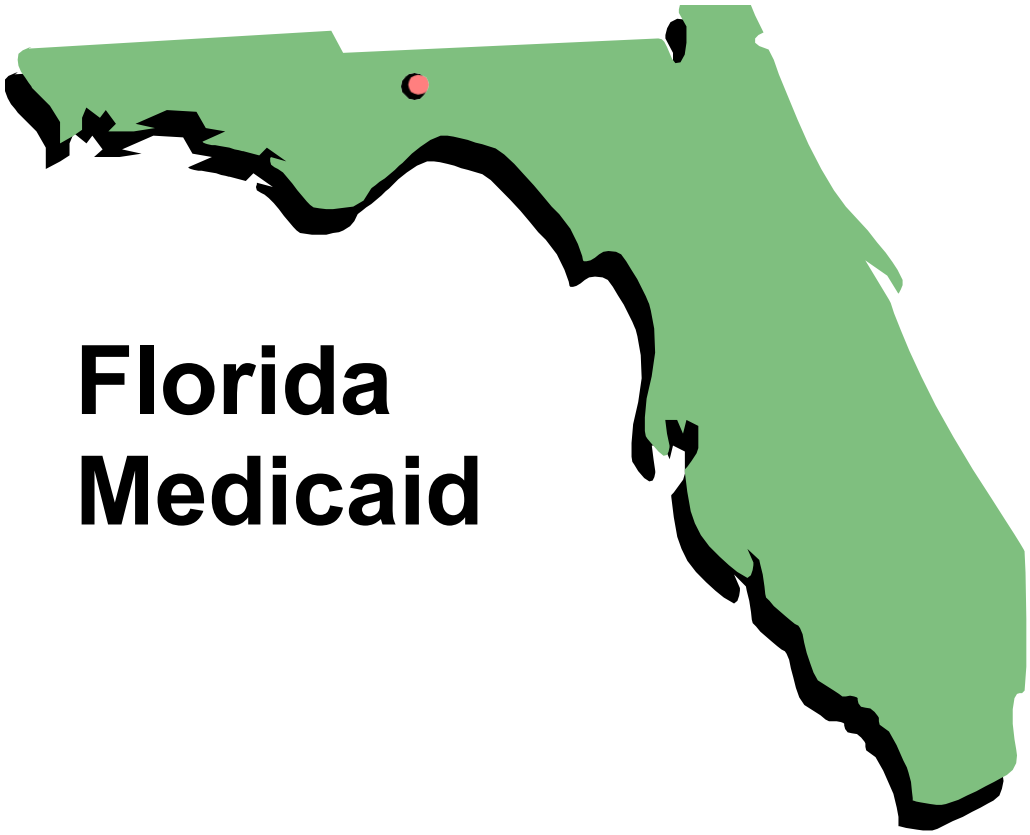


Florida Medicaid

Reproductive Services Coverage Policy

Agency for Health Care Administration

October 2026 ~~**July 2016**~~

Incorporated by reference in Rule 59G-4.030, F.A.C.

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1.0 Introduction

1.1 Description

Florida Medicaid reproductive services provide diagnostic and therapeutic procedures relating to the reproductive system, including obstetrical and family planning services.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render reproductive, obstetrical, and family planning services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website ~~Web site~~ at https://ahca.myflorida.com/medicaid/rules.html ~~http://ahca.myflorida.com/Medicaid/view/index.shtml~~.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of reproductive, obstetrical, and family planning services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Reproductive, obstetrical, and family planning services are authorized by the following:

- Title XIX of the Social Security Act, (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Sections 409.905 and 409.906, Florida Statutes (F.S.)
- ~~Rule 59G-4.030, F.A.C.~~

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Ddefinitions P~~p~~olicy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 Elective Delivery

An induction of labor or cesarean section performed before the 39th week of gestation when there is no medical or obstetric indication for delivery.

1.3.4~~1.3.3~~ General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5~~1.3.4~~ High-Risk Pregnancy

A pregnancy in which a woman's medical history and diagnosis indicates, without consideration of a previous cesarean section, that a normal uncomplicated

pregnancy and delivery are unlikely to occur.

1.3.6~~1.3.5~~ Medical Necessity/Medically Necessary
As defined in Rule 59G-1.010, F.A.C.

1.3.7~~1.3.6~~ Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.8~~1.3.7~~ Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary reproductive services. Some services may be subject to additional coverage criteria as specified in section 4.0.

Individuals enrolled in the Florida Medicaid Family Planning Waiver are only eligible for family planning services specified in sections 4.2.2 and 4.2.3 that are indicated with an asterisk (*). Visit https://ahca.myflorida.com/medicaid/medicaid-family-planning-waiver-program.html ~~http://ahca.myflorida.com/Medicaid/Family_Planning/index.shtml~~ for more information.

2.3 Coinsurance, Copayment, or Deductible

Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's Ccopayment and Ccoinsurance Ppolicy:

- $2.00 per practitioner office visit, per day
- $3.00 per federally qualified health center visit, per day
- $3.00 per rural health clinic visit, per day

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid Reproductive Services ~~be at least one of the following to be reimbursed for services rendered to eligible recipients~~.

- ~~Enrolled directly in Florida Medicaid if providing services through a fee-for-service delivery system~~
- ~~Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan~~

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- Birth centers operating and licensed in accordance with Chapter 383, F.S.
- County health departments (CHD) administered by the Florida Department of Health (DOH) in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Regional perinatal intensive care centers certified by DOH
- Rural health clinics certified by Medicare

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers ~~reimburses for~~ services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers ~~reimburses for~~ the following services in accordance with the American Medical Association Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Obstetrical Services

Prenatal, delivery, and postpartum services for pregnant recipients as follows:

- One prenatal visit that includes a Healthy Start prenatal risk screening
- Up to ten visits, per recipient, for prenatal care
- Testing for sexually transmitted diseases in accordance with section 384.31, F.S. and Rule 64D-3.042, F.A.C.
- Tobacco use screening, smoking cessation counseling, and treatment
- Supplies, medications, and treatments
- One delivery every 280 days, per recipient
- Repair during or following pregnancy
- One recovery service per home birth
- One newborn assessment, per recipient
- Up to two postpartum visits within 90 days following delivery, per recipient

Florida Medicaid reimburses for the following in addition to the services listed above, when medically necessary:

- Up to four additional prenatal visits, per recipient experiencing a high-risk pregnancy
- One neonatology consultation per specialty referral, per recipient
- Surgical excision during pregnancy
- Fetal invasive services
- Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome performed by providers with a maternal-fetal medicine subspecialty
- Induction of labor
- Cesarean section

4.2.2 Family Planning Services

Services that enable recipients to voluntarily plan family size or length of time between births, as follows:

- Family planning visits:*
  - One new patient visit, per recipient
  - One established patient visit every 365 days, per recipient
- Counseling visits*
- One supply visit per month, per recipient*
- Human immunodeficiency virus (HIV) counseling visits:*
  - Up to two preventive visits per lifetime, per recipient
  - Up to four visits per year, per recipient with acknowledged behavioral risks
- Laboratory tests*
- Sexually transmitted disease treatment and follow-up*

For information on Florida Medicaid coverage and reimbursement of contraceptives, please refer to the Florida Medicaid Prescribed Drug Services Coverage Policy.

4.2.3 Sterilization Services

Medical or surgical procedures to permanently prevent reproduction, in accordance with 42 CFR 441.253, as follows:

- ~~Essure® (non-incisional surgical procedure)*~~
- Tubal ligation~~*~~
- Vasectomy

4.2.4 Salpingectomy Services

Operative procedures for removal of one (unilateral) or both (bilateral) fallopian tubes.

4.2.5~~4.2.4~~ Hysterectomy Services

Operative procedures for partial or complete removal of the uterus, with or without removal of fallopian tubes and ovaries.

4.2.6~~4.2.5~~ Therapeutic Abortion Services

Legal terminations of pregnancies that are a result of rape or incest, or when the health of the woman is at risk in accordance with 42 CFR 441, Subpart E.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Aauthorization Rrequirements Ppolicy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered ~~reimbursed~~ when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover ~~reimburse for~~ the following:

- Delivery of two or more infants from a single pregnancy, by the same delivery method, separately
- Deliveries that are not assisted by a licensed practitioner acting within his or her scope of practice
- Elective delivery procedures prior to 39 weeks of gestation ~~that is not medically indicated~~
- Family planning counseling and supply visits on the same date of service
- Family planning procedure on the same date of service as an evaluation and management visit
- Fetal biophysical profile and a non-stress test, during the same visit
- Hysterectomy or salpingectomy services solely for rendering an individual permanently incapable of reproducing
- Infertility evaluation or treatment
- Prenatal visit and delivery service on the same date of service
- Routine newborn circumcision
- Routine prenatal and postpartum services for undocumented aliens
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives or caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid Ttelemedicine Ppolicy

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Rrecordkeeping and Ddocumentation Ppolicy.

6.2 Specific Criteria

Providers must complete and maintain the following documentation in the recipient's file, as applicable:

6.2.1 Obstetrical Services

The Florida Department of Health Healthy Start Prenatal Risk Screening Form, incorporated by reference, and available from the local county health department.

6.2.2 Family Planning Services

For HIV counseling services:

- Record of any identified risk factors or stating, "No acknowledged risk"
- Post-test HIV counseling session referrals, as appropriate to diagnosis

6.2.3 Sterilization Services

The U.S. Department of Health and Human Services' Consent for Sterilization Form - HHS-687 ~~(10/12)~~, incorporated by reference, and available at https://opa.hhs.gov/grant-programs/title-x-service-grants/key-resources-title-x-grantees ~~https://opa.hhs.gov/grant-rpograms/title-x-service-grants/key-resources-title-x-grantees~~.

~~Providers must specify Essure® method of sterilization on the consent form, if appropriate, and submit the form with the claim.~~

6.2.4 Hysterectomy Services

The appropriate AHCA form, incorporated by reference in Rule 59G-1.045, F.A.C.:

- State of Florida Exception to Hysterectomy Acknowledgment Requirement, ETA-5001, June 2016
- State of Florida Hysterectomy Acknowledgment Form, HAF-5000, June 2016

Providers must submit the applicable form with the claim.

6.2.5 Therapeutic Abortion Services

The State of Florida Abortion Certification Form, AHCA MedServ Form 011, June 2016, incorporated by reference in Rule 59G-1.045, F.A.C.

Providers must submit the form and any documentation required in 42 CFR 441.206 with the claim.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Aauthorization Rrequirements Ppolicy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization for the following:

- ~~Elective cesarean sections~~
- Twin-to-twin transfusion
- Vaginal delivery of one newborn followed by cesarean section of another

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type
Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Billing Code
Providers must include the following on the claim form, as appropriate:

- 59409 TC — Facility fee to birth center when birth occurs at birth center (reimbursable on the same date of service as delivery fee)
- 59820 or 59821 — Deliveries less than 20 full weeks of gestation
- 99401 and 99402 — HIV preventive counseling visits
- 99354 and 99355 — Labor management when recipient transferred from birth center or home to hospital for delivery
- 59400 and 59510 — Third-party liability delivery
- H1000 — Prenatal visit(s)
- H1001 — Prenatal visit with completion of Healthy Start Prenatal Risk screening
- ~~58565 and A4264 — Essure® sterilization device~~

Providers must include the Healthcare Common Procedure Coding System (HCPCS) code and valid National Drug Code number for injectable and implantable contraception services, and the specific HCPCS code for intrauterine device(s), as appropriate.

8.3.2 Modifier

- 26 — Professional component performed by a different provider than the technical component
- 91 — Repeat clinical diagnostic laboratory test, distinct or separate from a panel or other lab services performed on the same day, performed to obtain medically necessary subsequent reportable test values
- FP — Family planning visit billing codes
- TC — Technical component performed by a different provider than the professional component
- TG — Healthy Start Prenatal Risk Screening completed during the first trimester
- TH and # gestations — Fetal echocardiography, fetal non-stress tests, and fetal ultrasounds
- U7 — Elective cesarean section prior to 39 weeks gestation
- U8 — Scheduled cesarean section after 39 weeks gestation
- U9 — Emergency (intrapartum) cesarean section

Regional Perinatal Intensive Care Center providers must include the TG modifier on the claim form.

Providers may not include both the TC and 26 modifiers on the claim form for a single procedure.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, a incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA website ~~Web site~~ at https://ahca.myflorida.com/medicaid/rules.html ~~http://ahca.myflorida.com/Medicaid/review/index.shtm~~.

8.5.1 Global Surgery Package

Florida Medicaid reimbursement includes all necessary services normally furnished by a surgeon before, during, and after a procedure in accordance with the Centers for Medicare and Medicaid Services' (CMS) global surgery period specifications.

For more information, see the CMS website at https://www.cms.gov/search/cms?keys=global+surgery+package ~~http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf~~.

8.5.2 Enhanced Reimbursement Rate

Florida Medicaid reimburses pediatric surgery and urological specialty enrolled providers at the enhanced rate when indicated on the fee schedule.