

ALABAMA MEDICAID AGENCY  
ADMINISTRATIVE CODE

CHAPTER 560-X-14  
FAMILY PLANNING

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560-X-14-.01     Family Planning-General.

(1)           Family planning services are defined as the services provided to:

(a)           Prevent or delay pregnancy.

(2)           Family planning services are available through providers enrolled with the Alabama Medicaid Agency, including hospitals, primary care clinics, Rural Health Clinics, Federally Qualified Health Centers, Provider-based Rural Health Clinics, the Statewide Family Planning Project, and Planned Parenthood of Alabama, Inc. and private physicians.

(3)           Acceptance of any family planning information or service is strictly voluntary on the part of the recipient, and no form or duress or coercion should be applied to gain such acceptance. Individuals are required to give written or verbal consent prior to receiving family planning services. For any face-to-face encounter a written consent is required. For any telephonic encounter a verbal consent is required.

**Author:** Cheryl Cardwell, Program Manager, Managed Care Operations

**Statutory Authority:** State Plan; 42 C.F.R. §440.40(c); Title XIX, Social Security Act.

**History:** Rule effective October 1, 1982. **Amended** effective October 9, 1984; December 10, 1987; August 12, 1992. **Amended:** Filed August 6, 1993; effective September 10, 1993. **Amended:** Filed September 8, 1998; effective October 13, 1998. **Amended:** Filed May 12, 2003; effective June 16, 2003. **Amended:** Published November 30, 2020; effective January 14, 2021.

#### **560-X-14-.02 Eligible Individuals.**

(1) Eligible individuals are those females of childbearing age and males of any age, including minors who may be sexually active.

(2) In determining recipient eligibility for family planning services, childbearing age is considered to be between 8 and 55 years of age.

**Authors:** Deborah K. Crawford, Dee Lockridge

**Statutory Authority:** State Plan; 42 C.F.R. §441.20; Title XIX, Social Security Act.

**History:** Rule effective October 1, 1982. **Amended:** effective December 10, 1987; August 12, 1992. **Amended:** Filed April 11, 2012; effective May 16, 2012.

#### **560-X-14-.03 Family Planning Services.**

(1) The following services are covered services when provided by Family Planning providers. Details on criteria required for each type of service is listed in the Family Planning Program Manual.

(a) Initial Visit - an in-depth evaluation of a new patient requiring the establishment of medical records, evaluation of the data obtained, comprehensive history, complete physical examination, appropriate diagnostic lab tests and/or procedures, family planning counseling, and contraceptive management as indicated. Limited to one per provider.

(b) Annual Visit - the re-evaluation of an established patient requiring an update to medical records, evaluation of the new data obtained, interim history, complete physical examination, appropriate diagnostic laboratory tests

and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated.

(c) Periodic Revisit - a follow-up evaluation of a new or existing family planning condition. Services include a review with update of history, a review of the effectiveness of current contraceptive method with counseling regarding any existing problems and adjustment of contraceptive method to include issuance of supplies as indicated. This visit includes scheduled follow-up, as medically indicated, of chosen birth control method. Limited to no more than four (4) revisits per calendar year.

(d) Home Visit - a brief evaluation by a medical professional in the home of established patients. Services provided include an abbreviated history, weight and blood pressure, and contraceptive counseling with issuance of contraceptive supplies if indicated. A follow-up clinic appointment is scheduled if indicated. Limited to one visit during the 60-day post partum period.

(e) Extended Family Planning Counseling Visit - a separate and distinct counseling service provided at the time of the post partum visit requiring a minimum of 10 minutes of face-to-face contact. Limited to one service during the post partum examination.

(f) Routine laboratory screening tests such as pregnancy testing, VDRL, gonorrhea culture, Pap smear, hemoglobin or hematocrit and urine check are covered when performed as a part of the initial/annual family planning service.

(2) The following procedures are covered under Family Planning if provided for contraceptive purposes:

(a) Insertion or removal of implantable contraceptive capsules when performed by or under the supervision of a physician.

(b) Insertion or removal of intrauterine devices when performed by or under the supervision of a physician.

(c) Fitting of a diaphragm when performed by or under the supervision of a physician.

(3) Medically approved pharmaceutical supplies and devices such as oral contraceptive pills, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

**Author:** Leigh Ann Payne, Program Manager, Medical Services Program

**Statutory Authority:** State Plan; 42 C.F.R. §441.20; Title XIX, Social Security Act.

**History:** Rule effective October 1, 1982. **Amended** effective February 9, 1987; December 10, 1987; June 12, 1991; August 12, 1992. **Amended:** Filed August 6, 1993; effective September 10, 1993. **Amended:** Filed July 6, 1995; effective August 12, 1995. **Amended:** Filed April 11, 2003; effective May 16, 2003.

**560-X-14-.04 Sterilizations.** Surgical procedures for male and female recipients as a method of birth control are covered services under the rules and regulations set forth below:

(1) Rules and Regulations Concerning Federal Financial Participation for Sterilization, effective February 6, 1979, apply in the following instances:

(a) The individual is at least twenty-one (21) years old at the time consent is obtained;

(b) The individual is not a mentally incompetent individual;

(c) The individual has voluntarily given informed consent in accordance with all requirements;

(d) At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

(e) An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for the sterilization was given. In case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(2) Mentally Incompetent or Institutionalized Individuals: Payment is not available for the sterilization of a mentally incompetent or institutionalized individual.

(3) Claims for Sterilization Procedure Performed on or after February 6, 1979:

Sterilization claims will be paid only when in conformity with the guidelines set forth in this regulation, and completion of consent forms, (three (3) copies of form 193). See Chapter 560-X-28 for consent form sample. In the event that the recipient does not meet the above requirements and elects to have the sterilization, the provider may bill the recipient for the sterilization.

(4) Sterilization consent forms are to be completed as follows:

(a) The patient's birth date will reflect the patient was at least 21 years of age when he/she signed and dated the consent form.

(b) The counselor's signature date, as well as the patient's signature date will reflect at least 30 days, but not more than 180 days have passed prior to the procedure being done.

(c) Due to the wording of the physician's statement, the physician signature and date can only be affixed after the procedure has been completed. The physician statement and signature must reflect at least 30 but not more than 180 days have passed since the patient signed.

(d) It is of vital importance that each copy of the consent form 193 be utilized in the correct manner. When these forms are fully completed:

Copy 1 - Patient - to be given to the patient.

Copy 2 - Payment Purpose - to be utilized for payment.

Copy 3 - Patient's Permanent Record - to be placed in the patient's permanent record with copies being made to accommodate both the facility and physician.

(5) Providers must submit a sterilization consent form with his claim or it will be returned. The provider must

submit the claim within the time frame set forth by regulations in Chapter 1 of this Code, General.

(6) Sterilization reversals requested as a result of a previous voluntary surgical sterilization will not be covered.

**Author:** Leigh Ann Payne, Program Manager, Medical Services Division

**Statutory Authority:** State Plan; 42 C.F.R. §§441.250, 441.251, 441.252, 441.253, 441.257, 441.258 and Appendix to Subpart F; Title XIX, Social Security Act.

**History:** Rule effective October 1, 1982. **Amended:** effective July 9, 1984; October 11, 1986; December 10, 1987; August 12, 1992. **Amended:** Filed August 6, 1993; effective September 10, 1993. **Amended:** Filed May 12, 2003; effective June 16, 2003.

**560-X-14-.05 Non-Family Planning Services.**

(1) Medically necessary procedures for the treatment of illness or injury which would inevitably have a secondary effect of rendering an individual incapable of reproducing are not classified as family planning procedures. Claims for such procedures are payable based on determination of medical necessity under the same procedures used by the fiscal agent in claims processing.

(2) Sterilization by hysterectomy is not a family planning covered service.

(3) Abortions are not covered as a family planning service. Refer to Chapter 6 of this Code, Physician's Program.

(4) Hospital charges resulting from recipient deciding not to be sterilized after entering the hospital for sterilization purposes cannot be reimbursed as a family planning service.

(5) Removal of an IUD because the recipient has a uterine/pelvic infection is not considered a family planning service and is not reimbursable as such.

(6) Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions are not considered family planning services.

(7) Medical complications requiring treatment (i.e., perforated bowel) caused by or following a family planning procedure cannot be a covered family planning service.

(8) Any procedure/service provided to a woman who is known to be pregnant cannot be considered a family planning service.

(9) Removal of contraceptive implants due to medical complications are not family planning services; however, the removal may be covered as a medical service through the Physician's Program.

(10) Diagnostic or screening mammograms are not considered family planning services.

**Author:** Leigh Ann Payne, Program Manager, Medical Services Division

**Statutory Authority:** State Plan; 42 C.F.R. §§401, et seq.; 441.250, 441.251, 441.252, 441.255; Title XIX, Social Security Act.

**History:** Rule effective October 1, 1982. **Amended:** Effective July 9, 1984; March 12, 1987; December 10, 1987; August 12, 1992. **Amended:** Filed August 6, 1993; effective September 10, 1993. **Amended:** Filed May 12, 2003; effective June 16, 2003.

#### 560-X-14-.06 Plan First Waiver.

(1) The Plan First Waiver program operates under an approved Section 1115(a) Research and Demonstration Waiver which includes Special Terms and Conditions. It extends Medicaid eligibility for family planning services to all females of childbearing age (19 through 55) and men (ages 21 or older) who do not have creditable health insurance coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA) and who are not currently sterilized. The Medicaid income eligibility limit is income at or below 141% of the Federal Poverty Level (FPL) who would not otherwise qualify for Medicaid. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

(2) The program represents a collaborative effort between the Alabama Medicaid Agency (AMA) and the Alabama Department of Public Health (ADPH).

(3) The Plan First Waiver program is officially known as the "Plan First Program."

(4) Enrolled Medicaid providers are eligible to provide family planning services but must also enroll as a Plan First provider by completing a Plan First agreement. Upon receipt of the signed agreement, Medicaid's fiscal agent will add the Plan First provider specialty code to the provider's existing record. Those providers that only perform tubal ligations and vasectomies (surgeons, anesthesiologist and outpatient surgical centers) do not have to enroll as a Plan First provider.

(5) The following are the eligible groups for the Plan First Waiver:

(a) Women 19 through 55 years of age who have SOBRA-eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer yes to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

(b) SOBRA poverty level pregnant women 19 through 55 years of age are automatically eligible for family planning services after 60 days postpartum without a separate eligibility determination if they meet all eligibility criteria. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

(c) Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. An eligibility determination will be completed using poverty level eligibility rules and standards. Client declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the client's declaration and the income reported through data matches, the client will be required to provide documentation and resolve the discrepancy. Eligibility is redetermined every 12 months.

(d) Men, ages 21 and older, desiring a vasectomy and who meet the income eligibility limit. An eligibility



determination must be completed using poverty level eligibility rules and standards. Eligibility is determined for 12 months. Retro-eligibility is not allowed. If the individual does not receive a vasectomy within the 12-month eligibility period, he will have to reapply for Medicaid eligibility.

Newly awarded family planning recipients will receive a Medicaid plastic card based on the same criteria as other Medicaid recipients. Providers will be informed at the time of eligibility verification that services are limited to family planning only. If a recipient has received a plastic card in the recent past, another card will be sent only upon request.

(6) In order to be eligible for Family Planning Services an individual must:

- (a) Furnish a Social Security number or proof they have applied for a Social Security number
- (b) Be a female resident of Alabama age 19 through 55
- (c) Be a male resident of Alabama 21 or older
- (d) Meet citizenship and alienage requirements
- (e) Have family income at or below 141% of the federal poverty level. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.
- (f) Cooperate in establishing third party medical benefits, and apply for all benefits to which she may be entitled

(7) Once determined eligible, a male will remain eligible for covered services for 12 months unless he is terminated from the waiver for one of the reasons listed below. A female will remain eligible for benefits until the termination of the waiver unless she disenrolls or is terminated from the waiver for one of the following reasons:

- (a) The recipient's gross countable family income exceeds 141% of the FPL. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.
- (b) The recipient does not reside in Alabama

- (c) The recipient is deceased
- (d) The recipient has received a sterilization procedure
- (e) The recipient requests her family planning benefits be terminated
- (f) The recipient is outside the family planning age limit of 19 through 55
- (g) The recipient is eligible for Medicare benefits
- (h) The recipient becomes eligible for another Medicaid program
- (i) The recipient fails to cooperate with the Medicaid Agency in the eligibility process, receipt of services or Medicaid Quality Control Review
- (j) The recipient is determined ineligible due to fraud, misrepresentation of facts, or incorrect information
- (8) Medical services covered for the extended eligibles are limited to birth control services and supplies only. This can include, as applicable:
  - (a) Covered family planning birth control methods
  - (b) Outpatient tubal ligation
  - (c) Doctor/clinic visits (for family planning only)
  - (d) Vasectomies
- (9) Eligible recipients can also receive HIV pre- and post-counseling visits
- (10) Eligible participants have freedom of choice in the selection of an enrolled network provider.
- (11) Eligible recipients can receive care coordination. Care coordination services are provided by licensed social workers or registered nurses associated with the Alabama Coordinated Health Network Program (ACHN) who have received training on the Plan First program. Medicaid enrolled

providers can make referrals to the ACHN for care coordination services.

**Author:** Jerri Jackson, Managed Care Operations

**Statutory Authority:** Section 1115(a); Sections 1902(a)(10)(b), (e)(5) and (6) of the Social Security Act.

**History: New Emergency Rule:** Filed August 28, 2000; effective October 1, 2000. **New Rule:** Filed September 21, 2000; effective December 11, 2000. **Amended:** Filed November 8, 2001; effective December 13, 2001. **Amended:** Filed December 11, 2009, effective January 15, 2010. **Amended:** Filed November 12, 2013, effective December 17, 2013. **Amended:** Filed May 12, 2014; effective June 16, 2014. **Amended:** Filed May 11, 2018; effective June 25, 2018. **Amended:** Published December 31, 2019; effective February 14, 2020.

**Ed. Note:** Previous Rule, **Educational Materials** effective October 1, 1982. **Amended** effective December 10, 1987. **Repealed** effective August 12, 1992. Rule 560-X-14-.06 was move from Chapter 560-X-37 and replaced with Rule 560-X-37-.06 as per certification filed December 11, 2009; effective January 15, 2010.

**560-X-14-.07**     **Consent For Health Services For Certain Minors And Others.**

(1) Chapter 560-X-1, General, contains references to the Code of Ala. 1975, regarding the rights of minors to consent to any legally authorized medical, dental, or other health services for himself or herself.

(2) Illiterate recipients may give consent for family planning services by making their mark (i.e., X) on the appropriate line. This type of consent for services must be witnessed by an adult with his/her signature after the phrase witnessed by.

**Authors:** Deborah K. Crawford, Dee Lockridge

**Statutory Authority:** Code of Ala. 1975, §§22-8-1, et seq.; 42 C.F.R. §§401, et seq., 441.20.

**History:** Rule effective October 1, 1982. **Amended** effective December 10, 1987; August 12, 1992.

**560-X-14-.08**     **Family Planning Drugs.**

(1) The co-payment on prescription drugs, and any indicated refills for Medicaid recipients does not apply to drugs and supplies designated as family planning items.

(2) Medically approved pharmaceutical supplies and devices such as oral contraceptive pills, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

**Author:** Leigh Ann Payne, Program Manager, Medical Services Division

**Statutory Authority:** State Plan; 42 C.F.R. §§401, et seq.; Title XIX, Social Security Act.

**History:** Rule effective October 1, 1982. **Amended** effective August 12, 1992. **Amended:** Filed April 11, 2003; effective May 16, 2003.

**560-X-14-.09**     **Billing Of Medicaid Recipients By Provider.**

(1) Refer to Chapter 1 of this Code for general information regarding providers billing Medicaid recipients.

(2) Medicaid recipients are exempt from CO-payment requirements for family planning services.

**Author:** Dee Lockridge

**Statutory Authority:** State Plan; Title XIX, Social Security Act; 42 C.F.R. §447.15.

**History:** Rule effective August 12, 1992. **Amended** effective February 9, 1987. **Repealed** effective August 10, 1988. **Amended** Filed July 6, 1995; effective August 12, 1995.

**Ed. Note:** Previous Rule 560-X-14-.09, **Prenatal Services** effective October 1, 1982.

**560-X-14-.10**     **Reports.**

(1) The Medicaid fiscal agent will provide a report on sterilization claims adjudicated to be used for reporting expenditures to the Centers for Medicare and Medicaid Services.

(2) The fiscal agent shall generate a report of Family Planning expenditures to be used for reporting expenditures to the Centers for Medicare and Medicaid Services.

**Author:** Leigh Ann Payne, Program Manager, Medical Services Division

**Statutory Authority:** State Plan; 42 C.F.R. §§401, et seq.; Title XIX, Social Security Act.

**History:** Effective October 1, 1982. **Amended** effective August 12, 1992. **Amended:** Filed May 12, 2003; effective June 16, 2003.

**560-X-14-.11**     **Alabama Medicaid Provider Manual.**

(1)           The Alabama Medicaid Provider Manual, including Appendix C, which details the elements of each family planning visit, instructions for completion of forms, and procedures to follow in the administration of the local program, is provided to each enrolled provider.

(2)           Family planning providers will be required to follow procedures outlined in the manual. Failure to do so may result in the recoupment of claims paid to the provider.

**Author:** Leigh Ann Payne, Program Manager, Medical Services Division

**Statutory Authority:** State Plan; 42 C.F.R., §401, et seq.; Title XIX, Social Security Act.

**History:** Rule effective August 12, 1992. **Amended:** Filed May 12, 2003; effective June 16, 2003.