

## Plan First: Frequently Asked Provider 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 codes and it uses a diagnosis within the V25 series.

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

A: She cannot get Depo through a local pharmacy due to the Medicaid 34-day limit fee-for-service pharmacy rule. Her prescribing provider needs to order it and then can get reimbursed upon administration of the drug.

***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 and billed under Plan First. 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 if the problem was identified within the context of a family planning visit and the visit can be coded as a Family Planning visit, **but** it will **not** cover any necessary treatment.

#### Coding

***Q: Does the V25 diagnosis code have to be the primary code for reimbursement?***

A: The V25 family planning ICD-9 diagnosis code does not have to be primary but must be listed in one of the four diagnosis fields.

***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: Use 76881. It is coverable as a family planning-related service and reimbursable when a V25 series diagnosis code is included. Note: 76881 replaced 76880, which was deleted from CPT.

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

A: When you send labs, you should use the same V25 diagnosis code that was used by the referring physician for the office visit.

***Q: Why was our claim for an annual Pap denied?***

A: Plan First does **not** reimburse claims that use the **preventive** evaluation and management (E&M) CPT codes. The use of any preventive E&M code for a Plan First member will be denied as a non-covered

service. If you want to submit a claim for a visit and the reason for the visit was to receive the annual well woman exam and Pap smear, you may use the following guidelines for billing Plan First:

- Use the E&M office visit code that reflects the level of care given during the visit, including the administration of the pap smear.
- Provide documentation to support the level of care in the patient's medical records.
- Plan First claims require a family planning ICD diagnosis code (V25 series); however, providers should also enter any other relevant diagnosis 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.

## **Reimbursement and Patient Payment**

***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: 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 patient information sheet that summarizes basic services covered and not covered (also found on [www.PlanFirst.org](http://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: We provided, and were reimbursed for, covered services for a patient who ended up not being able to provide proof of legal residency within the 90 day period as required by DSS for non-citizens. What should we do?**

A: DMAS will not seek reimbursement of payments from providers if the member is disenrolled due to not meeting citizenship requirements.

**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 contraceptive diagnosis must also be used.

**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.

**For complete information about Plan First billing, go to**  
[http://dmasva.dmas.virginia.gov/Content\\_pgs/mch-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx)