A message from the Georgia Department of Community Health

Fee-For-Service Billing Instructions for Long-Acting Reversible Contraception Devices in Non-Inpatient Settings

Dear Providers:

This banner message is intended to clarify the Department of Community Health (DCH), Medicaid Division, GA Medicaid policy of reimbursement for billing Long-Acting Reversible Contraception (LARC) devices on Fee-For-Service (FFS) claims (in non-inpatient settings) and provide specific billing criteria and instructions for those claims. The LARC policy allows providers to bill for the insertion procedure and the cost of the LARC device using an appropriate J-code (HCPCS) billed with the FP modifier in various settings.

The following are the specific billing criteria for payment of the acceptable LARC J-codes in the non-inpatient settings. For non-inpatient settings, these billing instructions are to be followed using the most appropriate LARC J-code with the billed procedure code along with the correct ICD-10 diagnosis code.

1. **J-CODES (HCPCS)**
   Select one of the following LARC HCPCS J-codes below AND bill with the FP (Family Planning) modifier; i.e., J7397 FP:
   J7300 –Intrauterine copper contraceptive (Paragard)
   J7301-Levonorgestrel-releasing intrauterine contraceptive, 13.5 MG (Skyla)
   J7307-Etonogestrel contraceptive implant system, including implant and supplies (Nexplanon)
   J7296- Levonorgestrel-releasing intrauterine contraceptive, 19.5 MG (5 year Kyleena)
   J7297-Levonorgestrel-releasing intrauterine contraceptive, 52 MG (3 year Liletta)
   J7298-Levonorgestrel-releasing intrauterine contraceptive, 52 MG (5 year Mirena)

   NOTE:
   - J7302 was terminated by the Centers for Medicare and Medicaid (CMS) on 12/31/15).

2. **REVENUE CODES (OUTPATIENT SETTING ONLY – COS 070)**
   Bill the LARC HCPCS J-code on a separate detail line on the UB-04 claim form with the appropriate revenue code as indicated below:
   - Bill revenue code 636 for LARCS (J-code HCPCS); i.e., rev code 636, J7397 FP.
   - Can bill other applicable revenue codes used for LARC supplies as appropriate; 271, 272, etc.

3. **LARC BILLED AMOUNT**
   Bill the LARC device fee amount on the detail line as one (1) unit with your office or facility's acquisition or pharmacy's cost.

4. **PLACE OF SERVICE (POS)**
   Bill the appropriate POS (for non-inpatient settings): 11, 19, 22, 34, 50, 53, 71, 72, or 99. Billing of POS 99 should not be billed UNLESS that POS is billed for other services for your provider type and or program.
5. **FP MODIFIER**
   Bill the appropriate J-code on the 1500 claim form and or UB-04 claim [for outpatient setting] with the FP modifier (J7300, J7301, J 7307, J7296, and J7297). i.e., J7397 FP.

6. **BILLABLE PROCEDURE CODES WITH FP MODIFERS (PROFESSIONAL 1500 CLAIMS)**
   Bill the most appropriate CPT Evaluation and Management Code (99201 through 99215) with the FP modifier (based on the level of evaluation rendered during the visit).

NOTE: For COS 070 (Outpatient) claims, you can bill revenue code 510 (Clinic) on the UB-04 claim on a separate detail claim line along with the LARC HCPCS J-code and FP modifier.

Insertion and/or removal procedure codes (11981, 11982, 11983, 58300, and 58301) with the FP modifier.

7. DIAGNOSIS CODES

Bill the correct LARC's HCPCS J-code with the specific ICD-10 diagnosis code. Do not bill unspecified diagnosis codes for LARC devices. Bill with the most appropriate diagnosis code as listed below:

ICD-10: Z30.430, Z30.431, Z30.432, Z30.433, or Z30.49.

NOTE: If you bill one of these diagnosis codes above for LARC devices, your FFS claim should not deny in the GAMMIS payment system.

8. BILLABLE NDCs (GAMMIS PAYMENT SYSTEM)

J7301 NDC 50419042201
J7307 NDC 00052433001
J7297 NDC 52544003554
J7298 NDC 50419042101, 50419042301

NOTE: When billing ANY J-codes or drugs on a professional 1500 claim form, you must have a NDC number. Otherwise, an edit will post stating that an NDC number is missing for the billed drug or J-code. If you bill the appropriate NDC number as listed above, your LARC J-code's detail line on the 1500 claim form should not deny.

9. ELIGIBLITY STATUS OF THE MEMBER AND OR PROVIDER

Members' eligibility status must be checked before any services are rendered, including insurance coverage. Verify the member's eligibility to determine if the member is eligible for Medicaid/PeachCare for Kids® benefits AND if covered in FFS or a CMO plan. Their Rendering provider must be enrolled in GA Medicaid prior to billing for any Medicaid services, including the LARC device. The Division pays enrolled providers within numerous reimbursable categories for covered services furnished to eligible members.

If you have any questions regarding these LARC billing instructions for the non-inpatient settings, please contact the DXC Technology Call Center at 770-325-9600 or 1-800-766-4456 or Contact Us at www.mmis.georgia.gov.