Maximizing Family Planning Coding and the Family Planning Benefit Program

Caitlin Hungate & Ann Finn | August 12, 2026

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New York State Family Planning Training Center
nysfptraining.org

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Reminder!

- Today's session will be a conversation including best practices, sustainability, and operations.
- Discussions and scenarios are meant as educational examples only.
- Always follow NYSDOH and other program/payer guidance for compliance and billing requirements.
- Review any questions with NYSDOH.

Agenda

- Introductions
- Medicaid Changes
- FPBP: Optimizing Revenue
- Optimizing Medical Visit E/M Coding
- Challenging Cases & Discussion

Next Sessions

- **Session 3: September 9, 2026, 12 - 1:15 pm EST**,
  Diving into Key Performance Indicators (KPIs) and Making Data-Driven Decisions.
  Register here.
- **Session 4: October 14, 2026, 12 - 1:15 pm EST**, Identifying Missed Revenue Opportunities. Register here.

Today's Environment

- Medicaid eligibility fluctuations
- Increasing #'s of uninsured and underinsured patients
- Higher out-of-pocket healthcare costs
- Confidentiality concerns
- Economic uncertainty
- Staff turnover

Changes to NYS Medicaid

- Almost half of New Yorkers whose eligibility for the Essential Plan ended recently are eligible for coverage under the Family Planning Benefit Program (FPBP).
  - New Yorkers between 200 and 250% of the FPL are no longer eligible for the Essential Plan.
  - FPBP is available up to 223% of the FPL.
- ***Screening for FPBP is a must to protect revenue!***

Poll

How confident do you feel coding for family planning and FPBP visits?

1. Extremely confident
2. Moderately confident
3. Not confident
4. I am new to FP coding

FPBP: Optimizing Revenue

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Checking Coverage

- Essential to verify coverage at every visit and check under- and uninsured clients for Medicaid / FPBP coverage
- FPBP:
  - Limited FP services, eligible up to 223% of FPL
  - Teens can apply separate from parent's commercial coverage including CHP for Family Planning and STI visits
  - FPBP has presumptive coverage so you can get reimbursed for visit even if screening / enrolling that day

Presumptive Eligibility

- **Requirements**
  - **Age:** Teen, young adult, woman or man of any age
  - **Residency:** NYS resident
  - **Citizenship:** U.S. citizen or a lawfully present immigrant
  - **Income:** At or below 223% of the FPL (teens can use their own income not parents)
  - **Insurance:** Not already be enrolled in standard Medicaid. (If you have Medicaid, confidential family planning is already included)
  - **Documentation**: Not required
- **Coverage**
  - Covers same day services and can also be done up to 3 months retroactively
  - **Coverage good till end of the next month following application date**
  - **Full FPBP coverage = 1 year**
  - No limits on PE applications

NYS OHIP: FPBP Trainings

- Agencies should reach out directly to **Maximus Health Services, Inc.** (the contractor that now facilitates FPBP trainings) for an agency-level certification training.
- Email **RegistrationTSP@maximus.com** and cc the FPBP BML (**fpbp@health.ny.gov**) with the completed Training Request Form
- For additional visibility to your request, cc NYSFPP Director, Brittany DeWitt (brittany.dewitt@health.ny.gov)
- Other questions, reach out to OHIP at **fpbp@health.ny.gov**

Coding Matters - Payers Differ

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 visit rate for FQHCs that don't opt in to APGs – LARC devices are separately billed and reimbursed
- Other TPP payers:
  - Per contract – typically by CPT code/fee schedule

Lost Revenue

- FP method counseling, labs and LARC insertion:
  - **Not Billed → no FPBP screening done**:
    $0 revenue
  - **Screened for FPBP and billed presumptively**:
    ~$ revenue (APG): visit, insertion, lab, MD/DO claim if applicable
    ~$730 PLUS + Cost of LARC device - Over $1,000 revenue!

NYS FPBP – Essential $$

Under APGs, medical visits are paid **based on the primary diagnosis not E/M level**

Family planning is paid at a higher amount than other typical visits as a NYS funding mechanism so primary diagnosis matters

Primary Diagnosis – June 2026	**DS DTC**	**DS Hospital**
E/M CPT only with… Family planning (Z30- contraceptive mgmt.)	$271	$354
…Well visit, STD screen…	$116	$151
Increased Revenue: More than DOUBLE!		
Procedures, labs and contraceptives dispensed are reimbursed <u>in addition</u> to the medical visit		

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 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

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!

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 applicable
- 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)
- Talk to your patients ahead of the visit about FPBP

Poll

What is your biggest challenge when submitting FPBP claims?

1. Selecting the appropriate FP codes
2. Applying modifiers
3. Claims denied for non-covered services
4. Understanding payments
5. Other

Optimizing Medical Visit E/M Coding

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Problem-Oriented Visits

- 99202-99215
- Select E/M level based off of AMA 2021 updated guidelines:
  - **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, a sexually active new 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.)
  - time in activities performed by nurses (RN, LPN), MAs or front desk staff

Document this clearly!

Using Time

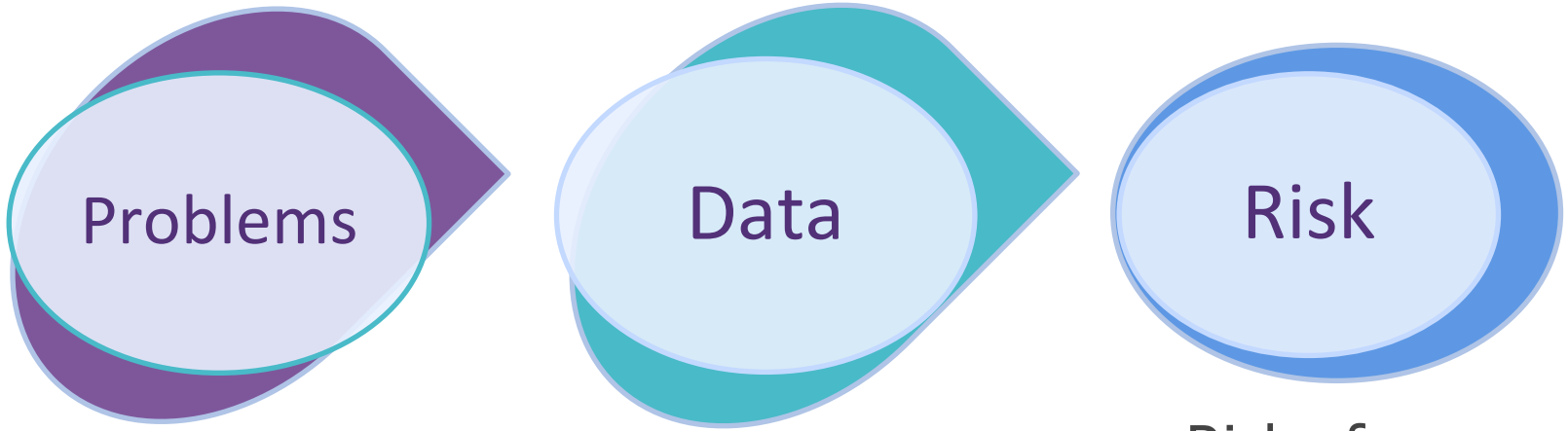
- **Before the Visit**
  - Prepare to see the patient (e.g., review test results)
  - Obtain and/or review separately obtained history
- **During the Visit**
  - Perform medically appropriate exam and/or evaluation
  - Counsel and educate
- **After the Visit**
  - Document clinical information in EHR
  - Order medication, contraceptives, labs, etc.
  - Independently interpret results (not separately reported) and communicate results to patient
  - 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

MDM Data Element: Nuggets

- You can count both send-out (CT/GC/RPR) and in-house POC tests (UPT, urinalysis, HIV rapid tests) as data
- If you order a test (send-out and/or 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

- One method may not— and will not— fit all visits
- Don’t be afraid to code Level 4 or 5 visits if it fits

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

Ava's Visit - FPBP

Hosp Clinic	CPT	ICD-10 Dx	NYS APG DS Hosp
E/M Code	99204-25 99051 after hours	Z30.013 Depo initial rx Z11.3 STD screen	$354.10 $ 16.48
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 screen	$ 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 $:	$594.32

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)**

Poll

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

Modifiers

- Modifiers—can be the function of the clinician or billing team or both - process needs to be clarified
- Review for accurate coding before claim submission
- Modifiers can impact payment. A claim might be paid - but was it paid correctly? Is this checked at payment posting time? Train your billers on this.
- See RHNTC tool: Modifier Coding

Family Planning Indicators Reminder

- When family planning is the primary diagnosis (Z30- Contraceptive Mgmt), billers must append to both visit and LARC claims:
  - **"A4" FP condition code**
    (institutional, UB claim format- condition code box 18-24 on header)
  - **"Y" FP indicator**
    (1500/HCFA claim (LARC) – Box 24H next to CPT/ HCPCS code)
- Per NYS - Failure to report this on FP claims, may result in $ take-back under review
- *Review Finding: Often missed on claims*

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
- Do analysis of E/M coding across providers and sites to ensure optimal codes are billed
- Provide feedback

Coding Q/A Internal Audits

- Type of service
- Level of service (i.e., E/M coding)
- LARC insertions matched to paid devices
- Contraceptives dispensed vs billed
- Procedures/injections with E/M
- Modifier use / billing
- Point-of-care testing, venipuncture for blood draw
- Add-ons: Depression screening, interpreter services
- Clinician charts (i.e., days open vs. billed)

Challenging Cases & Wrap Up

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Questions & Discussion

Challenging Cases

- Coding for telehealth visits
- Challenges with enrollment in FBPB
- Reimbursement for Depo injections
- Ordering of codes (e.g., does the family planning ICD-10 need to be listed first or the STI codes)

Discussion

Name one takeaway from today that you can share with your agency to maximize FPBP and improve family planning coding.

Resources - RHNTC.org

- Evaluation and Management Codes Job Aid
- Elements of MDM During Family Planning Visits Job Aid
- Coding Audit Tool
- Fiscal Chart Audit Tool
- Commonly Used CPT and HCPCS Codes in Reproductive Health Care Job Aid
- Coding Modifiers for Contraceptive Services
- Coding with Ann Podcasts (short FP coding podcasts)
- Coding for Telemedicine Visits Job Aid

Don’t Forget to Register

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Thank you!

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