

101 CMR 312.00: FAMILY PLANNING SERVICES

Section

- 312.01: General Provisions
- 312.02: General Definitions
- 312.03: General Rate Provisions
- 312.04: Reporting Requirements
- 312.05: Severability

312.01: General Provisions

- (1) Scope, Purpose and Effective Date. 101 CMR 312.00 shall govern the rates of payment by all governmental units to eligible providers which provide family planning services to publicly-aided individuals on and after February 1, 2014.
- (2) Coverage. 101 CMR 312.00 and the rates of payment contained in 101 CMR 312.00 shall apply to family planning services rendered by eligible providers at a family planning agency setting. The rates of payment under 101 CMR 312.00 are full compensation for all services rendered.
- (3) Disclaimer of Authorization of Services. 101 CMR 312.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 101 CMR 312.00. Governmental units that purchase care are responsible for the definition, authorization, and approval of care and services extended to publicly-aided clients.
- (4) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify its policy on and understanding of substantive provisions of 101 CMR 312.00, or to issue coding updates and corrections under 101 CMR 312.01(5).
- (5) Coding Updates and Corrections. EOHHS may publish procedure code updates and corrections in the form of Information or Administrative Bulletins. Updates may reference coding systems including but not limited to the American Medical Association's Current Procedural Terminology (CPT) and/or the Healthcare Common Procedure Coding System (HCPCS). The publication of such updates and corrections will list:
 - (a) codes for which only the code numbers change, with the corresponding cross references between existing and new codes;
 - (b) deleted codes for which there are no corresponding new codes; and
 - (c) codes for entirely new services that require pricing. EOHHS will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

312.02: General Definitions

As used in 101 CMR 312.00, unless the context clearly otherwise requires, the following terms shall have the following meanings:

Center. The Center for Health Information and Analysis established under M.G.L. c. 12C.

Comprehensive Family Planning Agency. A public or private agency that demonstrates the capability of providing family planning medical services, family planning counseling services, follow-up health care, outreach and community education.

Eligible Provider. A family planning agency which meets such conditions of participation as may be required by a governmental unit purchasing such services.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Established Patient. A patient who has received professional services from the provider within the past three years.

312.02: continued

Governmental Unit. The Commonwealth, any department, agency, board or commission of the Commonwealth and any political subdivision of the Commonwealth.

I.C. Individual Consideration. Providers will be reimbursed for the specified items at cost.

New Patient. A patient who has not received any professional services from the provider within the past three years.

Publicly-aided Individual. A person for whose medical and other services a governmental unit is in whole or in part liable under a statutory program.

Separate Procedure. Some of the listed procedures are commonly performed as an integral part of a total service and, as such, do not warrant a separate identification or payment. When, however, such a procedure is performed independently of, and is not immediately related to other services, it may be listed separately in the procedure description. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.

There are certain procedures designated as "(SP)" which are in addition to those procedures designated "separate procedure" by the AMA-CPT coding structure. These "(SP)" procedures were designated "Independent Procedures" (IP) in the former six-digit coding structure.

312.03: General Rate Provisions

(1) Reimbursement as Full Payment. Each eligible provider shall, as a condition of acceptance of payment made by the purchasing governmental unit for services rendered, accept the approved program rate as full payment and discharge of all obligations for the services rendered. Any third party payments or sliding fees received on behalf of a publicly assisted client shall reduce, by that amount, the purchasing governmental unit's payment for services rendered to the publicly assisted client.

(2) Rates. Subject to the conditions listed in 101 CMR 312.03, rates of payment for authorized family planning services shall be the lower of:

- (a) the eligible provider's usual fee to the general public; or
- (b) the schedule of allowable fees listed in 101 CMR 312.03(3).

(3) Schedule of Allowable Fees.

Code	Allowable Fee		Description
	Effective 2/1/14	Effective 2/1/15	
90649	I.C.	I.C.	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), three-dose schedule, for intramuscular use.
90650	I.C.	I.C.	Human Papilloma virus (HPV) vaccine, types 16, 18 (bivalent), three-dose schedule, for intramuscular use.
New Patient			
99201	\$34.20	\$34.56	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> ● a problem focused history; ● a problem focused examination; and ● straight forward medical decision making. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

312.03: continued

Code	Allowable Fee		Description (continued)
	Effective 2/1/14	Effective 2/1/15	
99202	\$56.22	\$56.81	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> ● an expanded problem focused history; ● an expanded problem focused examination; ● straightforward medical decision making. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
99203	\$80.84	\$81.68	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: <ul style="list-style-type: none"> ● a detailed history; ● a detailed examination; and ● medical decision-making of low complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
99204	\$120.15	\$121.40	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> ● a comprehensive history; ● a comprehensive examination; ● medical decision making of moderate complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
99205	\$149.36	\$150.92	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: <ul style="list-style-type: none"> ● a comprehensive history; ● a comprehensive examination; and ● medical decision making of high-complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
Established Patient			
99211	\$21.32	\$21.54	Office or other outpatient visit that for the evaluation and management of an established patient, that may not require the presence of a physician. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
99212	\$35.21	\$35.57	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> ● a problem focused history; ● a problem focused examination; ● medical decision making of low complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

312.03: continued

Code	Allowable Fee		Description (continued)
	Effective 2/1/14	Effective 2/1/15	
99213	\$53.73	\$54.29	Office or other outpatient visit for the evaluation and management of an established patient, that requires at least two of these three key components: <ul style="list-style-type: none"> ● an expanded problem focused history; ● an expanded problem focused examination; ● medical decision making of low complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
99214	\$79.38	\$80.20	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: <ul style="list-style-type: none"> ● a detailed history; ● a detailed examination; ● medical decision making of moderate complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
99215	\$105.68	\$106.78	Office or other outpatient visit for the evaluation and management of an established patient, that requires at least two of these three key components: <ul style="list-style-type: none"> ● a comprehensive history; ● a comprehensive examination; ● medical decision making of high complexity. (In addition, visit includes counseling, anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.)
Preventative Medicine Services			
99384	\$105.24	\$106.34	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	\$105.24	\$106.34	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99386	\$109.76	\$110.90	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99394	\$91.33	\$92.28	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

312.03: continued

Code	Allowable Fee		Description (continued)
	Effective 2/1/14	Effective 2/1/15	
99395	\$91.33	\$92.28	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years
99396	\$91.33	\$92.28	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years
99402	\$58.62	\$59.23	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individual (separate procedure); approximately 30 minutes. (HIV related)

Service Allowable Medical and Related Supplies

S4993	\$10.80	\$10.91	Oral contraceptives (birth control pills) actual cost up to a maximum cost of the allowable fee per cycle.
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All Other Medical and Related Supplies

S4989	I.C.	I.C.	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies.
A4261	I.C.	I.C.	Cervical cap for contraceptive use
A4266	\$9.30	\$9.40	Diaphragm for contraceptive use (includes applicator and contraceptive cream or jelly)
A4267	\$0.18	\$0.19	Contraceptive Supply, condom, male, each
A4268	\$2.04	\$2.06	Contraceptive Supply, condom, female, each
A4269	\$3.91	\$3.95	Contraceptive Supply, spermicide (e.g., foam, gel), each (per tube or package) (includes contraceptive sponges)
J1050	I.C.	I.C.	Injection, medroxyprogesterone acetate, 1 mg
J3490- FP	I.C.	I.C.	Unclassified Drugs (service provided as part of a Medicaid family planning program) (may be used by other governmental purchasers of family planning services)
J7300	I.C.	I.C.	Intrauterine copper contraceptive
J7301	I.C.	I.C.	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7302	I.C.	I.C.	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303	I.C.	I.C.	Contraceptive supply, hormone containing vaginal ring, each
J7304	I.C.	I.C.	Contraceptive supply, hormone containing patch, each
J7307	I.C.	I.C.	Etonogestrel (contraceptive) implant system

Medical and Surgical Procedures

11976	\$114.99	\$116.18	Removal, implantable contraceptive capsules.
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(4) Other Family Planning Services. The rates of payment for other family planning services that are authorized by the purchasing governmental unit, such as surgery and clinical laboratory, shall be based on the applicable EOHHS regulation.

312.04: Reporting Requirements

(1) Annual Reports. Each Eligible Provider must file an annual, and complete Uniform Financial Report in accordance with the filing requirements of the Operational Services Division as specified in its *Audit and Preparation Manual*.

312.04: continued

- (2) Upon the request of the Center, an eligible provider of family planning services shall forward to the Center the following information within 90 days of a written request:
- (a) an "agency or clinic cost report" and supplemental schedules supplied by the Center;
 - (b) financial statements certified by a certified public accountant. In the absence of certified statements, an eligible provider may submit uncertified statements or a Balance Sheet and Operating Statement prepared by the agency; and
 - (c) a complete schedule of charges to the public. Additionally, the eligible provider shall notify the Center of any change in charge to the public during the year.
- (3) Additional Information Requested by the Center. Each eligible provider shall file such additional information as the Center may from time to time request other than that specified in 101 CMR 312.04(1) no later than 30 days after a written request.
- (4) Examination of Records. Each eligible provider shall make available all records relating to its operation for audit, if requested by the Center.
- (5) Accurate Data. All reports, schedules, additional information, books and records which are filed or made available to the Center shall be certified under pains and penalties of perjury as true, correct, and accurate by the Executive Director or Financial Officer of the eligible provider.
- (6) Penalty for Non-compliance. EOHHS may reduce the payment rates by 15% for any Provider that fails to submit required information to the Center. EOHHS will notify the Provider in advance of its intention to impose a rate reduction. The rate reduction will remain in effect until the Center receives the required information.

312.05: Severability

The provisions of 101 CMR 312.00 are hereby declared to be severable and if any such provisions or the application of such provisions to any person or circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions to eligible providers or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 312.00: M.G.L. chs. c. 12C and 118E.