement exceed Medicaid's, it is considered payment in full.

Q: Can an Federally Qualified Health Center (FQHC) bill Plan First for IUD insertion if it secures the IUD through other means (e.g., pharmacy program that pays for prescriptions for indigent)?

A: Yes, the provider can bill for the insertion even if another source pays for the supply.

Q: Can we code for IUD insertion and/or removal for abnormal bleeding if the IUD is also being used for contraceptive purposes?

A: Yes. Bill the appropriate CPT codes and add diagnosis for abnormal bleeding. The "Encounter for contraceptive management" diagnosis must also be used and pointed to the procedure code for Plan First to cover.

Q: How long do we have to resubmit a denied claim?

A: You must submit within 13 months from the date of the denied claim. The original claim must be submitted within 12 months from date of service.

Q: Can we bill a "no-show" fee for a Plan First patient?

A: No. This would violate the DMAS Provider Enrollment agreement.

Q: Are there co-payments for services covered by Plan First?

A: No, there are no co-payments for family planning services.

For complete information about Plan First billing, go to
http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx