DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

April 29, 2014

Ms. Sandra Terrell
Acting Medical Director
North Carolina Department of Health and Human Services
1985 Umstead Drive, 2501 Mail Service Center
Raleigh, NC 27699-2501

Dear Ms. Terrell:

Thank you for the state's request to extend North Carolina's "Be Smart" section 1115 family planning demonstration, which is due to expire on April 30, 2014.

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of demonstration until September 30, 2014. This temporary extension will allow the state to work with CMS to implement its State Plan Amendment (SPA) to provide family planning services through Section 2302 of the Affordable Care Act. The demonstration is currently operating under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of expenditure authorities and special terms and conditions will continue to apply to the "Be Smart" demonstration until September 30, 2014.

If you have any questions, please do not hesitate to contact your project officer, Ms. Shanna Wiley. Ms. Wiley can be reached at (410) 786-1370, or at shanna.wiley@cms.hhs.gov. We look forward to continuing to work with you and your staff on this demonstration.

Sincerely,

/s/

Eliot Fishman
Director

cc: Jackie Glaze, Associate Regional Administrator, Region IV
Elaine Elmore, CMS Atlanta Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

October 25, 2013

Ms. Sandra Terrell
Acting Medical Director
North Carolina Department of Health and Human Services
1985 Umstead Drive, 2501 Mail Service Center
Raleigh, NC 27699-2501

Dear Ms. Terrell:

Thank you for the state's communication regarding the extension of North Carolina's Medicaid section 1115 family planning demonstration, entitled "Be Smart Family Planning Waiver." The state requested that the current program, which is due to expire on October 31, 2013, be extended to April 30, 2014.

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of your program until April 30, 2014. This period of time will allow the state to work with the Centers for Medicare & Medicaid Services (CMS) to implement its approved State Plan Amendment (SPA) to provide family planning services through Section 2303 of the Affordable Care Act (NC 11-040; approved September 21, 2012).

The demonstration is currently operating under the authority of section 1115(a) of the Social Security Act. The current lists of waiver and expenditure authorities and special terms and conditions will continue to apply to the demonstration until April 30, 2014.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Jennifer Ryan
Deputy Director

cc: Jackie Glaze, Associate Regional Administrator, Region IV
Elaine Elmore, CMS Atlanta Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

NOV 5 2004

Mr. Gary Fuquay
Director
Division of Medical Assistance
2517 Mail Service Center
Courier Number 56-20-06
Raleigh, NC 27699-2517

Dear Mr. Fuquay:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that North Carolina's request for its section 1115 Medicaid demonstration project for family planning services, project number 11-W-00182/4, has been approved for a 5-year period from the date of implementation.

Our approval of this demonstration (and the Federal matching funds provided thereunder) is contingent upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs define the nature, character, and extent of anticipated Federal involvement in the project. This award is subject to our receipt of your written acceptance of the award and STCs within 30 days of the date of this letter.

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), the following expenditures that would otherwise not be regarded as expenditures under section 1903 of the Act will, for a 5-year period beginning from date of implementation , be regarded as expenditures under the State's title XIX plan :

> Expenditures permitting the State to provide family planning services for uninsured men and women over the age of 18 with income at or below 185 percent of the Federal poverty level who are not otherwise eligible for any other Medicaid program.

Your project officer for this demonstration is Deborah Larwood, who is available to answer any questions regarding program and administrative matters. Ms. Larwood's contact information is as follows:

> Centers for Medicare & Medicaid
> Services Center for Medicaid and State
> Operations 7500 Security Boulevard
> Mail Stop: S2-0l-16
> Baltimore, MD 21244-1850
> Telephone: (410) 786-9500
> E-mail: DLarwood@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to the project officer and to Renard Murray, Associate Regional Administrator in our Atlanta Regional Office at (404) 562-7417. Mr. Murray's contact information is as follows

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Atlanta Federal Center
61 Forsyth Street, SW., Suite 4T20
Atlanta, GA 30303-8909

If you have questions regarding this correspondence, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We extend our congratulations to you on this award and look forward to working with you during the course of the demonstration.

Sincerely,
/s/

Mark B. McClellan, M.D., Ph.D.

Enclosure

cc: Marsha Montague, CMS Atlanta Regional Office

Centers for Medicare & Medicaid Services (CMS)
Special Terms and Conditions (STCs)

Project Number: 11-W-00182/4
Project Title: North Carolina Family Planning Waiver Program
State: State of North Carolina

Financial Issues

1. a. All requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the demonstration letter of which these STCs are part, will apply to the North Carolina family planning section 1115 demonstration. To the extent the enforcement of such laws, regulations, and policy statements would have affected state spending without the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for this family planning section 1115 demonstration program. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the family planning section 1115 demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the state's budget limit will be proportional to the size of the family planning section 1115 demonstration in comparison to the state's entire Medicaid program (as measured in aggregate medical assistance payments).

   b. The state will, within the time specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the date of the demonstration. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect state Medicaid spending without the demonstration, CMS will incorporate such changes into a modified budget limit for the family planning section 1115 demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the family planning section 1115 demonstration (e.g., laws affecting sources of Medicaid funding), the state will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in North Carolina, CMS would approve the methodology. Should CMS and the state, working in good faith to ensure state flexibility, fail to develop within 90 days of the implementation of the change in Federal law a methodology to revise the without-demonstration baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

c. The state may submit to CMS a request for an amendment to the family planning demonstration to request exemption from changes in law occurring after the date of the demonstration. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified family planning section 1115 demonstration program do not exceed projected expenditures without the family planning section 1115 demonstration (assuming full compliance with the change in law).

d. Budget Neutrality Monitoring Procedures (See Attachment A).

2. The following financial reporting procedures must be adhered to:

a. In order to track expenditures under this demonstration, North Carolina will report net expenditures in the same manner as is the practice under the current Medicaid program. The state will provide quarterly expenditure reports using Form CMS-64 to separately report expenditures for those receiving services under the Medicaid program and those participating in the demonstration. CMS will provide Federal financial participation (FFP) only for allowable demonstration expenditures that do not exceed the predefined limits as specified in Attachment A. Demonstration participants include all individuals who obtain one or more covered medical family planning services through the demonstration.

b. North Carolina will report demonstration expenditures through the Medicaid Budget Expenditure System, following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. In this regard, demonstration expenditures will be differentiated from other Medicaid expenditures by identifying on Forms CMS-64.9 Waiver and/or 64.9P Waiver the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, cost settlements attributable to the expenditures subject to the budget neutrality cap must be reported on line 10B, in lieu of lines 9 or 10C.

c. The Federal share for demonstration expenditures matched at the state's regular match rate should be reported using column (B) of Form CMS 64.9 Waiver and/or 64.9P Waiver and in column (D) for services eligible for the family planning match rate of 90 percent.

d. All claims for North Carolina's family planning services provided during the demonstration period (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. During the period following the conclusion or termination of the demonstration, the state must continue to separately identify demonstration expenditures using the procedures outlined above.

e. The state will provide to CMS, on a quarterly basis, the number of individuals enrolled in the demonstration as well as the number of participants. This information should be provided to CMS with the quarterly narrative report.

f. Administrative costs will not be included in budget neutrality; however, the state must separately track and report administrative costs attributable to the demonstration on Form CMS-64.10 Waiver and/or 64.10P Waiver.

g. The state will provide to CMS, on a yearly basis, the average total Medicaid expenditures for a Medicaid-funded birth. The cost of a birth includes prenatal services and delivery and pregnancy related services and services to infants from birth through age 1 year. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

h. The state will submit to CMS, on a yearly basis, the number of actual births that occur to demonstration participants.

i. The North Carolina Medicaid office must institute a data sharing relationship with the state agency that performs the calculation of the vital statistics in order to ensure state compliance with the birth data reporting requirements under the demonstration. The state must notify CMS if birth data will not be available within six months of the end of the demonstration year.

3. The standard Medicaid funding process will be used during the demonstration. The state must estimate matchable North Carolina Medicaid demonstration expenditures on the quarterly Form CMS-37. The state must provide supplemental schedules that clearly distinguish between demonstration expenditure estimates (by major component) and non-demonstration Medicaid expenditure estimates. CMS will make Federal funds available each quarter based upon the state's estimates, as approved by CMS. Within 30 days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on Form CMS-64 with Federal funding previously made available to the state for that quarter, and include the reconciling adjustment in a separate grant demonstration to the state.

4. CMS will provide FFP at the appropriate administrative matching rate for administrative costs associated with family planning services rendered under the North Carolina family planning program.

5. The state will certify that state/local monies are used as matching funds for demonstration purposes and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

6. FFP for services (including prescriptions) provided to women and men under the family planning demonstration will be available at the following rates:

a. For services whose primary purpose is family planning (determining family size) and which are provided in a family planning setting, FFP will be available at the 90 percent matching rate. Procedure codes for office visits, laboratory and other tests, and procedures must carry a diagnosis code that specifically identifies them as a family planning service. Procedures and services eligible for the 90 percent match are described in the CMS Revised Financial Management Review Guide for Family Planning Services, dated February 2002.

b. For medical diagnosis or treatment services that are provided in conjunction with a family planning service in a family planning setting--specifically, follow-up diagnostic tests, treatment for sexually transmitted infections (STIs) and complication services--and which carry a diagnosis code which indicates that they are related to a family planning service, FFP will be available at the Federal Medical Assistance Percentage (FMAP) rate. Inpatient hospital is excluded as a "family planning setting" for family planning related services.

c. FFP will only be provided for those service codes that are specified in Attachment B, and those additional codes that are approved by CMS prior to inclusion in the demonstration.

d. FFP will not be available for the costs of any services, items or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.

For example, in the instance of testing for an STI as part of a family planning visit, the match rate would be 90 percent. The match rate for the subsequent treatment would be the regular FMAP rate. This would include antibiotics for STI; hepatitis B and rubella immunizations if the beneficiary falls into a Medicaid-covered risk group; pap smears and colposcopies performed as follow-ups to abnormal pap smears performed during a family planning visit. For testing or treatment not associated with a family planning visit, no match would be available.

Administrative Issues

7. Outreach performed by the Medicaid agency or other entities under contract to the Medicaid agency will be available at the administrative match rate of 50 percent of FFP.

8. The state shall facilitate access to primary care services for enrollees in the Medicaid section 1115 family planning demonstration. The state shall submit to CMS a copy of the written materials that are distributed to the family planning demonstration participants as soon as they are available. The written materials must explain to the participants how they can access primary care services. In addition, the state must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design report that will be submitted to CMS (see term and condition #22).

9. Within 60 days from the date of approval of the demonstration, the state will provide to CMS an appropriate methodology for ensuring annual eligibility determination of individuals covered under the family planning demonstration based on income at or below 185 percent of the Federal poverty level (FPL).

10. The state will submit narrative progress reports 30 days following the end of each demonstration quarter. The format for the progress reports will be agreed upon prior to the submission of the first report. The fourth quarterly report will summarize the preceding demonstration year's activity and serve as the annual report. The annual report will be due 90 days following the end of the fourth quarter of each project year.

11. North Carolina shall submit a draft final report to the CMS project officer for comments. The final report will incorporate all evaluation findings. The draft final report will be due 180 days prior to the end of the demonstration award period. The state should consider CMS' comments for incorporation in the final report. The final report is due 90 days after the end of the demonstration award period.

12. The final report of the project may not be released or published without permission from the CMS project officer, except as required by law, within the first four months following receipt of the report by the CMS project officer. The final report will contain a disclaimer that the opinions expressed are those of the state and do not necessarily reflect the opinions of CMS.

13. North Carolina will notify the CMS project officer before formal presentation of any report or statistical or analytical material based on information obtained through this cooperative agreement. Formal presentation includes papers, articles, professional publications, speeches, and testimony. During this research, whenever the state or its designee determines that a significant new finding has been developed, he/she will immediately communicate it to the CMS project officer before formal dissemination to the general public.

14. The state will assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The CMS project officer will not direct the interpretation of the data in preparing these documents and reports.

15. CMS may suspend or end any project in whole, or in part, any time before the date of expiration, whenever it determines that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, with the effective date. The budget neutrality test will be applied on the time period through termination without adjustment.

16. CMS reserves the right unilaterally to terminate the demonstration and the accompanying Federal matching authority if CMS determines that continuing the demonstration would no longer be in the public interest. If a family planning demonstration is terminated by CMS, the state will be liable for cumulative costs under the demonstration that are in excess of the cumulative target expenditures specified in the Expenditure Review section of Attachment A for the demonstration year of withdrawal.

17. After the demonstration is approved, CMS reserves the right to terminate it if agreement cannot be reached on any item(s) cited in this document. The state also has the same right.

18. At any phase of the project, including the project's conclusion, the state, if so requested by the project officer, must submit to CMS analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the demonstration. The analytic file(s) may include primary data collected or generated under the demonstration and/or data furnished by CMS. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the state or its designee and the CMS project officer. The negotiated format(s) could include both the file(s) that would be limited to CMS internal use and the file(s) that CMS could make available to the general public.

19. At any phase of the project, including the project's conclusion, the state, if so requested by the project officer, must deliver any materials, systems, or other items developed, refined, or enhanced during or under the demonstration to CMS. The state agrees that CMS will have royalty-free, nonexclusive, and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use such materials, systems, or items for Federal Government purposes.

20. The state will cooperate fully with CMS or the independent evaluator, selected by CMS, to assess the impact of the Medicaid demonstrations. The state will submit the required data to the contractor or CMS.

21. Failure to operate the demonstration as approved and according to Federal and state statutes and regulations will result in withdrawal of approval for the demonstration. The Federal statutes and regulations with which the state must comply in the operation of the demonstration include civil rights statutes and regulations that prohibit discrimination on the basis of race, color, national origin, disability, sex, age, and religion, including Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act, and the nondiscrimination provisions of the Omnibus Budget Reconciliation Act of 1980.

22. An evaluation design report must be submitted to CMS for approval within 120 days from the award of the demonstration. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. Finally, it will discuss how the referral process for primary care will be evaluated.

23. A phase-out plan for the demonstration needs to be submitted for approval to CMS within 90 days of the award of the demonstration. The phase-out plan must address the fact that the state is responsible for informing enrollees of the fact that the demonstration will end 5 years from the beginning date.

24. Family planning expenditures under the Medicaid program have increased in recent years and CMS is interested in monitoring these expenditures. Thus, as part of its overall monitoring of the demonstration, CMS will also be monitoring the rate of expenditure growth for family planning services. This monitoring will be done on a per capita basis, using total expenditures recorded during the first year of the demonstration as a baseline. As a frame of reference, we will be comparing the annual rate of growth of actual expenditures with the baseline amount trended forward using Consumer Price Index (CPI) Medical. The comparison of actual per capita expenditures over the life of the demonstration and per capita expenditures trended using CPI Medical will be considered with respect to if the state seeks an extension of its family planning demonstration.

In addition, a Federally-contracted evaluation recently examined the appropriateness of the budget neutrality methodology of these demonstrations by assessing the births that have been averted as a result of the demonstrations, the data sources currently used to assess averted births and budget neutrality, and expenditures overall. Based on the evaluation findings and other information, CMS reserves the right to negotiate a new budget neutrality methodology, if CMS deems it appropriate. Such a methodology change could range from a change in data sources used to determine budget neutrality, to a total change in methodology, such as incorporating a per capita cap like the one described above. Any and all changes to the budget will be made in full consultation with the state, including expenditure data used in the methodology.

Attachment A, Monitoring Budget Neutrality, follows.

Attachment A
Monitoring Budget Neutrality for the
North Carolina Family Planning Waiver Program

The following is the method by which budget neutrality will be monitored for the North Carolina Family Planning Program.

North Carolina will be subject to a limit on the amount of Federal Title XIX funding it will receive for extending Medicaid eligibility for family planning services during the demonstration period. This limit will be determined using a pre/post comparison of fertility rates for demonstration participants. Thus, North Carolina will be at risk for the cost of family planning services (including traditional family planning services at the enhanced match rate and ancillary services described in STC #6 at the FMAP rate) that are not offset by the demonstration intervention. The demonstration aims to increase the number of women and men receiving comprehensive reproductive health services while reducing unintended pregnancy for non-Medicaid-participating, childbearing women with income at or below 185 percent of the Federal poverty level (FPL). The demonstration will not change the current division of Federal and State responsibility for costs of the current Medicaid program. CMS will confirm that the demonstration expenditures do not exceed the levels that would have been in the absence of the demonstration.

Annual Budget Limits

To calculate the overall expenditure limit for the demonstration, separate budget limits will be calculated for each year, and will be on a Demonstration Year (DY) basis. These annual estimates will then be added to obtain an expenditure estimate over the entire demonstration period. The Federal share of the estimate will represent the maximum amount of Federal financial participation (FFP) that the State can receive during the expanded family planning services demonstration. For each DY, the Federal share will be calculated using the FMAP rate(s) for that 12-month period.

The intent of the demonstration is to avert unplanned pregnancies to offset the cost of family planning services for demonstration participants. During each year of the demonstration, the number of births averted (BA) will be estimated by the following equation:

> BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the state may also adjust the fertility rates for ethnicity.

The calculation of the average cost of a birth (BC) during each year of the demonstration will be the following:

> BC = (cost of prenatal services + delivery and pregnancy related costs + costs for infants through year 1 of life)/number of deliveries, where the costs and number of deliveries pertains to the North Carolina Medicaid program.

The annual budget limit will be the savings that are calculated by multiplying the number of births averted (BA) by the average cost of a birth (BC).

Base-Year Fertility Rate

The state will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates. Preliminary base-year fertility rates must be submitted for approval within the first operational year of the demonstration and conform to the following requirements:

a. They must reflect fertility rates during Base Year 2003, for women in families with income at or below 185 percent of the FPL.

b. They must be adjusted for the age for all potential demonstration participants.

c. The fertility rates will include births paid by Medicaid.

The state will be allowed up to 6 months after the end of the first demonstration year to finalize these preliminary rates. Following the conclusion of each year of the demonstration, a demonstration year fertility rate will be determined by summing the age-specific rates using the age distribution of the demonstration participants during that DY to weight the age-specific fertility rates, unless the state demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates.

How the Budget Limit Will Be Applied

The budget limit calculated above will apply to waiver expenditures, as reported by the state on the CMS-64 forms. If, at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess Federal funds will be returned to CMS.

Expenditure Review

CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each demonstration year or as soon thereafter as the data are available, the state will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for

Medicaid. Using the schedule below as a guide, if the state exceeds these targets, it will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved program.

Year	Cumulative Target Expenditures	Percentage
Year 1	Year 1 budget limit amount	+ 16 percent
Year 2	Years 1 and 2 combined budget limit amount	+ 8 percent
Year 3	Years 1 through 3 combined budget limit amount	+ 4 percent
Year 4	Years 1 through 4 combined budget limit amount	+ 2 percent
Year 5	Years 1 through 5 combined budget limit amount	0 percent

The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, shall immediately collaborate with CMS on corrective actions, which shall include submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem. While CMS will aggressively pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance by the end of year 5.

The with and without waiver costs (Federal share) follow. The without waiver costs are estimates of the costs of births that would occur in the absence of the demonstration. The with waiver costs are estimates of costs of births that would occur during the demonstration plus the cost of family planning services provided to demonstration participants.

YEAR	WITHOUT WAIVER	WITH WAIVER	TOTAL SAVINGS
2005	$362,398,600	$363,371,536	$972,936.47
2006	$392,397,804	$389,956,745	$(2,441,058.46)
2007	$423,531,933	$419,854,645	$(3,677,288.07)
2008	$457,364,043	$452,183,808	$(5,180,234.83)
2009	$494,084,086	$487,332,435	$(6,751,650.80)
TOTAL	$2,129,776,465	$3,218,017,143	$(17,077,296)

Attachment B
Codes for the North Carolina Family Planning Waiver

These codes in this document will capture the enhanced Family Planning (FP) category of service (COS) rate of 90 percent if the claim has an FP diagnosis code, V25-V25.99, and an FP modifier or an "F" in the EPSDT/FP field. Family planning processing is performed at several different levels within the MMIS+ system. The enhanced rate is captured at the detail level of the claim. Each detail is examined to determine if it applies to family planning. For capturing the enhanced rate, the FP diagnosis code can appear in either the first diagnosis (primary) field or a secondary diagnosis field.

In general, N.C. Medicaid reimburses for an initial or one annual FP visit per 365 days at the 90 percent rate. There are situations in which Medicaid will reimburse codes in this document at the FMAP rate, including E/M codes. Those are specified in the document.

The screening tests (such as tests for STI and HIV, Pap smears, and pregnancy tests) performed at an initial or annual family planning visit as part of a comprehensive package will capture the enhanced rate. If a recipient needs to return to the office for the results of STD or HIV testing, the provider should not bill an E/M code. The antibiotic for an STI captures the FMAP rate. One course of treatment for an STI will be paid per year if the STI is directly related to the initial or annual family planning visit. If there is a return visit for a repeat Pap smear from a problem found at the time of an initial or annual FP visit (not enough cells to complete the test), one follow-up visit will be paid (E/M code) at the FMAP rate, and one repeat Pap smear will be paid at the FMAP rate. If there is a return visit due to a problem directly related to the insertion of an IUD, that E/M code will be reimbursed at the 90 percent rate. If the IUD has to be removed due to medical problem, such as an infection, however, that E/M code will be reimbursed at the FMAP rate. If a recipient returns to the provider for removal of an IUD so that pregnancy can occur, that E/M code will be reimbursed at the 90 percent rate.

Codes that are specific to females should have the ages 011-055 on them on the PR file, but for the FP Waiver, those 19 years of age through 55 will be covered. Codes that are specific to men should have age 011-060 on the PR file, and the FP Waiver will cover those males 19 years of age through 60. Codes that are not gender-specific should have 011-060 on the PR file, and the waiver will cover those 19 years of age or older.

As codes or coding conventions change, the codes listed in this document will be updated to reflect those changes. Coding updates do not indicate a change in coverage policy regarding this waiver.

A. Family planning initial or annual examinations (including appropriate physical exams):

99201	New patient, Office or Outpatient visit
99202	same

99203	same
99204	same
99205	same
99211	Established patient, Office or Outpatient visit
99212	same
99213	same
99214	same
99215	same
99221	New or established patient, Hospital
99222	same
99223	same
99231	same
99232	same
99233	same
99238	Hospital discharge services (day management)
99239	same
99241	New or established patient, Office or other Outpatient consultation
99242	same
99243	same
99244	same
99245	same
99251	New or established patient, Initial Inpatient Consultation
99252	same
99253	same
99254	same
99255	same
99261	Established patient, Follow-up Inpatient Consultation
99262	same
99263	same
99281	New or established patient, Emergency Department Visit
99385	New patient, Preventive Medicine Services, 18-39 years
99386	New patient, Preventive Medicine Services, 40-64 years
99395	Established patient, Preventive Medicine Services, 18-39 years
99396	same 40-64 years

B. Family planning counseling visits:

99050	After office hours
99052	10:00 p.m. – 8:00 a.m.
99054	Sundays and holidays
99056	Patient request, other than in the office
99201	
99202	
99203	
99204	
99205	

99211
99212
99213
99214
99215
99241
99242
99243
99244
99245
99261
99262
99263
99385
99386
99387
99395
99396
99397

Note: Some of these codes may be used for annual visits; therefore, we have included some codes in both places (A and B).

C. Family planning supply visits:

Health departments supply birth control pills and condoms to recipients. Birth control pills are also reimbursed through the Pharmacy Drug Program. IUDs are reimbursed through the Physician's Drug Program.

99201-99205 and 99212-99215, new and established patient visits.

99058 – Office services provided on an emergency basis – used for Emergency Contraception

D. All FDA approved and Medicaid covered methods of birth control (including removal of implants/inserts):

A4260	Norplant system, including implants and supply
J1055	Depo-provera J1055 Lunelle
J7300	Paragard IUD
J7302	Mirena IUD
W5142	Projestacert IUD - This code is no longer covered because it is not manufactured.
11975	Insertion, implantable contraceptive capsules
11976	Removal, implantable contraceptive capsules
11977	Removal with reinsertion, implantable contraceptive capsules

57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of IUD
58301	Removal of IUD
W5135	Norplant kit (end-dated 10/01/2000)

ICD-9-CM procedure codes:

96.17	Insertion of vaginal diaphragm
97.24	Replacement and refitting of vaginal diaphragm
97.29	Other non-operative replacement
97.71	Removal of IUD
97.73	Removal of vaginal diaphragm
69.7	Insertion of IUD
97.89	Removal of other therapeutic device. This could be used for the removal of Norplant.

Codes 96.17 through 97.89 listed above will capture the 90 percent reimbursement rate, if billed with a diagnosis in the range of V25-V25.99. For the waiver recipients, if these codes are billed for a medical problem, they will be reimbursed at the FMAP rate.

Preven, a "morning after pill," also known as emergency contraception, is covered under the Pharmacy Drug Program. This drug will be covered under the Family Planning Waiver. The NDCs for this are 63955001001 and 63955002002.

Ortho-Evra, the birth control patch (NDC 00062192001 and 00062192015) and Nuvaring (NDC 00052027301) will be covered under the pharmacy program.

E. Tubal ligations and vasectomies and necessary post-procedure follow-up (upon receipt of proper federal sterilization consent form per current Medicaid regulations and the recipient is a minimum of 21 years of age)

W5075	State-assigned code for sterilization procedure was end-dated September 30, 2003. New CPT codes that replaced W5075 are: 58600, 58670, 58611, 58671, and 58615.
W8208	Epidural anesthesia for sterilization – the crosswalk for this code is 00851 for CPT 58600 and 58605; 00840 for 58615, 58670, and 58671; and 00921 for 55250.
55250	Vasectomy
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
58600	Ligation of fallopian tubes
58605	Ligation of fallopian tubes, post-partum
58611	Ligation of fallopian tubes, at the time of C-Section
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy, with fulguration of oviducts

58671	Laparoscopy, with occlusion of oviducts by device

The ICD-9-CM procedure codes:

63.70	Male Sterilization, NOS
63.71	Ligation of vas deferens
63.72	Ligation of spermatic cord
63.73	Vasectomy
66.21	Bilateral endoscopic ligation and crushing of fallopian tubes
66.22	Bilateral endoscopic ligation and ligation of fallopian tubes
66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes
66.31	Other bilateral ligation and crushing of fallopian tubes
66.32	Other bilateral ligation and division of fallopian tubes
66.39	Other bilateral destruction or occlusion of fallopian tubes
66.63	Bilateral partial salpingectomy, not otherwise specified

F. Laboratory tests performed in conjunction with a family planning visit:

81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	automated, with microscopy
81002	non-automated, without microscopy
81003	automated, without microscopy
81005	Urinalysis, qualitative or semiquantitative, except immunoassays
81007	bacteriuria screen, except by culture or dipstick
81015	microscopic only
81020	two or three glass test
81025	Urine pregnancy test, by visual color comparison methods
84702	Gonadotropin, chorionic (HCG)
84703	qualitative
85007	Blood count, blood smear, microscopic examination with manual differential WBC count
85008	blood smear, microscopic examination without manual differential WBC count
85009	manual differential WBC count, buffy coat
85013	spun microhematocrit
85014	hematocrit (Hct)
85018	hemoglobin (Hgb)
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count 85027 complete (CBC), automated (Hgb, Hct, RBC, WEB and platelet count)
85041	red blood cell (RBC) automated
85044	reticulocyte , manual

85045	reticulocyte, automated
85046	reticulocytes, hemoglobin concentration
85048	white blood cell (WBC)
86592	Syphilis test, qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test, quantitative
86631	Antibody: Chlamydia
86632	Chlamydia, IgM
86689	Antibody: HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86694	herpes simplex, non-specific type test
86695	herpes simplex, type 1
86696	herpes simplex, type 2
86701	Antibody, HIV-1
86702	HIV-2
86703	HIV-1 and HIV-2, single assay
86762	Antibody, rubella
96781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)
86900	Blood typing; ABO
86901	Rh (D)
86903	antigen screening for compatible blood unit using reagent serum, per unit screened
86904	antigen screening for compatible unit using patient serum, per unit screened
87081	Culture, presumptive, pathogenic organisms, screening only
87110	Culture, Chlamydia, any source
97207	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (herpes)
87210	Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87273	Herpes simplex, type 2
87274	Herpes simplex, type 1
87285	Treponema pallidum
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis

Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method;

87390	HIV-1
87391	HIV-2

Infectious agent detection by nucleic acid (DNA or RNA);

87490	Chlamydia trachomatis, direct probe technique

87491	Chlamydia trachomatis, amplified probe technique
87492	Chlamydia trachomatis, quantification
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87530	Herpes simplex virus, quantification
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique
87536	HIV-1, quantification
87537	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique
87539	HIV-2, quantification
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87592	Neisseria gonorrhoeae, quantification
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis
87850	Gonorrhea
88302	Surgical pathology, gross and microscopic examination
89300	Semen analysis, presence and/or motility of sperm including Huhner test (post coital)
89310	motility and count (not including Huhner test)
89320	complete (volume, count, motility and differential)

For the above codes, if there is a diagnosis in the range of V25-V25.99 on the claim, and the tests were performed in conjunction with an annual family planning visit, the code will capture 90 percent. Otherwise, the claim will deny. Pregnancy tests will be allowed at FP visits at the 90 percent rate.

G. EKGs if performed in preparation for a tubal ligation will be reimbursed at the FMAP rate if there is a diagnosis of V25.2 (sterilization) on the claim, either primary or a secondary. Otherwise, the claim will deny.

93000
93005
93010
93040
93041
93042

Anesthesia codes that will capture 90 percent when billed in relation to a sterilization procedure are 00840, 00851, and 00921.

H. X-rays if performed in preparation for a sterilization procedure will be reimbursed at the FMAP rate if diagnosis code V25.2 (sterilization) is on the claim, either the primary or a secondary diagnosis. Otherwise, the claim will deny.

71010
71015

I. Evaluation and management visits for an STI diagnosis or for HIV testing in conjunction with an initial or annual family planning visit will be reimbursed at the 90 percent rate if a diagnosis in the range of V25-V25.99 is on the claim, with the FP modifier in the appropriate field. These codes are listed below. HIV testing, performed at the annual FP visit, will only capture 90 percent when billed with an FP diagnosis code in the range of V25-V25.99, with the FP modifier in the appropriate field. If an FP diagnosis code is not present, the code will deny. As stated in the beginning of this document, if a recipient returns to the office for results of the testing, a second E/M code should not be billed or paid. The antibiotic for an STI will be paid through the Pharmacy or Physician's Drug Program at the FMAP rate. One of the established appropriate antibiotics must be billed for a particular STI diagnosis in order for payment to be made. If a recipient is HIV positive, the recipient will be referred to an appropriate provider for treatment. No E/M code will be paid for the return visit.

Many of the codes listed in this category were also listed in Section A above.

99050
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99281
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99396

These codes will capture 90 percent if a diagnosis in the range of V25-V25.99 is on the claim with the FP modifier in the appropriate field. In cases where the individual is returning for treatment for an STI following a family planning visit (results were not available on the day of the FP visit), the antibiotic will be reimbursed at the regular FMAP rate as described above. Medicaid will reimburse one antibiotic treatment per year for an STI if the treatment is associated with the initial or annual FP visit.

J. Pap smears, when provided as part of a family planning encounter:

88141	88142	88143			88147
88148	88150	88152	88153	88154	88155
88160	88161	88162	88164	88165	88166
88167					

If there is a diagnosis code in the range of V25-V25.99 on the claim, these codes will be paid at the FMAP rate. Otherwise, the codes will deny. As stated earlier, these codes will be allowed one time for a follow-up to the initial or annual FP visit for insufficient cells if there is an appropriate FP diagnosis code on the claim. The claim for the repeat Pap code will initially deny, and the provider will have to send in an adjustment with the pathology report. The repeat Pap will be claimed at the FMAP rate. The referring lab performing the test usually bills the codes. Only labs that are CLIA certified to perform the test will be reimbursed for these codes. An E/M code may be reimbursed at the FMAP rate if there is an appropriate FP diagnosis on the claim. The collection of the Pap smear is included in the E/M visit.

K. Testing for HIV when provided to women and men in conjunction with an annual family planning encounter will be reimbursed at the 90 percent rate. The return visit (E/M code) for HIV positive recipients will not be reimbursed. The recipients will be referred to an appropriate provider for treatment. One course of treatment per year for STI will be reimbursed at the FMAP rate if it is one of the approved antibiotics for the specific STIs paid for by the waiver.

The code was Y2013 for the comprehensive package of services that included HIV testing. This local code is now end-dated, and all providers should bill an appropriate E&M code for the service provided.

L. Therapeutic Injections if given for family planning: CPT code 90782 (administration fee).

If J1055 (Depo-provera for FP) is on the claim with the FP modifier and the FP diagnosis code, the drug and 90782 will capture 90 percent.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid & State Operations, Family and Children's Health Programs Group

November 4, 2009

Dr. Craigan L. Gray
Director
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Dear D. Gray:

We are pleased to inform you that North Carolina's request to amend Attachment B of the North Carolina family planning section 1115 demonstration Special Terms and Conditions (STCs) has been approved, and is effective as of the date of this approval letter.

Under this technical amendment, the State may offer the additional family planning procedures described in the table below. Please note that the Demonstration will continue to operate under the Expenditure Authorities and STCs that were approved on November 5, 2004. The only change being made is to the list of codes found in Attachment B, a copy of which is enclosed.

Procedure	Procedure Code	Procedure Code Description
Essure	58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpinography
	58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
	74740	Hysterosalpinography, radiological supervision and interpretation
Implanon	J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (lmplanon)
	11981	Insertion, non-biodegradable drug delivery implant
	11982	Removal, non-biodegradable drug delivery implant

Thin Prep Pap Smear	88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
	88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
Contraceptive Pills	S4993	Contraceptive pills for birth control

Your project officer is Ms. Julie Sharp. She is available to answer any questions concerning this demonstration project. Ms. Sharp's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
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Telephone: (410) 786-2292
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Official communications regarding program matters should be submitted simultaneously to Ms. Sharp and Ms. Mary Kaye Justis, Acting Associate Regional Administrator, in the Atlanta Regional Office. Ms. Justis' contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Regional Office
Atlanta Federal Center, 4th Floor
61 Forsyth St., SW., Suite 4T20
Atlanta, GA 30303-8909
E-mail: MaryJustis@cms.hhs.gov

We look forward to continuing to work with you and your staff on this Demonstration.

Sincerely,

/Ed Hutton/

Ed Hutton
Acting Director
Division of State Demonstration and Waivers

Enclosure

Attachment B
North Carolina Family Planning Waiver Procedure Code List

Code	Description	90% FFP	90% FFP with FP &/or V25-V25.99	FMAP	Approved
11976	Norplant – implant removal	X			previous
11981	**Insertion, non-biodegradable drug delivery implant**		**X**		**current**
11982	**Removal, non-biodegradable drug delivery implant**		**X**		**current**
55250	Vasectomy, unilateral or bilateral (including postop semen examination(s))	X			previous
55450	Ligation of vas deferens, unilateral or bilateral	X			previous
57170	Diaphragm - fitting with instructions	X			previous
58300	IUD insertion	X			previous
58301	IUD removal	X			previous
58340	**Catheterization and introduction of saline or contracst material for saline infusion sonohysterography (515) or hysterosalpingography.**		**X**		**current**
58565	**Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants**		**X**		**current**
58600	Tubal ligation by abdominal incision	X			previous
58615	Tubal ligation by suprapubic approach	X			previous
58670	Tubal ligation by laparoscopic surgery	X			previous
58671	Tubal ligation by laparoscopic surgery	X			previous
71010	Radiology examination; chest; single view, frontal		X (sterilization pre-op only)		previous
74740	**Hysterosalpinography, radiological supervision and interpretation**		**X**		**current**
81000	Urinalysis by dip stick or tablet reagent		X		previous
81001	Urinalysis; automated with microscopy		X		previous
81002	Urinalysis; non-automated without microscopy		X		previous
81003	Urinalysis; automated without microscopy		X		previous
81025	Urine pregnancy test		X		previous
84702	HCG quantitative		X		previous
84703	HCG qualitative		X		previous
85013	Blood count; spun microhematocrit		X		previous
85014	Blood count; other than spun hematocrit		X		previous
85018	Blood count; hemoglobin		X		previous
85027	Blood count; RBC only		X		previous
86592	Syphilis		X		previous
86593	Syphilis		X		previous
86631	Chlamydia		X		previous
86632	Chlamydia, IgM		X		previous

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North Carolina Family Planning Waiver Procedure Code List

Code	Description	90% FFP	90% FFP with FP &/or V25-V25.99	FMAP	Approved
86689	HTLV or HIV antibody		X		previous
86694	Herpes simplex, non-specific type test		X		previous
86695	Herpes simples, type 1		X		previous
86696	Herpes simplex, type 2		X		previous
86701	HIV -1		X		previous
86701	Antibody HIV-2		X		previous
86703	HIV -1&2		X		previous
86781	Treponema pallidum, confirmatory test		X		previous
87081	Culture, bacterial, screening only, for single organisms		X		previous
87110	Culture, chlamydia		X		previous
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)		X		previous
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites		X		previous
87270	Infectious agent antigen detection by enzyme immunoflourescent technique; adenovirus; Chlamydia trachomatis		X		previous
87273	Herpes symplex virus, type 2		X		previous
87274	Herpes simplex virus, type 1		X		previous
87285	Treponema pallidum		X		previous
87320	Infectious agent antigen detection by enzyme immunoassay technique; 87320 adenovirus; Chlamydia trachomatis		X		previous
87390	HIV·1		X		previous
87391	HIV-2		X		previous
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia 87490 Trachomatis. Direct probe technique.		X		previous
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia 87491 Trachomatis. Amplified probe technique.		X		previous
87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification		X		previous
87528	Herpes simplex virus, direct probe technique		X		previous
87528	Herpes simplex virus, amplified probe technique		X		previous
87530	Herpes simplex virus, quantification		X		previous
87534	HIV-1, direct probe technique		X		previous
87535	HIV-1, amplified probe technique		X		previous

Attachment B
North Carolina Family Planning Waiver Procedure Code List

Code	Description	90% FFP	90% FFP with FP &/or V25-V25.99	FMAP	Approved
87536	HIV-1, quantification		X		previous
87537	HIV-2, direct probe technique		X		previous
87538	HIV-2, amplified probe technique		X		previous
87539	HIV·2, quantification		X		previous
87590	Neisseria gonorrhea, direct probe technique		X		previous
8759	Neisseria gonorrhea, amplified probe technique		X		previous
87592	Neisseria gonorrhea, quantification		X		previous
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis		X		previous
87850	Neisseria gonorrhea		X		previous
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)		X		previous
88142	Cytopathology, cervical or vaginal, automated thin layer preparation		X		previous
88143	Cytopathology, manual screening & rescreening under physician supervision		X		previous
88147	Cytopathology smears, screening by automated system under physician supervision		X		previous
88148	Cytopathology, screening by automated system with manual rescreening		X		previous
88150	Cytopathology, manual screening under physician supervision		X		previous
88152	Cytopathology, slides, cervical or vaginal		X		previous
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)		X		previous
88154	Cytopathology, slides, computer assisted		X		previous
88164	Cytopathology, slides, cervical or vaginal		X		previous
88165	Cytopathology, slides, cervical or vaginal		X		previous
88166	Cytopathology, slides, computer assisted rescreening		X		previous
88167	Cytopathology, slides, cervical or vaginal		X		previous
88174	**Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision**		**X**		**current**
88175	**Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision.**		**X**		**current**

Attachment B
North Carolina Family Planning Waiver Procedure Code List

Code	Description	90% FFP	90% FFP with FP &/or V25-V25.99	FMAP	Approved
88302	Surgical pathology, gross and microscopic examination		X		previous
89310	Semen analysis; motility and count (not including Huhner test)		X		previous
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report		X (sterilization pre-op only)		previous
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only		X (sterilization pre-op only)		previous
99050	Services requested after posted office hours in addition to basic service		X		previous
99201	Office/outpatient visit; new patient physician time approximately 10 minutes		X		previous
99202	Office/outpatient visit; new patient moderate, physician time approximately 20 minutes		X		previous
99203	Office/outpatient visit; new patient moderate, physician time approximately 30 minutes		X		previous
99204	Office/outpatient visit; new patient complex, physician time approximately 40 minutes		X		previous
99205	Office/outpatient visit; new patient complex, physician time approximately 60 minutes		X		previous
99211	Office/outpatient visit; established patient minimal, physician time approximately 5 minutes		X		previous
99212	Office/outpatient visit; established patient minor, physician time approximately 10 minutes		X		previous
99213	Office/outpatient visit; established patient severe, physician time approximately 15 minutes		X		previous
99214	Office/outpatient visit; established patient severe, physician time approximately 25 minutes		X		previous
99215	Office/outpatient visit; established patient severe, physician time approximately 40 minutes		X		previous
99241	Office consultation; new or established patient minor, physician time approximately 15 minutes		X		previous
99242	Office consultation; new or established patient low, physician time approximately 30 minutes		X		previous
99243	Office consultation; new or established patient moderate, physician time approximately 40 minutes		X		previous
99244	Office consultation; new or established patient severe, physician time approximately 60 minutes		X		previous

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North Carolina Family Planning Waiver Procedure Code List

Code	Description	90% FFP	90% FFP with FP &/or V25-V25.99	FMAP	Approved
99245	Office consultation; new or established patient complex, physician time approximately 80 minutes		X		previous
99385	Initial comprehensive preventive medicine, new patient, 18-39 years		X		previous
99386	Initial comprehensive preventive medicine, new patient, 40-64 years		X		previous
99395	Periodic comprehensive preventive medicine, established patient, 18-39 years		X		previous
99396	Periodic comprehensive preventive medicine, established patient, 40-64 years		X		previous
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.		X		previous
00921	Anesthesia for procedure on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral.	X			previous
J1055	Depo-Provera - 150mg/ml- Limited to one injection *every 70 days*		X		previous
J7300	Intrauterine copper contraceptive (Paragard T380A)		X		previous
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena IUD)		X		previous
J7307	**Etonogestrel (contraceptive) implant system, including implant and supplies (Implanon)**		**X**		**current**
S4993	**Contraceptive pills for birth control**		**X**		**current**
Key: Previous = previously approved; current = currently being approved					