Billing and Coding Essentials for Family Planning Services:

Fall Update & Refresher

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Learning Objectives

By the end of this session, participants will be able to:

- Identify codes needed for common visits in Title X and LARC services
- Discuss the importance of screening for FPBP coverage and its reimbursement impact
- Describe one billing and coding practice that may support better reimbursement from third-party payers for services provided
- Describe a strategy mentioned by a peer that is a best practice to monitor billing and coding for family planning services.

Agenda

- Reimbursement Nuggets:
  - NYS Visit Payments
  - Checking Coverage
  - FP Medicaid and FPBP Reimbursement
- Evaluation and Management Coding
- Other Important Codes
- Scenarios
- Q&A

Reimbursement Nuggets

Reimbursement – Coding Matters

NYS Medicaid Article 28/FQHC including FPBP:

- Ambulatory Patients Groups (APG) payment system
  - Medicaid Managed Care plans may also pay under APGs
  - Dependent on CPT, modifier and diagnosis coding
- Prospective Payment System (PPS)
  - Facility threshold visit rate for FQHCs that don't opt in to APGs – LARC devices are separately reimbursed
- Other TPP payers:
  - Per contract – typically by CPT code/fee schedule

Checking Coverage - 2025

- It is essential to verify coverage ***at every visit*** and check uninsured clients for Medicaid / FPBP coverage.
- FPBP has presumptive coverage so you can get reimbursed for the visit even if screening / enrolling that day.
- Don’t miss out on valuable revenue!

NYS FP Includes FPBP

- Current enhanced rate for family planning visits when **Z30- is the primary diagnosis** under APG billing
- This includes in-person, A/V and telephone visits
- **Documentation and coding impact revenue!**

Primary Dx for E/M Only	UP DTC	DS DTC	UP Hospital	DS Hospital
Family planning (Z30- contraceptive mgmt.)	$233	$278	$271	$354
Well visit, STD screen…	$100	$119	$116	$151

FPBP: Covered Visits

1) Family planning visit including telehealth:

- Primary diagnosis must = Z30- contraceptive mgmt.

2) Follow-up visits for limited related conditions such as colpos, lesion removals, infections etc.

- Secondary diagnosis must be Z30- such as Z30.09 FP advice

3) STI screening and/or treatment:

- Primary Dx must represent STI screening (Z11.3) or treatment
- Secondary diagnosis: Z30- (i.e. Z30.09 FP advice)
- Males and females!

Primary Diagnosis

- Code assigned to the **diagnosis, condition, problem, or other reason shown in the documentation to be chiefly responsible for services provided** **at end of visit**
- Sometimes the reason the client scheduled the visit ends up NOT being the primary diagnosis recorded by the clinician due to multiple issues treated during one visit
- If 2+ diagnoses/problems are being equally monitored, and treated, and/or evaluated, the diagnoses are considered co-equal and the treating clinician may select which diagnosis is sequenced first

TIP: Accurately coding and sequencing Z30- as primary diagnosis may directly impact your reimbursement for family planning visits

NYS Family Planning Indicators

- NYS receives a 90% federal match on FP services
- Billers need to include a FP indicator on claim when Primary Diagnosis is Z30- Contraceptive Mgmt:
  - **"A4" FP condition code** (institutional, UB claim format – APG claim)
  - **"Y" FP indicator** (1500/HCFA claim format – LARC, professional claims…)
- Failure to report this on FP claims, may result in $ take-back under payer review

- Often missed on FP claims

FPBP Billing Nuggets

- If the patient has private, CHP or no insurance – screen them for FPBP – don't lose revenue by not billing these visits!
- Make sure contraceptive visits have Z30- as the primary diagnosis if family planning
- STI screening and treatment FPBP visits – code the STI as primary but make sure there is a required Z30- as a secondary diagnosis or it will deny (i.e., Z30.09 General FP advice)
- Add "A4" condition code to FP claims as a family planning indicator to avoid audit take backs
- Talk to your patients ahead of the visit about FPBP

Evaluation and Management Coding

Evaluation & Management Codes

The "Office or Medical Visit"

There are 2 types of E/M codes commonly used for family planning office visits:

- Preventive well visit codes (993xx)
- Problem focused codes (992xx)

New vs. Established Patient

- Impacts E/M code selection and potential reimbursement dependent on your payer
- How do you distinguish this during a visit?

New Patient: A new patient is one who has NOT received professional services from the physician/qualified health care professional (e.g., MD/DO,NP,PA) or another physician/QHCP of the same specialty and subspecialty who belongs to the same group practice, within the past three years.

Established Patient – inside the 3-year window

Preventive E/M Codes

E/M codes 99381-99397

- No changes in 2021
- Used for periodic health screening visits (well visits, check-ups)

Age-specific

- (not based on time)

A periodic health screening visit for a **22-year-old** client **new** to your clinic might be reported as…

AGE	NEW	EST.
5-11 years	99383	99393
12-17 years	99384	99394
18-39 years	99385	99395

Problem-Oriented Visits

- 99202-99215 coding changed in 2021
- Select codes using:
  - **Updated Medical-decision making (MDM) criteria OR**
  - **Total clinician time on the date of the encounter**
- E/M rules apply to telehealth visits as well
- Document the clinician's total time in visit note

Ava: Initiating Contraception

- Ava, 22-year-old sexually active new female patient presents wanting contraception to avoid pregnancy during regularly scheduled evening clinic hours (7 pm).
- Administered a urine pregnancy and HIV rapid test —both negative; urine and blood samples are collected for GC, CT, and syphilis screening.
- Ava decides to use Depo and is given her first injection.
- NP spends 18 minutes face-to-face with Ava and 30 minutes total time on the date of the encounter reviewing Ava's history, providing patient-centered counseling, ordering labs/supplies, and documenting the visit in the EHR.

1) Time Method

- Use clinician's **TOTAL cumulative time on the date of the encounter** including all face-to-face and non-face-to-face activities – *this is a big change!*
- EXCLUDES time spent on separately reported services such as a LARC insertion/ removal/ exchange, injections/vaccines, or POC testing (UPT, Rapid tests, microscopy etc.)
- EXCLUDES time in activities normally performed by nurses (RN, LPN), MAs or front desk staff

Document this clearly!

Using Time

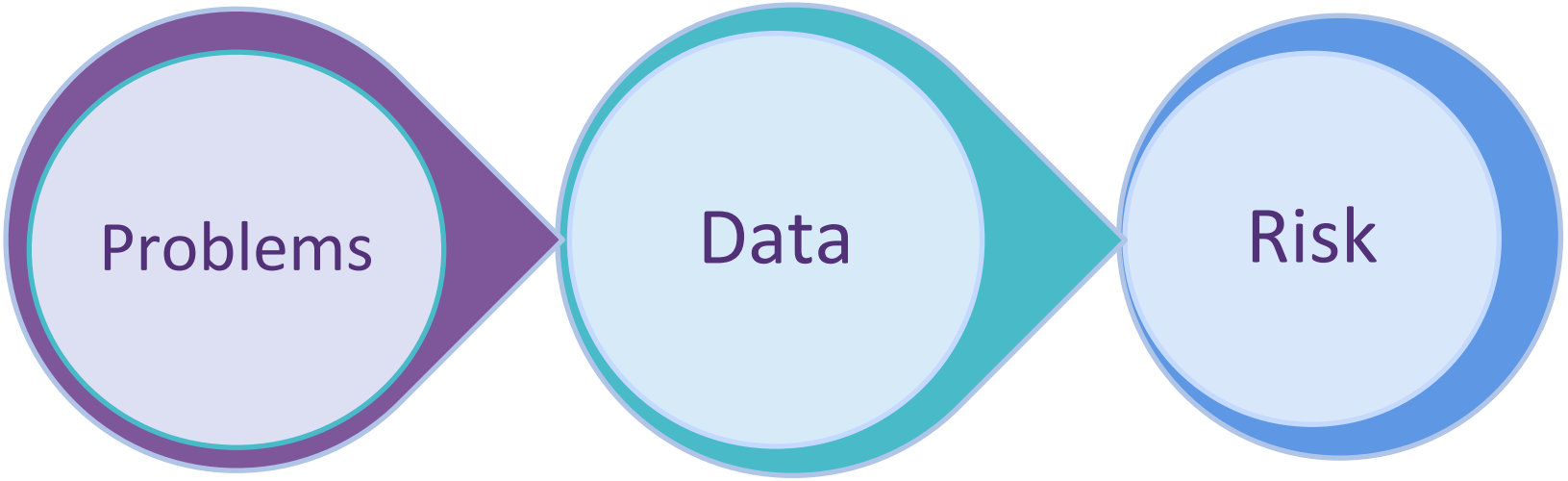
Before the visit
•Prepare to see the patient (e.g., review test results)
•Obtain and/or review separately obtained history
During the visit
•Perform medically appropriate exam and/or evaluation
•Counsel and educate the patient/family/caregiver
After the visit
•Document clinical information in the health record
•Ordering medications, contraceptives, labs etc.
•Independently interpret results (not separately reported) and communicate results to the patient/family/caregiver
•Care coordination (not separately reported)

Ava - Using Time

- NP spent **18 minutes face-to-face** and **30 minutes total time** on the date of the encounter; Ava is a new patient.
- What time would you use to select a code—18 or 30?
- Code for new patient? Established?

New	Time	Established	Time
99202	15–29 min	**99212**	10–19 min
99203	30–44 min	**99213**	20–29 min
99204	45–59 min	**99214**	30–39 min
99205	60–74 min	**99215**	40–54 min

2) Medical Decision Making (MDM) Method



Number and Complexity of Problems

Amount and/or Complexity of Data to be Reviewed and Analyzed

Risk of Complications and/or Morbidity or Mortality of Management

MDM Element: **# and complexity of problem(s) addressed**

- Ava wants contraception to avoid pregnancy.

A. Minimal

B. Low

C. Moderate

D. High

Minimal •**1** self-limited or minor problem
Low •**2** or more self-limited or minor problems; OR •**1** stable chronic illness; OR •**1** acute, uncomplicated illness or injury or 1 stable, uncomplicated single problem
Moderate •**1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR •**2** or more stable chronic illnesses OR •**1** undiagnosed new problem with uncertain prognosis; OR •**1** acute illness with systemic symptoms; OR •**1** acute complicated injury
High •**1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR •**1** acute or chronic illness or injury that poses a threat to life or bodily function

MDM Element: **Amount and/or complexity of DATA to be reviewed and analyzed.**

- Ava had a UPT and HIV rapid test, and a sample was sent for CT and GC screening

A. Minimal or none

B. Limited

C. Moderate

D. Extensive

Minimal or none

Limited (Must meet the requirements of at least 1 of the 2 categories)

Category 1: Tests and Documents

•**Any combination of 2 from the following:**

•Review of prior external (note(s) from each unique source*;

•Review of the results of each unique test*;

•Ordering of each unique test*; **OR**

Category 2: Assessment requiring an independent historian(s)

(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

Moderate (Must meet the requirements of at least 1 out of 3 categories

Category 1: Tests, documents, or independent historian(s)

•**Any combination of 3 from the following:**

•Review of prior external note(s) from each unique source*;

•Review of the result(s) of each unique test*;

•Ordering of each unique test*;

•Assessment requiring an independent historian(s); **OR**

Category 2: Independent interpretation of tests

•Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported); **OR**

Category 3: Discussion of management or test interpretation

•Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

Extensive (Must meet the requirements of at least 2 out of 3 categories)

Category 1: Tests, documents, or independent historian(s)

•**Any combination of 3 from the following:**

•Review of prior external note(s) from each unique source*;

•Review of the result(s) of each unique test*;

•Ordering of each unique test*;

•Assessment requiring an independent historian(s) ; **OR**

Category 2: Independent interpretation of tests

•Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR**

Category 3: Discussion of management or test interpretation

•Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

MDM Data Element: Nuggets

- You can count both send-out (CT/GC/RPR) and in-house tests (UPT, urinalysis, HIV rapid tests) as data
- If you order a test (send-out and in-house POC), it includes review of the result as 1 point, whether you review it today or next week
- "Review of test results" can be counted only for tests that you didn't order
- Each unique "test" has a CPT code; a "panel" counts as 1 unique test

MDM Element: **Risk of complications, and/or morbidity or mortality of patient management**

- Ava was given prescription level drug or contraceptives - Depo

A. Minimal

B. Low

C. Moderate

D. High

Minimal risk of morbidity from additional diagnostic testing or treatment

Low risk of morbidity from additional diagnostic testing or treatment

Moderate risk of morbidity from additional diagnostic testing or tx

Examples only:

- **Prescription drug management**
- Decision regarding minor surgery with identified patient or px risk factors
- Decision regarding elective major surgery w/o identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health

High risk of morbidity from additional diagnostic testing or treatment

Examples only:

- Drug therapy requiring intensive monitoring for toxicity
- Decision regarding elective major surgery with identified patient or procedure risk factors
- Decision regarding emergency major surgery
- Decision regarding hospitalization
- Decision not to resuscitate or or to de-escalate care because of poor prognosis

Risk: Commonly Used Elements

- **Straightforward** – counseling visit or no treatment
- **Low** – typically OTC drugs without other complications
- **Moderate** – prescription drug management
- **High** - drug therapy requiring intensive monitoring for toxicity; major surgery or hospitalization

Ava: MDM

Level of MDM is based on the highest *2 out of the 3 elements*:

Problems	Data	Risk	E/M Code
Minimal	Minimal or none	Minimal	99202 99212
Low ✓	Limited	Low	99203 99213
Moderate	Moderate ✓	Moderate ✓	99204 99214
High	Extensive	High	99205 99215

Ava: Determining the E/M Code

- **It is important to remember that one method may not— and will not— fit all visits**
- **Don't be afraid to code Level 4 visits if it fits**

	New	Est.
MDM Method	99204	99214
Time Method	99203	99214
Code Billed = >	**99204**	**99214**

MDM: Common Visits

Seeking family planning and contraception

- Problem: **1 problem** = low
- Data: UPT and HIV rapid done **2 tests** = low
- Risk: **BC prescription given** = moderate
- Overall level (2/3 elements) = **LOW (99203, 99213)**

STI dx and treatment

- Problem – **1 problem** = low
- Data – UPT, CT, GC, RPR done **3+ tests** = moderate
- Risk – **Prescription given** = moderate
- Overall level (2/3 elements) = **MODERATE (99204, 99214)**

Asymptomatic patient wanting STI screening

- Problem – **1 self limited/minor problem** = minimal
- Data – CT, GC done **2 tests** = limited
- Risk – **No treatment** = minimal
- Overall level (2/3 elements)= **MINIMAL (99202, 99212)**

Coding Check

Lucy is having an LARC inserted, when would you bill an E/M code?

A. When you separately counsel Lucy on different options and together decide on the LARC then insert it
B. When you take care of a separate and distinct issue along with the LARC insertion
C. Each time you are inserting an LARC
D. A and B
E. All of the above

E/M with Same Day Procedures

If clinician and patient discuss a number of contraceptive options, decide on a method, and then a LARC is inserted during same visit, an E/M service may be reported, if separately documented

Use Z30.09 (FP advice) to support contraceptive counseling

If patient presents for scheduled LARC insertion followed by a brief discussion of benefits and risks, an E/M service is NOT be reported since the E/M services are minimal and not separate from procedure

If patient comes in for a procedure and while there says "Oh by the way…" and has a separate issue managed, both the E/M code and procedure may be reported.

Use separate ICD codes to support each service

TIP: Add Modifier 25 to the E/M to indicate it is separate and distinct from the procedure

Office Procedures

- Procedure CPT Codes such as LARC Insertion Include:
  - Brief focused history
  - Checking use of medications and allergies
  - Administration of local anesthesia
  - Performance of procedure
  - Post-operative observation
- Bill only the procedure CPT code when…
  - Counseling provided was in the context of the procedure
  - Other cognitive services given on same day did not require significant history, exam, or MDM

E/M Coding Strategies

- Calculate E/M codes using both MDM and total time on the date of the encounter – choose the higher code
- Don't double dip and count separately reported services like LARC procedures in your total time
- Document time on all visits – get in the habit
- Don't forget to capture all the services you provide such as microscopy, contraceptives dispensed, other testing and counseling
- Do some analysis of E/M coding across providers and sites to ensure optimal codes are being captured and billed

Other Important Codes

Procedures

Procedure	CPT	MA/FPBP UP Hosp Clinic	MA/FPBP DS Hosp
Nexplanon Insertion, removal or reinsertion	11981, 11982 11983	$292.07	$381.44
IUD Insert or removal	58300 58301	$210.08	$210.08
IUD re-insertion	58301-59, 58300	$315.12	$315.12
Injection(Depo, ceftriaxone)	96372	$13.36	$13.36
Venipuncture	36415	$7.32	$9.56

Contraceptives - MA/FPBP

Code	Desc and Units	FQHC	APG
J1050	Depo Provera 1 mg x 150 units	Included in PPS rate	APG $48.00
J7295	Nuva ring - monthly		Split OA - cost
J7304	Patch - report 1 unit to MA/FPBP		APG ~$68
S4993	OCP and EC (up to 3 units total)		APG $6.06 ea (Initial OCP up to 3 packs)
J7296	IUD Kyleena	Split OA claim - cost	
J7297	IUD Liletta		
J7298	IUD Mirena		
J7300	IUD ParaGard		
J7301	IUD Skyla		
J7307	Nexplanon		

Z30- Codes: Contraceptive Mgmt.

Method	ICD-10	Description
OCP	Z30.011	Initial prescription of Oral Contraceptive Pills
	Z30.41	Surveillance / refill of OCP
Depo Provera	Z30.013	Initial rx of Depo
	Z30.42	Surveillance / refill of Depo
EC	Z30.012	Prescription of Emergency Contraception (EC)
Patch	Z30.016	Initial rx of patch
	Z30.45	Surveillance / refill of patch
Ring	Z30.015	Initial rx of ring
	Z30.44	Surveillance / refill of ring
Other	Z30.018	Initial rx of other contraception *(diaphragm, other barrier)*
	Z30.49	Surveillance of other contraception
FABM	Z30.02	Counseling for natural family planning (NFP) to avoid pregnancy (fertility awareness- based methods)
BCM Counseling	Z30.09	General FP Advice *(i.e., Counseling on all methods before deciding on a LARC insertion, No method dispensed)*

LARC Specific ICD-10 Codes

Method	ICD-10	Description
IUD	Z30.014	Encounter for initial rx of IUD *(Note: not coded for actual insertion)*
	Z30.430	Insertion of IUD
	Z30.431	Routine Checking of IUD
	Z30.432	Removal of IUD
	Z30.433	IUD removal and reinsertion
Implant	Z30.017	Initial rx / Insertion of Nexplanon implant
	Z30.46	Routine checking, removal or reinsertion of Nexplanon
BCM Counseling	Z30.09	General FP Advice *(i.e., Counseling on all methods before deciding on a same day LARC insertion)*

Breast Exams

- Breast exams are typically included in the GYN well visit exam (Z01.41-)
- Z12.39 is used for breast exams that are diagnostic or not part of a well visit
- Z12.31 is used for screening mammograms
- Diagnostic codes are used when a problem is suspected or when a lump or abnormal finding is detected
- You can use an additional code to specify any family history of malignant neoplasm
- FPBP: include a Z30- code (i.e., Z30.09 FP general advice)

Breast Exams - Screening

Code	Definition	Comment
Z01.411	Routine GYN exam *with* abnormal findings	Well visit, with *new* abnormal findings
Z01.419	Routine GYN exam *without* abnormal findings	Well visit, without *new* abnormal findings
Z12.39	Screening breast exam	Use when the encounter is not a well visit or periodic health screening
Z12.31	Screening mammogram for breast cancer	Ordering mammogram

Breast Exams - Diagnostic

Code	Definition	Comment
N63.1- N63.2-	Unspecified lump in the right breast … left breast	Mass or lump not yet diagnosed, right; add last digit to describe quadrant location
N64.4	Mastodynia	Breast pain
N64.52	Nipple discharge	Serous, green, or bloody nipple discharge
R92.8	Abnormal mammogram	Abnormal findings on diagnostic imaging of breast

Interpreter Services

- Provided either face-to-face or by language line including tele-visits
- Need for interpreter services must be documented in medical record and provided by a third-party interpreter
- **CPT T1013 – document time and report 1-2 units**

APG Payment	Units	DS Hosp
8 - 22 minutes of medical language interpreter services	**1**	**$14.94**
23 + minutes…	**2**	**$29.88**

HIV Counseling and Testing

- If HIV counseling is provided by an HIV counselor separate from the E/M service and > 8 minutes, counseling may be billed in addition to the medical visit
- Add modifier 25 to E/M if same day
- Pays ~ $38 or more depending on documented time
  - **< 8 minutes – not billable**
  - **8 - 14 min – bill to APG claim with 99401-U5 modifier**
  - **> 15 minutes – bill to appropriate CPT (99401-99404)**

- Bill separately for any HIV testing (i.e., 86703 = $15.59)

Smoking Cessation Counseling (SCC)

SCC is a billable service under APGs. Check with other payers re reimbursement.

- Covered providers include: MD/DO, PA, NP, or midwife, dentists, RN, LPN, clinical psychologists, LCSW, LMSW.
- If < 3 minutes, not separately billable (Include in E/M)
  - **99406: For individual counseling (3–10 min)**
  - **99407: For intensive counseling (11+ min).**
    - Use the HQ modifier for group sessions.
- Must Include a valid ICD-10 code for nicotine dependence (see F17- series)
- Related medications are billable under NYS pharmacy
- NYS allows for as many sessions as medically necessary for all Medicaid patients.

SCC

APG Expected Payment			
Service	CPT	NYC DTC	NYC Hosp
Smoking and tobacco use cessation counseling visit; indiv, 3 – 10 minutes	99406	$47.85	$60.87
…, > 10 minutes	99407		
Tobacco counseling for the control and prevention of oral disease, indiv, > 3 min.	D1320		
…, Group counseling, > 10 min	99407-HQ	$23.93	$30.44

Modifiers

- Who adds modifiers – billing or clinician?
- Who is reviewing before sending to payer?
- Who is review payments to ensure ALL services are paid

Modifier	Description	Examples	APG/FPBP Application of Modifier
22	Increased Procedural Services	Complicated LARC insert or removal (not commonly used)	Not recognized under APG billing; Review other payer documentation for payment increases.
25	Distinct E/M Service with another service on same day by the same clinician	• E/M w Depo injection / vaccine • Counseling E/M w same day LARC insertion or other px • E/M w HIV Counseling • E/M w Smoking Cessation Counseling	Will allow the E/M code to be paid in full when billed with other services avoiding NCCI edit
33	Preventive Service identified by USPSTF	Family planning options counseling (i.e., 99213)	Not recognized under APG billing; Indicates patient should not be billed for cost-sharing (deductible, coinsurance, or copayment) for the preventive service. Review other payer documentation.
52	Reduced Services	Failed IUD insertion due to stenosis	50% reduction in payment for procedure (Use only with procedure codes not E/M's)
59	Separate Procedures or Distinct Procedural Service	• Vaginal and vulvar lesion removal • IUD removal and implant insertion	First service will pay at 100% and second will typically discount to 50% payment; Note: 2nd procedure will not pay if missing this modifier when needed.
73	Terminated Procedure	Failed LARC procedure due to patient's safety (student experiencing pain and asks to stop)	50% reduction in payment for procedure (Use only with procedure codes not E/M's)
XE	Separate Encounter	Medical visit with clinical provider (i.e. APG claim ratecode (1432, 1422)) on the same day as a patient sees a mental health provider (i.e. LCSW claim ratecode 3257-3262)	2nd claim received for same day will deny payment without the proper modifier being appended to service (Can also use modifier 25 or XP on the services to override NCCI edit)
U5	Reduced Services	Used to note 8 – 15 minutes of HIV counseling (appended to 99401)	30% reduced in payment for HIV counseling; Note <8 minutes not billable to APGs)
U6	DTCS only: Reimbursable Ancillaries (Labs…)	POCT tests: UPT, HIV Rapid, Urinalysis; Inhouse US Send-out Labs: CT/GC, RPR – when you are paying the lab directly	Allows payment to a D&TC for rendering an ancillary service in–house, or has a service/payment agreement in place with a separate provider not seeking direct Medicaid reimbursement

Telehealth Today

- A/V and telephone medical visits pay in person rates
  - Don't bill those COVID era telephone specific ratecodes! Delete from systems.
- Location of provider and patient may impact billing
- Can't use Zoom or facetime any longer - HIPAA matters

NYS Teleheath Manual:
https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf

Modifier	Description	Application of Modifier
93	Telephone (Audio Only) Visit	Currently paid the same as in-person rates
95	Audio Visual Encounter	

Other Billable Telehealth

- **Virtual Check-ins:** Brief medical interactions between a MD/DO, NP, PA (providers who bill E/M service) and a patient. Helpful for patients with ongoing chronic conditions that would benefit from recurring check-ins with their provider. Conducted via HIPAA compliant technology including patient portal, secure email, or secure text-based messaging. Must be patient or parent/caregiver initiated.
- **eVisits:** Patient-initiated communications with a medical provider through a text-based HIPAA compliant digital platform, such as a patient portal. eVisits are a type of Virtual Check-In but neither real-time nor face-to-face. They are intended to remotely assess non-urgent conditions and prevent unnecessary in-person visits.
- **eConsults:** Used to answer patient-specific treatment questions through electronic communication between a treating/requesting provider and a consultative QHCP (i.e., MD/DO/PA/NP) to improve access to specialty expertise without an in-person visit.

Other Billable Telehealth

- **Remote Patient Monitoring:** Collection and interpretation of physiologic data (e.g., Electrocardiography, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the MD/DO, NP, PA and effective July 1, 2025, it is now billable when ordered by the medical clinician but provided by clinical staff.
- **Store and Forward:** Asynchronous (not real-time), electronic transmission of health info such as pre-recorded videos and/or digital images from a provider who is with the patient to a consulting provider at a distant site to aid in diagnosis. Example – picture sent to a dermatologist for diagnosis.
- **Virtual Patient Education:** Education and training for patient self-management by a MD/DO or QHCP via telehealth. Delivers health education to patients, families, or caregivers.

Scenarios

1) Let's Revisit Ava: Initiating Depo

- Ava presented wanting contraception during regularly scheduled evening clinic hours (7 pm).
- Administered a UPT and HIV rapid test —both negative; urine and blood samples are collected for GC, CT, and syphilis screening.
- Was counseled on all methods and administered her first Depo injection.
- We determined the E/M code was 99204 if she is a new patient and 99214 if she is considered established.

Extended Hours Access

- If the visit is after 6 pm, on a weekend, or a national holiday, you can bill for additional payment along w E/M
- If telehealth, include appropriate modifier (i.e., 95 A/V, 93 telephone)
- *Often goes unbilled - Who codes this in your clinic?*

CODE	Desc
99051 - 95 or 93	**Services provided in the office DURING regularly scheduled evening, weekend, or holiday office hours, in addition to basic service**
99050 - 95 or 93	**Services provided in the office at times OTHER than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.**

MD/DO APG Reimbursement

- If your clinic is part of a hospital, a MD/DO can ALSO bill a professional claim in addition to the APG claim
- DTC's and FQHCs cannot bill a professional claim
- NP, midwives, PA etc can also not bill a professional claim

99204 = $56.57 additional physician fee reimbursement

Ava's Visit - Includes FPBP

Facility: Hosp Clinic	CPT Code	ICD-10-CM Code	NYS APG DS Hosp $
E/M Code	99204-25 99051 After hours	Z30.013 Depo initial rx Z11.3 STD screen	$354.10 $ 16.47
Modifier	25 (when coded with injection)		
Procedure	96372 injection 36415 venipuncture	Z30.013 Z11.3	$ 13.36 $ 9.56
POC labs	81025 UPT 86703 HIV rapid	Z32.02 Pregnancy test negative Z11.4 HIV screening	$ 3.22 $ 15.59
Send out labs	87591 GC 87491 CT 86592 RPR	Z11.3 STD sceen	$ 38.29 $ 19.15 $ 0.00
Contraceptive	J1050 x 150 units	Z30.013	$ 48.00
Facility capital add-on under APGs (estimate only)			$ 20.00
MD/DO Professional claim if hospital setting - 99204			$ 56.57
		TOTAL $:	$594.31

Billing: Charge vs Full Fee

- Remember to set your fee's above your highest commercial contractual rates in order to not lose out on reimbursement due you
- NYS Medicaid and FPBP require you to bill contraceptives at cost not your full fee
- If contraceptives are purchased through 340B discount program, add UD modifier

2) Lyndsey - Same Day LARC

- Lyndsey, a sexually active new patient, presents wanting contraception to avoid pregnancy.
- Total time of the visit and related activities on the date of encounter excluding the insertion and POCTs is 28 minutes
- She is administered a urine pregnancy and HIV rapid test —both are negative; urine and blood samples are collected for GC and CT screening.
- Is counseled on all methods and decides to use Nexplanon which the NP is able to successfully insert during the visit.

Lyndsey - Using Time

- NP spent **28 minutes total time** on the date of the encounter; Lyndsey is a **new patient**. What is she was established?

New	Time	Established	Time
99202	15–29 min	**99212**	10–19 min
99203	30–44 min	**99213**	20–29 min
99204	45–59 min	**99214**	30–39 min
99205	60–74 min	**99215**	40–54 min

Lyndsey: Using MDM

Level of MDM is based on the highest *2 out of the 3 elements*:

Problems	Data	Risk	E/M Code
Minimal	Minimal or none	Minimal	99202 99212
Low ✓	Limited	Low	99203 99213
Moderate	Moderate ✓	Moderate ✓	99204 99214
High	Extensive	High	99205 99215

Lyndsey Nexplanon - Includes FPBP

Facility: Hosp Clinic	CPT Code	ICD-10-CM Code	NYS APG DS Hosp $
E/M Code	99204-25	Z30.09 General FP advice	$ 354.10
Modifier	25 (when coded with procedure)		
Procedure	11981 inseertion	Z30.017 Nexplanon Insertion	$ 381.44
POC labs	81025 UPT 86703 HIV rapid	Z32.02 UPT negative Z11.4 HIV screening	$ 3.22 $ 15.59
Send out labs	87591 GC 87491 CT	Z11.3 STD sceen	$ 38.29 $ 19.15
Contraceptive	J7307-UD (340B)	Z30.017	$ 440.00
Facility capital add-on under APGs (estimate only)			$ 20.00
MD/DO Professional claim if hospital setting	99204 11981		$ 56.57 $ 81.81
		TOTAL $:	$1,394.57

IUD - Includes FPBP

Facility: Hosp Clinic	CPT Code	ICD-10-CM Code	NYS APG DS Hosp $
E/M Code	99204-25	Z30.09 General FP advice	$ 354.10
Modifier	25 (when coded with procedure)		
Procedure	58300 IUD insert	Z30.430 IUD Insertion	$ 210.08
POC labs	81025 UPT 86703 HIV rapid	Z32.02 UPT negative Z11.4 HIV screening	$ 3.22 $ 15.59
Send out labs	87591 GC 87491 CT	Z11.3 STD sceen	$ 38.29 $ 19.15
Contraceptive	J7298-UD (340B)	Z30.017	$ 350.00
Facility capital add-on under APGs (estimate only)			$ 20.00
MD/DO Professional claim if hospital setting	99204 58300		$ 56.57 $ 49.49
		TOTAL $:	$1,116.49

Coding Check

Dr. Jones spent 35 minutes reviewing the client's history, counseling, consent and ordering labs / contraceptive including 10 minutes inserting an IUD. The next day Dr. Jones spent an additional 10 minutes charting the visit in the medical record.

What time amount can be used to determine E/M code?

A. 45 minutes total time
B. 35 minutes total time
C. 25 minutes total time
D. You can't use time

Coding Check

During Lyndsey's IUD insertion, she was experiencing a lot of pain and wanted the procedure stopped. Can we still bill for insertion?

- Yes! You can bill for a procedure that is terminated **BUT** you do need to append the correct modifier (52 or 53) to signal payer insertion was started but not finished.
- Payment is typically discounted to 50%
- Contact the device supplier for a replacement LARC
- Document why procedure was not completed in Ava's chart and include appropriate ICD codes

Coding Check

I billed an E/M for an office visit, 96372 for the injection and J1050 for the Depo. My office visit and injection did not pay correctly. How can I fix this?

- Resubmit an adjustment claim as instructed
- Append Modifier 25 to E/M service since it is billed along with an injection code due to NCCI edits
- Review modifier usage and assignment
- Ensure you report 150 units or 104 if sub-Q not 1 for Depo
- Track payers that don't pay both services on the same day to ensure the E/M is appropriately paid

Coding Check

When determining E/M code based on MDM method, I should count up each unique test done during the test and give myself a point for each order and a point for each test result.

A. TRUE

B. FALSE

Golden Rules

- If it's not documented – it can't be billed! Documentation matters!
- Compliance matters! Code for the services you provide and the reimbursement will follow.
- It takes a team! Billers and clinicians need to communicate and resolve questions before the claim is billed.
- FPBP screening and application is worth your time!
- Follow up on payment questions and resolve root causes! Discuss as a team – support eachother!

Resources – RHNTC.org

- Coding in the Reproductive Health Care Environment: The Fundamentals of Coding eLearning (Modules 1-3)
- Elements of Medical Decision Making During Family Planning Visits Job Aid
- Evaluation and Management Codes Job Aid
- Coding Modifiers for Contraceptive Services
- Evaluation and Management Codes Job Aid
- Commonly Used CPT and HCPCS Codes in Reproductive Health Care Job Aid
- ICD-10 Codes for Family Planning Services Job Aid

Resources – NYS Medicaid

- eMedNY
- Edit/Error Knowledge Base (EEKB) Search Tool
- Ambulatory Patient Groups (APGs)
- APG Provider Manual
- Medicaid Fee-for-Service Comprehensive Guidance for New York State FQHCs and Rural Health Clinics
- NYS Telehealth Policy Manual (July 2025)

Wrapping Up…

What is one take away from today's session you plan to bring back to your team internally?

Questions?

Disclaimers

- The guidance, scenarios and potential payments provided today are meant for education purposes only. NYS Medicaid and other payer official guidance supersedes any instruction presented in tools and trainings.
- Code selection and claim submission are based upon medical record documentation for services rendered and diagnoses considered for each individual encounter.
- We encourage Providers to contact Medicaid, FPBP and TPP for specific information on their coding, coverage, and payment policies.

Thank you!

Contact | nysfptraining.org/
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