MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Family Planning Clinics 02-04

Issued: April 15, 2002

Subject: Revised Chapter III

Effective: Upon Receipt

Programs Affected: Medicaid

Attached is the revised Chapter III explaining family planning services available through the Family Planning Clinics enrolled in the Medicaid program as Provider Type 23. The Chapter describes the Medicaid coverage available through this provider type and has been updated to incorporate the changes in program policy related to the Uniform Billing Project and other routine program updates.

Also attached is a revised Procedure Code Appendix of the Family Planning Clinic manual that has been updated to reflect procedure codes currently covered for family planning clinics.

Manual Maintenance

Replace Chapter III of the Family Planning Clinic Manual with the attached revised Chapter III.

The following bulletins should be discarded:

FP 97-01/MSA 97-07, Issued June 1, 1997
FP 97-03/MSA 97-16, Issued November 3, 1997
FP 01-03 Issued April 15, 2001, effective August 1, 2001

Replace Appendix F with the attached Procedure Code Appendix.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved

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SECTION 1 - GENERAL INFOMATION

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GENERAL

The primary objective of the Medicaid Program is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The services listed as covered are those determined to be necessary to the beneficiary's health and wellbeing.

The services provided, as well as the type of provider and setting, must be appropriate to the specific medical needs of the beneficiary.

Determination of medical necessity is the responsibility of the attending physician (MD or DO), and must be within the scope of current medical practice and the limitations of the Program. Submission of the claim for payment serves as the provider's certification of the medical necessity for these services.

This determination of medical necessity is subject to review, in the context of accepted standards of medical practice.

EXPLANATION OF SERVICES

Family planning services can be obtained from a family planning clinic or a primary care provider, i.e., M.D., D.O., or other Medicaid-approved provider, i.e., Certified Nurse-Midwife and Nurse Practitioner. Family planning clinics are limited to providing family planning services only.

Family planning services are defined as follows:

Any medically-approved means, including diagnostic evaluation, drugs, supplies, for voluntarily preventing or delaying pregnancy.

These services can be furnished under the supervision of a physician or dispensed by a pharmacy for beneficiaries of child-bearing age, including minors who can be considered to be sexually active, for purposes of enabling such beneficiaries to voluntarily choose not to risk initial pregnancy or to limit the number of and spacing of their children.

Covered services include an office call for a complete exam, drugs, supplies and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or eligible family planning provider. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and purchased at a pharmacy. An exception is condoms and similar supplies which do not require a prescription.

Covered family planning services do not include services for treatment of infertility.

REIMBURSEMENT

Reimbursement for family planning services provided to Medicaid beneficiaries enrolled with a Medicaid Health Plan (MHP) is the responsibility of the MHP. Family planning clinics are encouraged to establish a sub-contract arrangement with the MHP and work out terms of services/reimbursement. The Department will reimburse for services provided to beneficiaries enrolled in a fee for service program. MHP enrollees do not require a referral to obtain family planning services from a family planning clinic provider.

In order to receive reimbursement, family planning clinics must be certified by the Michigan Department of Community Health, Division of Family and Community Health, and meet the established guidelines. Family planning clinic procedure codes are located in the Procedure Code Appendix of this manual. Physician services, lab tests, prescription drugs, or supplies beyond those specified in the Procedure Code Appendix are not reimbursable by the Medicaid Program when billed by a family planning clinic. Additional services, when appropriate, are available through the primary care provider and other providers, such as Pharmacy, Labs, etc., in accordance with Medicaid policy and procedures. Family planning clinics wishing to provide services in addition to contraceptive management may specifically enroll in the Medicaid program to provide the broader range of services (i.e., Physicians/Nurse Practitioners provider type 10, 11 or Medical Clinics provider type 77).

Where applicable, special billing instructions for family planning clinics are noted with the service definitions. General billing instructions are located in Chapter IV of this manual.

DIAGNOSIS CODES

The appropriate diagnosis codes from the International Classification of Diseases-Ninth Revision-Clinical Modification (ICD-9-CM) are to be indicated on the claim form when billing for family planning services. The V25 code to the highest level of specificity must be entered on the claim form.

PREVENTIVE MEDICINE SERVICES

Evaluation and Management/Office Visits

Family Planning Clinic providers are limited to providing preventive services for purposes of delaying or preventing pregnancy, i.e., family planning services. Services provided must be in accordance with the standards of care established for contraceptive management for initial and follow-up services as needed. The appropriate lab services required to manage contraceptive services must be made available, either by the clinic or through a referral process.

Providers must bill using the appropriate Preventive Medicine Evaluation and Management codes from the Current Procedural Terminology (CPT) manual and/or the Health Care Procedure Coding System (HCPCS) for the services and products listed in the Procedure Code Appendix. If in the course of providing preventive medicine services additional problems are identified which need follow-up services, the beneficiary must be referred to their primary care provider.

Counseling services are considered to be a part of evaluation and management services. As such, no separate reimbursement is available for counseling-only services. The appropriate evaluation and management code that most closely describes the service provided must be billed.

INFORMATION AND EDUCATION REGARDING CONTRACEPTIVE METHODS

The beneficiary must be given information and education for all methods of contraception available, including reversible methods (e.g., oral, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (e.g., tubal ligation, vasectomy) with regard to relative effectiveness, common side effects, and difficulty in usage. Basic information concerning sexually transmitted disease must also be discussed.

The prescription for a contraceptive method shall be according to the beneficiary's choice, except where such choice is in conflict with sound medical practice.

Problem Visits: Beneficiaries should be encouraged to return whenever they have specific problems related to the contraceptive method or wish additional guidance or service, including additional supplies. For follow-up care not related to contraception, referrals must be made to the primary care provider.

It is encouraged that all beneficiaries, regardless of the contraceptive method chosen, return for a physical examination, laboratory services, and health history at least once per year.

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LABORATORY

Laboratory testing related to contraceptive management or sexually transmitted diseases is a covered benefit. The family planning clinic or a licensed laboratory may provide services. The family planning clinic is limited to the lab services listed in the Procedure Code Appendix.

The lab provider who renders the service must bill for the service using its own provider identification number for the location where services were actually rendered. The clinic can bill only for services actually performed by the family planning clinic. Lab services provided by outside laboratory providers must be billed by that lab directly to Medicaid. For example, the pap smear specimen sent for testing to a lab outside the clinic must be billed by the lab performing the lab test.

Clinics seeking reimbursement for lab services are required to obtain Clinical Laboratory Improvement Act (CLIA) certification. The type of certification obtained will determine the level of complexity of the lab tests the clinic can perform. Clinics that have obtained CLIA certification must forward the certification number to Medicaid Provider Enrollment to be filed along with the provider ID number. Medicaid may conduct post-payment reviews to verify the certification level and tests paid for by the Department.

Lab tests conducted by the clinic are subject to the $50 per beneficiary per day limit. For information on exemptions from the daily limit, refer to the Medicaid Laboratory Manual, Chapter III, Section 3.

Laboratory tests other than those listed in the Procedure Code Appendix are available to beneficiaries when medically necessary, ordered by a physician, and provided by an independent laboratory or outpatient hospital laboratory. For additional information, reference the laboratory section in Chapter III of the Practitioner Manual.

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STERILIZATION

For Medicaid purposes, a sterilization procedure is defined as any medical procedure, treatment, or operation for the purpose of rendering a beneficiary (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed consent form (MSA-1959 Informed Consent to Sterilization) 30 days prior to surgery. A copy of the form can be found on Page 4 of this section.

Sterilizations will be covered only if:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.
- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

EXCEPTIONS FOR STERILIZATION

All of the above requirements may not be met in some instances, e.g., in case of premature delivery and emergency abdominal surgery. Exceptions apply when the beneficiary to be sterilized has signed a consent form, and during the required 30-day waiting period a premature delivery or an emergency abdominal surgery is necessary. To avoid an additional surgery at the conclusion of the required 30-day waiting period, federal regulations permit the sterilization to be performed at the same time as the premature delivery or emergency abdominal surgery, if 72 hours have elapsed since the beneficiary signed the consent form. In cases of premature delivery, an additional requirement is that the consent form was signed at least 30 days before the expected delivery date.

Sterilization requires the beneficiary's voluntary informed consent. Criteria to be met for sterilization are:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days but not more than 180 days after he/she signs the Informed Consent to Sterilization form (MSA-1959), except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains informed consent must offer to answer any questions the beneficiary to be sterilized may have concerning the procedure.
- Suitable arrangements must be made to insure that information is effectively communicated to the deaf, blind, or otherwise physically challenged.
- An interpreter must be provided if the beneficiary to be sterilized does not understand the language used on the informed consent form or the language used by the person obtaining informed consent.
- The beneficiary to be sterilized is permitted to have a witness of his/her choice present when informed consent is obtained.

- At the time of the informed consent, a copy of the consent form must be given to the beneficiary to be sterilized.

- Informed consent may not be obtained while the beneficiary to be sterilized is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

- All of the following sterilization information and advice must be presented orally to the beneficiary to be sterilized both at the time the beneficiary signs the informed consent form and again by the physician performing the sterilization shortly before the procedure, normally during the pre-operative examination.

    - Advice that the beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.

    - Provide a description of available alternative methods of family planning and birth control.

    - Advice that the sterilization procedure is considered to be irreversible.

    - A thorough explanation of the specific sterilization procedure to be performed.

    - A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

    - A full description of the benefits or advantages that may be expected as a result of the sterilization.

- The beneficiary to be sterilized, the person who obtained the consent, and the interpreter (if required) must sign the informed consent form at least 30 days but not more than 180 days prior to the sterilization. Also, the physician performing the sterilization must sign and date the informed consent form after the sterilization has been performed.

REIMBURSEMENT POLICY FOR STERILIZATION

Pre- and post-operative examinations for the sterilization procedure are included in the reimbursement for the surgical procedure. No additional reimbursement will be allowed for the pre-operative examination or the sterilization explanation.

The reimbursement for a vasectomy includes pre- and post-operative visits for counseling, clamp removal, the post-operative semen analysis, etc; no additional charges are allowed for these services.

Reimbursement for female sterilization and other related medical procedures is available to the physician performing the service and who is enrolled in the Medicaid program by billing for services under his/her own Medicaid ID number. Reimbursement for female sterilization is not available to a Family Planning Clinic.

SPECIAL BILLING INSTRUCTIONS

All items of the Informed Consent to Sterilization (MSA-1959) must be completed except as noted below. The ethnic information on MSA-1959 is optional. The interpreter statements on MSA-1959 must be completed only when applicable. All invoices submitted to the Department of Community Health by the clinic for the sterilization must include a copy of the fully completed Informed Consent to Sterilization (MSA-1959). This requirement applies to all practitioners, technical surgical assistants, anesthesiologists, etc., as well as the hospital and clinics. All sterilization claims will pend and documentation will be reviewed. Invoices submitted without the appropriate documentation will be rejected.

Instructions on completing the Informed Consent to Sterilization (MSA-1959) form are provided on Page 5 of this section. If any field on the form is improperly completed, your claim will be rejected.

You must provide a copy of the completed Informed Consent to Sterilization (MSA-1959) when billing for charges related to a sterilization procedure. This form may be submitted by fax or accompany the claim.

CONSENT FORM FOR STERILIZATION (MSA-1959)

To encourage paperless billing and reduce administrative burden, the DCH allows for submission of Informed Consent to Sterilization forms via fax. Federal regulations require that this form be submitted to the Medicaid program before reimbursement can be made for any sterilization procedure. This process can eliminate submitting paper attachments for sterilization claims, and will pre-confirm the acceptability of the completed consent form, as well as reduce costly claim rejections.

The provider who obtains the required consent and completes the MSA-1959 may fax the completed consent form, along with a cover sheet, to the Payment Processing Division at the fax number noted below. The form will be reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file will be returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted to the program without paper attachments.

PROCEDURE FOR SUBMITTING CONSENT FORM

Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.

- Fax the cover sheet and completed consent form to: Department of Community Health, Payment Processing Division, Sterilization Consent Form Approval, fax number (517) 241-7856. DO NOT FAX INVOICES.

- Wait for a response. When you are notified that the consent form has been accepted and is on file, inform the other providers via a copy of the response.

- You and other providers may then submit claims (either paperless or hard copy) to Medicaid. The "Remarks" section or "Comment Record" must include the statement "Consent on File."

- When sterilization claims are received with this information in the Remarks, consent form edit requirements will be forced if the submitted invoice matches the consent form on file.

- If there is no response within five working days, confirm that your fax is working. Be sure that your cover sheet included the necessary information for Medicaid staff to contact you. Resend the information if necessary.

This process is an option. You may still continue to attach a copy of the consent form to your claim without going through this pre-approval process.

MSA-1959

INFORMED CONSENT TO STERILIZATION

Michigan Department of Community Health

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from [1] _____ When I first asked
(Doctor or Clinic)

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand [2] I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on [3] _____
(Month / Day / Year)

I, [4] _____, *(Name of Individual Being Sterilized)*

hereby consent of my own free [5] o be sterilized by

_____ [6]
(Name of Doctor and Professional Degree))

by a method called _____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form. [7] [8]

_____ _____
(Signature of Person Giving Consent) *(Month / Day / Year)*

You are requested to supply the following information, but it is not required: *Race and ethnicity designation (please check)* [9]

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ White (not of Hispanic origin)
- ☐ Multiracial (parents are different races)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining [10] consent. I have also read him / her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and b[10] e/she understood this explanation [10]

_____ _____
(Signature of Interpreter) *(Date)*

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

MSA-1959 (Rev.5/97) Formerly DSS-1959 which may be used

STATEMENT OF PERSON OBTAINING CONSENT

Before [11] _____
(Name of Individual)

signed the consent form, I explained to him/her the nature of the sterilization operation [12] _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He / she knowingly and voluntarily requested to be sterilized and appears to understan[13] nature and consequence of the procedur[14]

_____ _____
(Signature of person obtaining consent) *(Date)*

[15] _____
(Facility)

[16] _____
(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before [17] ormed a sterilization operation u[18]

_____ on _____
(Name of individual to be sterilized) *(Date of sterilization)*

I explained to [19] er the nature of the sterilization operation _____, the fact that it is intended
(specify type of operation)

to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. he / she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delive[20] emergency abdominal surgery where the sterilization is perf[20] less than 30 days after the date of the individual's signature [20] consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed. [21]

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent from because of the following circumstances (check applicable box and fill in information requested): [22] [23]

- ☐ Premature delivery
- ☐ Individual's expected date of delivery : _____
- ☐ Emergency abdominal surgery

(describe circumstances): [24]

_____ [25]
(Signature of Physician and Professional Degree) *(Date)*

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.

Instructions to Complete Informed Consent to Sterilization Form

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

PHARMACEUTICAL

The clinic may dispense and receive reimbursement for contraceptives and limited pharmaceutical supplies listed in the Procedure Code Appendix of the manual.

Oral contraceptives may be dispensed for a period not to exceed a six-month supply. All other contraceptive supplies should be dispensed for one month, with the exception of implants and hormonal contraceptives such as Norplant and Depo Provera.

If the only service provided is supplies, no visit code should be billed. A billing unit must equal a billing quantity of one on the claim.

Medicaid covers a broader range of pharmaceuticals than those listed in the Procedure Code Appendix. These products need to be prescribed by a physician and dispensed by a Medicaid-enrolled pharmacy. The Medicaid Pharmacy Manual or the local pharmacy may be referenced/contacted for details.

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OTHER SERVICES

REFERRALS: Each clinic is responsible for making appropriate referrals in the following circumstances:

- Medical problems identified by the history or physical examination,
- All positive Gonorrhea cultures and/or serology,
- Vaginal infections,
- Beneficiaries with abnormal cervical cytology,
- Beneficiaries with positive urine cultures,
- For prenatal services,
- Beneficiaries suffering from anemia, and
- Female sterilizations.

INPATIENT SERVICES: Each clinic must make provision for inpatient care for fee for service beneficiaries requiring such care as a result of complications arising from contraceptive services provided by that clinic. For Health Plan enrollees, this would be through their Health Plan.

EMERGENCY SERVICES: Each clinic must make provision for handling emergency services related to contraceptive services for after regular clinic hours.

INFERTILITY SERVICES: Infertility services are not a Medicaid covered benefit.

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The service procedure codes listed are published by the American Medical Association and are referred to as the Current Procedural Terminology (CPT) codes. The individual procedures covered for Family Planning Clinics are listed under the appropriate CPT category headings. Refer to the CPT coding manual for code definitions.

The contraceptive and pharmaceutical supplies codes are HCPCS Level II or Level III codes. The complete definitions for the Level III codes are listed. Refer to the HCPCS coding manual for Level II code definitions.

EVALUATION & MANAGEMENT

Preventive Medicine Services

CODE	DESCRIPTION
99383	Prev Visit, New, Age 5-11
99384	Prev Visit, New, Age 12-17
99385	Prev Visit, New, Age 18-39
99386	Prev Visit, New, Age 40-64
99387	Prev Visit, New, Age 65 & Over
99393	Prev Visit, Est, Age 5-11
99394	Prev Visit, Est, Age 12-17
99395	Prev Visit, Est, Age 18-39
99396	Prev Visit, Est, Age 40-64
99397	Prev Visit, Est, Age 65 & Over

Office or Other Outpatient Services

CODE	DESCRIPTION
99201	Office/Outpatient Visit, New
99202	Office/Outpatient Visit, New
99203	Office/Outpatient Visit, New
99211	Office/Outpatient Visit, Est
99212	Office/Outpatient Visit, Est
99213	Office/Outpatient Visit, Est

LABORATORY & PATHOLOGY

Waived CLIA Tests

CODE	DESCRIPTION
81002	Urinalysis, Non-Auto, W/O Scope
81003	Urinalysis, Auto, W/O Scope
81025	Urine Pregnancy Test
82465QW	Assay, Bld/Serum Cholesterol
82947QW	Assay, Glucose, Blood Quant
84703QW	Chorionic Gonadotropin Assay
85013	Hematocrit
85014QW	Hematocrit
85018QW	Hemoglobin
87077QW	Culture Aerobic

Physician Performed Microscopy Procedures

CODE	DESCRIPTION
81000	Urinalysis, Non-Auto, W/Scope
81001	Urinalysis, Auto, W/Scope
81015	Microscopic Exam Of Urine

CLIA Certificate of Compliance/Accreditation

CODE	DESCRIPTION
82948	Reagent Strip/Blood Glucose
85660	Rbc Sickle Cell Test
87081	Culture Screen Only
87205	Smear, Gram Stain
87207	Smear, Special Stain
87210	Smear, Wet Mount, Saline/Ink
87220	Tissue Exam For Fungi
87270	Chlamydia Trachomatis

NOTE: Modifier QW designates the procedure as a waived CLIA test.

SURGERY – INTEGUMENTRY SYSTEM

CODE	DESCRIPTION
11975	Insert Contraceptive Cap
11976	Removal Of Contraceptive Cap
11977	Removal/Reinsert Contra Cap

SURGERY – MALE GENITAL SYSTEM

Vas Deferens

CODE	DESCRIPTION
55250	Removal Of Sperm Duct

(Informed consent form required)

SURGERY – FEMALE GENITAL SYSTEM

Vagina

CODE	DESCRIPTION
57170	Fitting Of Diaphragm/Cap

Corpus Uteri

CODE	DESCRIPTION
58300	Insert Intrauterine Device
58301	Removal Intrauterine Device

CONTRACEPTIVE SUPPLIES

CODE	DESCRIPTION
Z8500	Oral Contraceptive
Z8505	Preven (emergency contraception)
Z8506	Plan B (emergency contraception)
Z8510	Diaphragm
Z8511	Condoms, male
Z8512	Condoms, female
Z8513	Foam or Jelly or Cream

HCPCS Level II Codes

CODE	DESCRIPTION
A4260	Levonorgestrel Implant
J0696	Ceftriaxone Sodium Injection
J1055	Medrxyprogester Acetate Inj
J1056	Injection Medroxyprogesterone Acetate/Estradiol
J7300	Intraut Copper Contraceptive
J7302	Levonorgesterel-Releasing Intrauterine Contraceptive System
S4989	Cost Of Intrauterine Progesterone Contraceptive System (Progestasert)

PHARMACEUTICAL SUPPLIES

Providers are requested to **use generic drugs** when appropriate. Drugs to be dispensed only for services related to family planning.

CODE	DESCRIPTION	BILLING UNIT
Z8090	Flagyl	4 TABS
Z8091	Flagyl	14 TABS
Z8092	Floxin 400mg	1 TAB

Creams

CODE	DESCRIPTION
Z8003	Monistat Cream
Z8004	Sultrin Cream
Z8005	Terazol Cream
Z8006	Nystatin Cream

Antibiotics

CODE	DESCRIPTION	BILLING UNIT
Z8050	Amoxicillin 250 mg	30 Caps
Z8051	Amoxicillin 250 mg	40 Caps
Z8052	Amoxicillin 500 mg	40 Caps
Z8053	Ampicillin 250 mg	40 Caps
Z8054	Ampicillin 500 mg	28 Caps
Z8055	Ampicillin 500 mg	7 Tabs
Z8056	Ampicillin 500 mg	20 Tabs
Z8057	BAC/SEP 400/80 mg	40 Tabs
Z8058	BAC/SEP 800/160 mg	28 Tabs
Z8059	Benemid 500 mg	28 Tabs
Z8060	Diflucan 150 mg	1 Tab
Z8061	Erythromycin 250 mg	40 Tabs
Z8062	Erythromycin 500 mg	28 Tabs
Z8063	Keflex 250 mg	40 Caps
Z8064	Keflex 500 mg	28 Caps
Z8065	Suprax 200 mg	20 Caps
Z8066	Suprax 400 mg	1 Cap
Z8067	Suprax 400 mg	10 Caps
Z8068	Tetracycline 250 mg	40 Caps
Z8069	Tetracycline 500 mg	28 Caps
Z8070	TMP-SMZ-DS	28 Tabs
Z8071	Trimethoprim 100 mg	6 Tabs

CODE	DESCRIPTION	BILLING UNIT
Z8072	Trimethoprim 100 mg	28 Tabs
Z8073	Trimethoprim 200 mg	28 Tabs
Z8074	Vibramycin 50 mg	20 Caps
Z8075	Vibramycin 100 mg	14 Caps
Z8076	Zithromax 250 mg	6 Caps
Z8077	Zithromax 1 gm	Suspension

Other

CODE	DESCRIPTON	UNITS
Z8080	Terazol Inserts	3
Z8081	Terazol Inserts	7
Z8082	Monistat Inserts	7