

Health and Recovery Services Administration (HRSA)



Family Planning Provider Billing Instructions for:

- Reproductive Health Services
- Family Planning Only Services
- TAKE CHARGE Services

[Chapter 388-532 WAC]

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About this publication

This publication replaces all previous HRSA Family Planning Services Billing Instructions, TAKE CHARGE Billing Instructions, and Numbered Memoranda, including 01-53 MAA, 01-66 MAA, 03-76 MAA, 04-37 MAA, 04-105 MAA , 05-05 MAA, 05-44 MAA, 05-112 MAA, 06-01, 06-21, 06-43 and 06-77.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

Who do I contact to obtain information on becoming a HRSA-Approved Family Planning Provider?

Family Planning program manager:
Phone: 360.725.1664; or

TAKE CHARGE program manager:
Phone: 360.725.1652

Who do I contact if I am an HRSA-approved Family Planning provider and I want to submit a change of address or ownership, or find out about the status of a provider application?

Provider Enrollment:
<http://maa.dshs.wa.gov/provrel/> or
Phone: 866.545.0544 (toll free)

Who do I contact if I am a TAKE CHARGE provider and I want to submit a change of address, phone number, or fax number?

Family Planning program manager:
Phone: 360.725.1664; or

TAKE CHARGE program manager:
Phone: 360.725.1652

Where can I get the TAKE CHARGE Application DSHS form # 13-781?

To **download** DSHS forms, visit:
<http://www1.dshs.wa.gov/msa/forms/eforms.html>
scroll down to form # 13-781.

To **have a copy mailed**, contact:
DSHS Forms Management
Phone: 360.664.6047 or
Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity desired;
- Your name and your office name; and
- Your full mailing address.

How do I obtain information regarding the Family Planning program?

Visit the **Family Planning Resources link on HRSA's web site:**
<http://maa.dshs.wa.gov/familyplan/>

E-mail the Provider Relations unit:
providerinquiry@dshs.wa.gov

Family Planning program manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
Phone: 360.725.1664

HRSA-Approved Family Planning Providers

Where do I obtain information regarding the TAKE CHARGE program?

Visit the TAKE CHARGE page on HRSA's Family Planning web site: <http://maa.dshs.wa.gov/familyplan/> (select the *Family Planning Resource* link.)

Email the Provider Relations unit: providerinquiry@dshs.wa.gov

TAKE CHARGE program manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
Phone: 360.725.1652

TAKE CHARGE Eligibility Unit
PO Box 45531
Olympia, WA 98504-5531
Phone: 877.787.2119
Fax: 866.841.2267

How do I submit my client's TAKE CHARGE applications on-line?

You must be registered with HRSA to submit your client's TAKE CHARGE application on line. To register with HRSA contact:

Family Planning program manager
Phone: 360.725.1664

How do I find out about internet billing (Electronic Claims Submission)?

WinASAP and WAMedWeb
<http://www.acs-gcro.com/>
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
<https://wamedweb.acs-inc.com/>

To use HIPAA Transactions and/or WinASAP 2003, enroll with ACS EDI Gateway by visiting ACS on the web at:

<http://www.acs-gcro.com/docs/wa-home.php?menuItem=enroll>

or by calling: 800.833.2051.

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800.833.2051.

Where do I send my hard copy claims?

Division of Healthcare Services
PO Box 45530
Olympia, WA 98504-5530

Who do I contact if I have questions regarding...

HRSA policy, payments, denials, general questions regarding claims processing, or HRSA Managed Care?

Provider Relations
<http://maa.dshs.wa.gov/provrel>
Phone: 800.562.3022 (toll free)

Private insurance or third-party liability, other than HRSA Managed Care?

Coordination of Benefits
Phone: 800.562.6136

How do I obtain pharmacy information?

HRSA's Pharmacy Web Site:

<http://maa.dshs.wa.gov/pharmacy/>

Prescriptions By Mail web site:

<http://www.medco.com>

Providers Call: 888.327.9791

Clients Call: 800.903.8639

Or go to HRSA's web site:

<http://maa.dshs.wa.gov/RxByMail/>

How can I obtain copies of billing instructions or numbered memoranda?

To **view and download**, visit:

<http://hrsa.dshs.wa.gov> and click on

Billing Instructions/Numbered

Memoranda

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used throughout these billing instructions.

Actual Acquisition cost (AAC) – The actual cost that a provider pays for a drug marketed in the package size of drug purchased or sold by a particular manufacturer or labeler. The AAC must reflect special discounts or pricing arrangements through the manufacturer, wholesaler or buying cooperative. [WAC 388-530-1050]

Ancillary services - Those family planning services provided to TAKE CHARGE clients by HRSA’s contracted providers who are not TAKE CHARGE providers. These services include, but are not limited to, family planning pharmacy services, family planning laboratory services, and sterilization surgical services. [WAC 388-532-710]

Applicant - A person applying for TAKE CHARGE family planning services.

Application assistance - The process a TAKE CHARGE provider follows in helping a client to complete and submit an application to HRSA for the TAKE CHARGE program. [WAC 388-532-710]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Complication – A condition occurring subsequent to and directly arising from the family planning services received. [WAC 388-532-050]

Comprehensive Family Planning Preventive Medicine Visit (Women only) – Includes evaluation and management of an individual including age appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and ordering labs and diagnostic procedures that are covered under the client’s respective HRSA program. These services can only be provided by and paid to TAKE CHARGE providers.

Contraception - Preventing pregnancy through the use of contraceptives. [WAC 388-532-050]

Contraceptive - A device, drug, product, method, or surgical intervention used to prevent pregnancy. [WAC 388-532-050]

Core Provider Agreement - The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services. [WAC 388-500-0005]

Dispensing fee - The department's established fee that may be paid to family planning clinics for expenses involved in acquiring, storing and dispensing contraceptives. A dispensing fee is paid on a unit-by-unit basis for prescription drugs or devices given to the client at a family planning clinic. [WAC 388-530-1050]
A dispensing fee is not paid for nondrug items, devices or supplies.
[WAC 388-530-1450]

Education and Counseling for Risk Reduction (ECRR) - The cornerstone of the TAKE CHARGE program is client-centered education and counseling services designed to strengthen decision making skills and support clients' safe, effective and successful use of their chosen contraceptive method. For women, ECRR is part of the annual comprehensive family planning preventive medicine visit. For men, ECRR is a stand-alone service for those men seeking family planning services and whose partners are at moderate to high-risk of unintended pregnancy.
[Refer to pages C.21 – C.25 for further information on ECRR services and WAC 388-532-710.]

Estimated Acquisition Costs - The department's estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler.
[WAC 388-530-1050]

Explanation of Benefits (EOB) - A numeric message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Family Planning Only program - The program providing an additional 10 months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the 60-day postpregnancy coverage for women who received medical assistance benefits during the pregnancy. This program's coverage is strictly limited to family planning services.
[WAC 388-532-505]

Family planning services – Medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies.
[WAC 388-532-050]

Fee-for-service (FFS) - The general payment method HRSA uses to pay for covered family planning medical services provided to clients.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Informed consent - When an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the client's diagnosis;
- Offered the client an opportunity to ask questions about the procedure and to request information in writing;
- Given the client a copy of the consent form;
- Communicated effectively using any language interpretation or special communication device necessary per 42 CFR 441.257; and
- Given the client oral information about all of the following:
 - √ The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
 - √ Alternatives to the procedure including potential risks, benefits, and consequences; and
 - √ The procedure itself, including potential risks, benefits, and consequences.

HRSA-approved Family Planning provider - A physician, advanced registered nurse practitioner (ARNP), or clinic that has:

- Agreed to the requirements of WAC 388-532-110;
- Signed a Core Provider Agreement with HRSA;
- Been assigned a unique family planning provider number by HRSA; and
- Been given special permission to bill for family planning laboratory services provided to self-referred clients enrolled in a HRSA managed care plan through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA). [WAC 388-532-050]

Managed care – A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either a managed care organization (MCO) or Primary Care Case Management (PCCM) provider. [WAC 388-538-050]

Maximum Allowable Fee - The maximum dollar amount that the department pays a provider for specific services, drugs, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy and Medically Needy programs.

Medical Identification (ID) card - The document DSHS uses to identify a client's eligibility for a medical program.

Medical chart - A written summary (kept by the provider) of the nursing or medical care rendered to an individual patient.

Medically necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government's health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Natural family planning - Also known as the fertility awareness method. These are methods such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle in order to identify the fertile days of the menstrual cycle and avoid unintended pregnancies. [WAC 388-532-050]

Over-the-Counter (OTC) – Drugs that do not require a prescription before they can be sold or dispensed. [WAC 388-530-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Provider (PCP) - A person licensed or certified under Title 18 RCW including, but not limited to, a physician or advanced registered nurse practitioner (ARNP) who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialists and ancillary care, and maintains the client's or enrollee's continuity of care.

Provider or provider of service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Public Health Services Act (PHS) - The federal act governing the 340B program administered through the Office of Pharmacy Affairs. Per federal regulations, any drugs or items purchased through this program must be billed using the actual acquisition cost. [WAC 388-530-1425]

Remittance and Status Report (RA) - A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Retroactive period - The three calendar months before the month of application for full scope Medicaid clients. [WAC 388-500-0005]

Revised Code of Washington (RCW) - Washington State laws.

State Children’s Health Insurance Program (SCHIP) – The federal Title XXI program under which medical care is provided to uninsured children under age 19 whose family income is between 200% and 250% of the federal poverty level and who are not otherwise eligible under Title XIX of the Social Security Act.

Sexually Transmitted Disease-Infection (STD-I) – Is a disease or infection acquired as a result of sexual contact.
[WAC 388-532-050]

TAKE CHARGE - HRSA’s demonstration and research program, approved by the federal government under a Medicaid program waiver that provides family planning services. [WAC 388-532-710]

TAKE CHARGE Provider - A provider who is approved by HRSA to participate in TAKE CHARGE by:

- Being an approved HRSA family planning provider; and
- Having a supplemental TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally-approved Medicaid waiver for the TAKE CHARGE program.
[WAC 388-532-710]

Third-Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.
[WAC 388-500-0005]

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

U.S. Citizenship and Immigration Services (USCIS) – [Refer to USCIS for definition.](#)

Usual and Customary Fee - The amount that providers bill the department for certain services. This amount may not exceed:

- The usual and customary charge billed to the general public for the same services; **or**
- If the general public is not served, the amount normally offered to other contractors for the same services.

Unless otherwise noted, billing should reflect the usual and customary fee and not the department’s maximum allowable fee. Reimbursement is either the usual and customary fee or the department’s maximum allowable fee, whichever is less.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Reproductive Health Services

How does HRSA define reproductive health services?

[WAC 388-532-001]

HRSA defines reproductive health services as those services that:

- Assist clients in avoiding illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically necessary care when needed; and
- Assist clients in making informed decisions about using medically safe and effective methods of family planning.

Provider Requirements [Refer to WAC 388-532-110]

To be paid by HRSA for reproductive health services provided to eligible clients, physicians, advanced registered nurse practitioners (ARNPs), licensed midwives, and HRSA-approved Family Planning providers must:

- Meet the requirements in [Chapter 388-502 WAC Administration of Medical Programs - Providers](#);
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the requirements above must refer the client to an appropriate provider.

Who is eligible? [Refer to WAC 388-532-100(1)]

HRSA covers limited, medically necessary reproductive health services for clients presenting DSHS Medical Identification (ID) Cards with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP - CHIP	CNP – Children’s Health Insurance Program
GAU No Out of State Care	General Assistance Unemployable
General Assistance	ADATSA
LCP-MNP	Limited Casualty Program-Medically Needy Program

Note: Family Planning Only and TAKE CHARGE clients are **only** eligible to receive services that are related to preventing unintended pregnancy and are **not** eligible for other reproductive health services.

Limited Coverage:

- HRSA covers reproductive health services under Emergency Medical Only programs **only** when the services are directly related to an emergency medical condition.
- HRSA pays Medicare premium copays, coinsurance, and deductibles for Qualified Medicare Beneficiary (QMB) clients only.

Which reproductive health services may an HRSA managed care client receive outside of the client's plan?

[Refer to WAC 388-532-100(2)]

Clients enrolled in an HRSA managed care plan may **self-refer** outside their plan for family planning*, abortions, and sexually transmitted disease-infection (STD-I) services to any of the following:

- An HRSA-approved Family Planning provider; or
- An HRSA-contracted local health department/STD-I clinic; or
- An HRSA-contracted provider who provides abortions; or
- An HRSA-contracted pharmacy (see HRSA's *Prescription Drug Program Billing Instructions*) for:
 - √ Over-the-counter contraceptive supplies; and
 - √ Contraceptives and STD-I related prescriptions from an HRSA-approved Family Planning provider or HRSA-contracting local health department/STD-I clinic.

* *Excludes sterilizations for clients 21 years of age and older.*

[WAC 388-532-140(2)]

When a client enrolled in a department-approved managed care plan self-refers **outside the plan** to either a department-approved Family Planning provider or a department-contracted local health department STD-I clinic, all laboratory services must be billed through the family planning provider.

When a client enrolled in a department-approved managed care plan obtains family planning or STD-I services from a department-approved family planning provider or a department-contracted local health department STD-I clinic that has a contract with the client's managed care plan, those services **must** be billed directly to the managed care plan.

What services are covered? [Refer to WAC 388-532-120]

- **Food and Drug Administration (FDA)-approved prescription contraception methods** (See HRSA's *Prescription Drug Program Billing Instructions*)
- **OTC contraceptives, drugs, and supplies** (See HRSA's *Prescription Drug Program Billing Instructions*)
- **Maternity-related services** (See HRSA's *Physician-Related Services Billing Instructions*)
- **Abortions** (See HRSA's *Physician-Related Services Billing Instructions*)
- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if the procedures are:
 - √ Requested by the client; and
 - √ Performed in an appropriate setting for the procedure(s).

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days but no longer than 180 days prior to surgery.

Services for women who are seeking and needing contraception

Every female Medicaid client needing contraception and an annual exam is eligible for one comprehensive family planning preventive medicine visit every 11-12 months, if it is provided by a TAKE CHARGE provider. A Medicaid client who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning preventive medical visit.

In addition to the reproductive health services listed in HRSA's *Physician-Related Services Billing Instructions*, HRSA covers all of the following reproductive health services:

- An initial or annual comprehensive family planning preventive medicine visit is allowed with a family planning diagnosis, once every 11-12 months.

The comprehensive family planning preventive medicine visit includes the following:

- A clinical breast examination and a pelvic examination;
- Client-centered counseling that incorporates anticipatory guidance and risk factor reduction intervention regarding the prevention of unintended pregnancy;
- May include a pap smear, according to current clinical guidelines; and

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- **STD-I screening and treatment as clinically indicated.**

If the provider is an Infertility Prevention Project (IPP) provider, the Gonorrhea (GC) and Chlamydia (CT) test must be sent to a laboratory that has a Medicaid provider number instead of the non-Medicaid IPP laboratory.

For providers who have a delayed pelvic examination protocol, these services may be divided between two visits. See pages C.19 for more information about billing for a delayed pelvic examination.

Refer to CPT codes 99384 – 99386 and 99394 – 99396 for services provided at the annual comprehensive family planning preventive medicine visit. *Only TAKE CHARGE providers can bill these preventive codes.*

Note: Historically, HRSA has paid providers for preventive examinations under the EPSDT program for clients who are 20 years of age and younger and for Developmentally Delayed (DD) clients. Under the terms of the TAKE CHARGE Waiver, only TAKE CHARGE providers can bill for an annual comprehensive family planning preventive medicine visit using Preventive Medicine Current Procedural Terminology (CPT™) codes for women ages 13 through menopause. Clients receiving this service must be seeking and needing contraception.

Note: The annual comprehensive family planning preventive medicine visit cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) **or an office visit.**

- **Cervical, vaginal, and breast cancer screening examination**, once every 11-12 months as medically necessary. The screening HCPCS code G0101 must be billed with one of the following diagnosis codes **for women who are not needing or seeking contraception:**
 - √ V72.31 routine gynecological exam with Pap cervical smear;
 - √ V76.47 routine vaginal Pap smear; or
 - √ V76.2 cervical Pap smear without general gynecological exam.

You may also bill an office visit on the same day using modifier 25, when you provide a separately identifiable Evaluation and Management (E/M) service.

Screening and treatment for STD-I, including laboratory tests and procedures for

- √ HIV testing use CPT code 86703.

- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence

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- **Mammograms** for clients 40 years of age and older, once every 12 months. Clients 39 years of age and younger require prior authorization for mammograms (see *Physician-Related Services*, Section I).
- **Colposcopy** and related medically necessary follow-up services.

Note: HIV testing and counseling is **not** a covered service for TAKE CHARGE and Family Planning Only clients.

- **Screening and treatment for STD-I**, including laboratory tests and procedures for
√ HIV testing use CPT® 86703.
- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence.
- **Mammograms** for clients 40 years of age and older, once every 12 months. Clients 39 years of age and younger require prior authorization for mammograms (see *Physician-Related Services*, Section I).
- **Colposcopy** and related medically necessary follow-up services.

Note: HIV testing and counseling is **not** a covered service for TAKE CHARGE and Family Planning Only clients.

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Services for Men

In addition to the reproductive health services listed in HRSA's *Physician-Related Services Billing Instructions*, HRSA covers all of the following reproductive health services for men:

- **Office visits** where the primary focus and diagnosis is contraceptive management (including condoms and vasectomy counseling) and/or there is a medical concern.
- **OTC contraceptives, drugs, and supplies** (as described in HRSA's [Prescription Drug Program Billing Instructions](#)).
- **Sterilization** procedures that meet the requirements of HRSA's [Physician-Related Services Billing Instructions](#), if the procedures are:
 - √ Requested by the client; and
 - √ Performed in an appropriate setting for the procedure(s).
- **Screening and treatment for STD-I**, including laboratory tests and procedures for
 - √ HIV testing use CPT 86703.
- **Education and/or supplies** for FDA-approved contraceptives, natural family planning, and abstinence.
- **Prostate cancer screening** for men, when ordered by a physician, physician's assistant or ARNP, once every 12 months. See [Billing](#) section on page E.1 for billing specifics.

Note: HIV testing and counseling is **not** a covered service for TAKE CHARGE clients.

What services are not covered? [Refer to WAC 388-532-130]

HRSA does not cover the reproductive health services listed as noncovered in HRSA's *Physician-Related Billing Instructions*. HRSA reviews requests for noncovered services according to WAC 388-501-0160.

Reimbursement

[Refer to WAC 388-532-140, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA pays providers for covered reproductive health services using the fee schedule contained in HRSA's *Physician-Related Services Billing Instructions*. (To view billing instructions, go to: <http://maa.dshs.wa.gov/> and select **Billing Instructions/Numbered Memoranda**.)

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Department-Approved Family Planning Clinics that Dispense Contraception:

Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services:** Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment is either your *usual and customary fee* or HRSA's maximum allowable fee, whichever is less.
- If a HRSA fee schedule lists a drug or item as “actual acquisition cost,” the provider **must** bill its actual acquisition cost and not a usual and customary fee or maximum allowable fee.
- **For drugs purchased under the Public Health Services Act:** Providers must comply with Pharmacy Services WAC 388-530-1425.

WAC 388-530-1425

(1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid MAA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under the Public Health Service (PHS) Act and paid by **HRSA** are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs.

- **For other contraceptives, drugs, drug supplies and devices not purchased under the Public Health Services Act:** Bill HRSA your usual and customary fee. Reimbursement is your usual and customary fee or the department’s maximum allowable fee, whichever is less. [Refer to WAC 388-530-1050]

Managed Care: For clients who are enrolled in an HRSA managed care plan and who self-refer to an HRSA-approved Family Planning provider or HRSA-contracted local health department/STD-I clinic **outside their plan**, all laboratory services must be billed through the Family Planning provider.

Note: Only the provider who rendered the services is allowed to bill for those services except in the case where a client self-refers outside of managed care for Family Planning services.

Family Planning Only Program

What is the purpose of the Family Planning Only program?

[Refer to WAC 388-532-500]

The purpose of the Family Planning Only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy.

The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This 10-month benefit follows HRSA's 60-day postpregnancy coverage. **Men are not eligible for the Family Planning Only program.**

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a Medical ID Card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Family Planning Only Medical ID Card.

Provider Requirements [Refer to WAC 388-532-520]

To be paid by HRSA for services provided to clients eligible for the Family Planning Only program, physicians, advanced registered nurse practitioners (ARNPs), and HRSA-approved Family Planning providers must:

- Meet the requirements in Chapter 388-502 WAC, *Administration of Medical Programs - Provider* rules;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who is eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined to be eligible for a retroactive period (see [Definitions](#) section) covering the end of the pregnancy.

What services are covered? [Refer to WAC 388-532-530]

Every female Medicaid client needing contraception and an annual exam is eligible for one comprehensive family planning preventive medicine visit every 12 months, if it is provided by a TAKE CHARGE provider. A Medicaid client who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning preventive medicine visit.

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

HRSA covers all of the following services under the Family Planning Only program:

- An initial or annual comprehensive family planning preventive medicine visit is allowed with a family planning diagnosis, once every 11-12 months.

The comprehensive family planning preventive medicine visit includes the following:

- A clinical breast examination and a pelvic examination;
 - Client-centered counseling that incorporates anticipatory guidance and risk factor reduction intervention regarding the prevention of unintended pregnancy; and
 - May include a pap smear according to current clinical guidelines.
-
- For women between the ages of 13 and 25, this visit may also include routine Gonorrhea (GC) and Chlamydia (CT) testing and treatment.

If the provider is an Infertility Prevention Project (IPP) provider, the GC and CT test must be sent to a laboratory with a Medicaid provider number instead of the non-Medicaid IPP laboratory.

For providers who have a delayed pelvic examination protocol, these services may be divided between two visits. See pages C.19 for more information about billing for a delayed pelvic examination.

Refer to CPT codes 99384 – 99386 and 99394 – 99396 for services provided at the annual comprehensive family planning preventive medicine visit. *Only TAKE CHARGE providers can bill these preventive codes for Family Planning Only clients.*

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- **Cervical, vaginal, and breast cancer screening examination**, once every 11-12 months as medically necessary. The screening HCPCS code G0101 must be billed with an ICD-9 CM diagnosis code within the V25 series, excluding V25.3. The examination must be:
 - √ Provided according to the current clinical guidelines; and
 - √ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3).

Note: The annual comprehensive family planning preventive medicine visit cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) or an office visit.

- An office visit directly related to a family planning problem when medically necessary.
- **FDA-approved prescription and nonprescription contraceptives** as provided in Chapter 388-530 WAC, including, but not limited to, the following items:
 - √ Birth control pills
 - √ Birth control patch
 - √ Birth control vaginal ring
 - √ Injectable and implantable hormonal contraceptives
 - √ Diaphragm and cervical cap and cervical sponge
 - √ Male and female condoms
 - √ Intrauterine devices (IUDs)
 - √ Spermicides (foam, gel, suppositories, and cream)
 - √ Emergency contraception

Note: Pap smears, while not technically related to any contraceptive method, may be provided according to the current standard of care and schedule. Providers must have and follow a Pap smear protocol based on the guidelines of a nationally recognized organization such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF).

- **Sterilization** procedures that meet the requirements of HRSA's [Physician-Related Services Billing Instructions](#), if the procedures are:
 - √ Requested by the client; and
 - √ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days but no longer than 180 days prior to surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures **only** when the screening and treatment are:

HRSA-Approved Family Planning Providers

- √ A part of the comprehensive family planning preventive medicine exam for women 13-25 years of age (only GC or CT); or
 - √ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3); **and**
 - √ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.
- **Education and/or supplies** for FDA-approved contraceptives, natural family planning, and abstinence.

What drugs and supplies are paid under the Family Planning Only program?

HRSA pays for the family planning related drugs and contraceptives within the following therapeutic classifications:

Contraceptives and supplies that can be dispensed from a HRSA-approved Family Planning clinic.	Family Planning related drugs and supplies that can be dispensed from a pharmacy.
Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, sponge, spermicides, vaginal film, creams. Azithromycin	Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, spermicides, vaginal film, creams. Vaginal antifungals Vaginal Sulfonamides Vaginal Antibiotics Tetracyclines Macrolides Antibiotics, misc. other Quinolones Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Absorbable Sulfonamides Nitrofurans Derivatives Antifungal Antibiotics Antifungal Agents Anaerobic antiprotozoal – antibacterial agents
	* Antianxiety Medication – Before Sterilization Procedure Diazepam Alprazolam
	* Pain Medication – After Sterilization Procedure Acetaminophen with Codeine #3 Hydrocodone Bit/ Acetaminophen Oxycodone HCl/Acetaminophen 5/500 Oxycodone HCl/ Acetaminophen

* Selected drugs are copied from Numbered Memorandum [05-05](#) HRSA.

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, etc.) may also be obtained in a 30-day supply through a pharmacy or a family planning clinic with a Medical ID card.

Hormonal Contraceptives Dispensed from HRSA-Approved Family Planning Clinics:

For fee-for-service clients, hormonal contraception must be dispensed at a minimum of three cycles/months. A maximum of 13 cycles may be dispensed on the same day. If the hormonal contraception is dispensed for less than three months/cycles, there must be documentation in the chart stating the reason the why only one or two cycles were dispensed.

Hormonal Contraceptive Prescriptions filled at the pharmacy.

HRSA's Point-of-Sale system currently cannot fill a contraception prescription for more than a three month supply at one time. We are working on system changes to allow refills for up to a 12 month supply. Until further notice, you must dispense three months/cycles unless the prescriber writes a prescription for less than three months/cycles.

Managed care clients will receive their hormonal contraceptives according to the terms set by their managed care plans.

Note: All services and prescriptions billed for Family Planning Only clients **must** have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

What services are *not* covered? [WAC 388-532-540]

Medical services are not covered under the Family Planning Only program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Abortions are **not** covered under the Family Planning Only program.

Note: If the client's DSHS Medical ID card says *Family Planning Only* but she is pregnant, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full scope of care.

Inpatient Services: HRSA does not pay for inpatient services under the Family Planning Only program. However, providers may request an exception to this policy on a case-by-case basis for inpatient costs incurred as a result of complications arising from covered family planning services. If this happens, providers of inpatient services must submit a complete report to HRSA detailing the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-92, 1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Benefits and Case Management at 360.586.1471.

Reimbursement

[Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA limits reimbursement under the Family Planning Only program to visits and services listed on the Fee Schedule (see section D) that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (ICD-9-CM V25 series diagnosis codes); and
- Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Department-Approved Family Planning Clinics that Dispense Contraception:

Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services:** Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment is either your *usual and customary fee* or HRSA's maximum allowable fee, whichever is less.
- If a HRSA fee schedule lists a drug or item as “actual acquisition cost,” the provider must bill its actual acquisition cost and not a usual and customary fee or maximum allowable fee.
- **For drugs purchased under the Public Health Services Act:** Providers must comply with Pharmacy Services WAC 388-530-1425.

WAC 388-530-1425

(1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid MAA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under the Public Health Service (PHS) Act and paid by **HRSA** are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs.

- **For other contraceptives, drugs, drug supplies and devices not purchased under Public Health Services Act:** Bill HRSA your usual and customary fee. Reimbursement is your usual and customary fee or the department's maximum allowable fee, whichever is less. [Refer to WAC 388-530-1050]
- Any non-contraceptive take-home drugs dispensed at a family planning clinic are not reimbursable.

TAKE CHARGE Program

What is the purpose of TAKE CHARGE?

[Refer to WAC 388-532-700]

TAKE CHARGE is a family planning demonstration and research program. The purpose of the TAKE CHARGE program is to make family planning services available to women and men with incomes at or below 200 percent of the federal poverty level. TAKE CHARGE is approved by the federal government under a Medicaid program waiver.

The goal of TAKE CHARGE is to reduce unintended pregnancies by offering family planning services to an expanded population of low-income women and men.

TAKE CHARGE will increase access to family planning (birth control) services for persons for whom an unintended pregnancy might make it difficult to attain self-sufficiency and/or to remain self-sufficient.

The program objectives are to:

- Decrease the number of unintended pregnancies;
- Increase the use of contraception methods;
- Increase the availability of family planning services for low-income women and men; and
- Raise the provider's awareness regarding the importance of client-centered education, counseling, and risk reduction to increase successful use of contraception methods.

Note: A TAKE CHARGE client may be seen only by an HRSA-approved and trained TAKE CHARGE provider and only for family planning services. Exceptions to this include sterilizations, pharmacy services, and laboratory services. See page C.5 for further information.

Program Information

The TAKE CHARGE and Family Planning Only programs provide a narrow range of services for reproductive healthcare. Services provided under TAKE CHARGE and Family Planning Only program *must be directly related to the goal of preventing unintended pregnancy*.

The TAKE CHARGE and Family Planning Only programs **do not** provide comprehensive reproductive healthcare. By providing family planning services to low income people, these two programs focus on improving the health of Washingtonians by reducing the physical, psychosocial, and financial burdens to individuals, families and communities that are related to unintended pregnancy.

Book Resource: For more information on the impacts of an unintended pregnancy, read “The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families” by Sara S. Brown and Leon Eisenberg.

The aspects of reproductive health that relate to preventing an unintended pregnancy is contraception, including reversible, permanent, and abstinence. The following reproductive health services have no relationship to the prevention of an unintended pregnancy: infertility treatment, prenatal care, and the treatment of breast, cervical, ovarian or testicular cancer.

Note: While Pap smears are not directly related to the safe, effective and successful use of any contraceptive method, they are covered by TAKE CHARGE and the Family Planning Only programs. There have been recent changes to national guidelines. HRSA will cover Pap smears (once every 12 months) that fall under the new guidelines set by any of the following: the American College of Obstetrics and Gynecology, the American Cancer Society, or the U.S. Preventive Service Task Force.

Many providers are concerned about the areas of reproductive healthcare that are not so clear-cut. Using contraceptives safely, effectively and successfully can be complicated.

When determining what is covered under the TAKE CHARGE or Family Planning Only programs, the provider must consider the following for each client at the time of each visit, “How do the presenting issues and diagnosis at this visit relate to the safe, effective and successful use of their chosen contraceptive method?”

Refer to the Bull’s Eye illustration on page E.3: The services covered under the TAKE CHARGE and Family Planning Only programs are part of reproductive healthcare (the target) but they must be directly related to preventing unintended pregnancy (the bull’s eye).

When a service falls into an area that feels “gray” or unclear to you, ask yourself how the services that you are providing are assisting this client to prevent unintended pregnancy. Detailed and thorough charting will be the justification. See page E.2 for clinic visit scenarios.

How do I qualify to be a TAKE CHARGE provider?

[Refer to WAC 388-532-730(1)(a) through (c)]

A TAKE CHARGE provider must:

- Be an HRSA-approved Family Planning provider (see the [Definitions](#) section);
- Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to HRSA's TAKE CHARGE program guidelines; and
- Participate in HRSA's specialized training for TAKE CHARGE prior to providing TAKE CHARGE services. Providers must also assure and have documentation that each individual responsible for providing TAKE CHARGE services is trained on all aspects of the TAKE CHARGE program.

What must I agree to before I am considered an approved TAKE CHARGE provider? [Refer to WAC 388-532-730(1)(d) and (e)]

TAKE CHARGE providers must comply with the required general HRSA policies and specific TAKE CHARGE provider policies, procedures, and administrative practices.

Administrative Practices

You must agree to provide:

- Service to eligible clients in accordance with state and federal law;
- Service to eligible clients in accordance with the TAKE CHARGE WAC 388-532-700 through 790;
- Initial and annual client application assistance to screen for eligibility;
- TAKE CHARGE client files, billing, and medical records when requested by DSHS staff; and
- Referral for clients regarding available and affordable non-family planning primary care services.

Evaluation and Research Responsibilities

If requested by HRSA, you must be willing to participate in the research and evaluation component of TAKE CHARGE.

Services offered at the research and evaluation sites may be contracted and billed separately.

What policies and procedures do I need for confidentiality, consent, and release of information?

You must have policies and procedures that:

- Safeguard the confidentiality of clients' records. These safeguards must:
 - √ Allow for timely sharing of information with appropriate professionals and agencies on the client's behalf; **and**
 - √ Ensure that confidentiality of disseminated information is protected.
- Ensure you obtain all necessary and properly completed:
 - √ Consent form DSHS 13-364, for all sterilization procedures;
 - √ Authorization from clients for release of information related to this program; and
 - √ Informed consent as defined in WAC 388-531-0050 and as required by WAC 388-531-1550, as necessary.
- Ensure the proper release of client information:
 - √ To transfer information to another approved TAKE CHARGE provider when a client changes providers;
 - √ To transfer information to another approved TAKE CHARGE provider when you are unable to provide the service or unable to provide the service in a timely manner;
 - √ To conform to all applicable state and federal laws; and
 - √ To transfer information to a primary care provider when a client is in need of non-family planning related services.

When can providers who are not TAKE CHARGE providers furnish services for TAKE CHARGE clients?

[WAC 388-532-730(2)]

HRSA providers (e.g. pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary services (see [Definitions](#) section) to eligible TAKE CHARGE clients.

HRSA pays for these services under the rules and fee schedules applicable to the specific services provided under HRSA's other programs.

Note: The family planning provider's partnership with pharmacists is especially critical since they provide immediate access to methods not received at the TAKE CHARGE agency/clinic.

Who is eligible? [WAC 388-532-720(1) and (2)]

The TAKE CHARGE program is for both men and women. To be eligible for the TAKE CHARGE program, applicants must:

- **Attest** that they are a United States (U.S.) citizen, U.S. national, or qualified alien eligible for Medicaid as described in chapter 388-424 WAC;
- Be a resident of the state of Washington as described in WAC 388-468-0005;
- Have income at or below 200% of the federal poverty level (FPL) as described in WAC 388-478-0075;
- Apply voluntarily for family planning services with a TAKE CHARGE provider; and
- Need family planning services but have no family planning coverage through another HRSA program or health insurance plan.

Note: Clients who are currently pregnant, sterilized, in the military on active duty, or incarcerated are not eligible for TAKE CHARGE.

A client may enroll in TAKE CHARGE at one TAKE CHARGE provider's office and receive services at a different TAKE CHARGE provider's office. Some clients may apply for TAKE CHARGE in order to obtain contraceptives appropriately prescribed by a non-TAKE CHARGE provider. **TAKE CHARGE providers must assist** these clients with enrollment so that they may go to a pharmacy to fill their prescription using their TAKE CHARGE Medical ID card. TAKE CHARGE providers have the obligation to help all potentially eligible clients enroll in the program, regardless of where they choose to receive services.

How long can a client receive TAKE CHARGE coverage?

[WAC 388-532-720(3)]

A client is authorized for TAKE CHARGE coverage for one year from the date HRSA determines eligibility, or for the duration of the demonstration and research program, whichever is shorter, as long as the clients continue to meet the eligibility criteria.

When a client reapplies for TAKE CHARGE, HRSA may renew the coverage for additional periods of up to one year each, or for the duration of the demonstration and research program, whichever is shorter.

Note: Always check Medical Eligibility Verification (MEV) to make sure that a client's one year eligibility for TAKE CHARGE is still valid or that the client is not on another HRSA program that covers family planning services.

How do I help a client apply for TAKE CHARGE?

Applicants must apply in person for TAKE CHARGE at an HRSA-approved TAKE CHARGE clinic or agency. Client eligibility is determined at the state level. **You, the provider,** must provide the applicant with:

- A TAKE CHARGE client application, including an affidavit to establish U.S. citizenship, if client claims U.S. citizenship, and citizenship has not previously been established by HRSA.
- Application assistance in completing the document prior to submitting the TAKE CHARGE client application to HRSA for eligibility determination.

The completed initial or recertification application must be entered into the TAKE CHARGE application database no later than 20 working days from the date of the client's signature.

Note: The application must be completed at the provider's office. You may not send the application home with the client to complete, nor may you mail the application to the client.

What is application assistance?

Application assistance is a reimbursable service for helping the client enroll in the TAKE CHARGE program.

Only applicants seeking and needing family planning services should be given a TAKE CHARGE application. Do not routinely give TAKE CHARGE applications to every client who comes in to your office/clinic. Give applications only to uninsured clients seeking to avoid an unintended pregnancy.

Sometimes it is **only** after seeing the clinician that it is determined that it is appropriate for the client to apply for TAKE CHARGE. The client can apply at the end of the office visit.

Every application that comes into the HRSA Eligibility Unit is thoroughly reviewed. Applications from clients who do not need family planning slow down the eligibility determination process for everyone – especially with all the new eligibility requirements that require documentation and verification.

Providers are monitored for the percentage of clients that they submit applications for who never use any TAKE CHARGE services. If providers are submitting applications inappropriately, HRSA may recoup the application assistance payment.

Clients must be informed that the eligibility information that they provide can and will be verified. All clients will have their income, SSN and lack of insurance verified. Clients must be counseled about the importance of being very accurate and honest on their application. Clients found to be ineligible based on any of the eligibility requirements will be disenrolled.

Assist the client with the following actions in sequential order:

1. Help the applicant accurately complete the required TAKE CHARGE application, on a question by question basis, if needed. This may mean reading the entire application for clients with low literacy skills or translating, if necessary, each question and answer for clients who have English as a second language. Do not have the client sign the application until you have reviewed it, according to step 2 below.
2. Review the TAKE CHARGE Client application for completeness and accuracy before the client leaves the office. If it appears the client does not meet eligibility requirements, do **not** have the client sign the application, and **inform** the client that they do not meet the eligibility requirements.

Note: If a client does not meet eligibility requirements, please shred the application.

If it appears that the client does meet the eligibility requirements, have the client sign the application and enter the application into the TAKE CHARGE online database.

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3. If the client is a citizen and citizenship has not been previously determined by HRSA, have the client complete the affidavit of U.S. citizenship (DSHS 13-789) and obtain a copy of the client's photo ID.
4. If the client is a U.S. national or U.S. qualified alien, make a copy of the client's U.S. Citizenship and Immigration Services (USCIS) paperwork and photo ID and fax these documents to the TAKE CHARGE Eligibility Unit. Retain a copy of these documents with the client's application.

Fax USCIS documents to the TAKE CHARGE Eligibility Unit at 866.841.2267.

5. Electronically submit the completed TAKE CHARGE application to the HRSA TAKE CHARGE Eligibility Unit for final eligibility determination.
6. Retain the completed and signed citizenship affidavit and a copy of the proof of identity with the client's application.
7. Regularly check the TAKE CHARGE eligibility database for final eligibility determination.
8. When appropriate, inform the client that the client may be eligible for other HRSA programs

Note: Billing for application assistance for clients transitioning from full scope Medicaid or Family Planning Only to TAKE CHARGE.

If a client has full scope Medicaid or Family Planning Only that is 30 days from expiring, the client may apply for TAKE CHARGE before their other Medicaid coverage expires in order to have continuous contraceptive coverage. HRSA will pay the provider for application assistance in this situation. Contact either the TAKE CHARGE or Family Planning program managers for specific details on payment.

EXAMPLE:

Susie Jones has full scope HRSA coverage that expires May 31st. She goes to a TAKE CHARGE provider on May 15th for a *Depo-Provera* shot. She can apply for TAKE CHARGE at this visit. The provider can bill for application assistance as well as the office visit. Providers may not bill for ECRR until the client has transitioned to TAKE CHARGE.

How do I check the TAKE CHARGE Client Application?

Check the application for accuracy, completeness, and potential eligibility.

Medical Need for Family Planning:

- The applicant must state that they need family planning. The applicant is **not** in need of family planning and **not** eligible for TAKE CHARGE if the applicant:
 - √ Has been sterilized;
 - √ Is seeking pregnancy;
 - √ Does not plan to use birth control; or
 - √ Is pregnant.

Note: If the applicant meets any of these conditions, **do not proceed** with the application process.

Health Insurance Section:

- If the applicant has a DSHS Medical ID Card (is a current client of a department's program with family planning coverage), the client is **not** eligible for TAKE CHARGE.
- After November 1, 2006, if the applicant has **any** health insurance with any family planning coverage, they are not eligible for TAKE CHARGE.
- If the client was enrolled in TAKE CHARGE prior to November 1, 2006 and has health insurance with family planning coverage, their health insurance must be billed first, before billing HRSA for any services provided. See [TAKE CHARGE Eligibility for Clients with Health Insurance on page C.11.](#)

Exceptions to Third-Party Insurance Coverage (Good Cause):

If a teen 18 years of age or younger (less than 19 years of age) is dependent on a parent/guardian's medical insurance and wishes to maintain confidentiality regarding his or her use of family planning services, consider that health insurance is not available to the client to prevent unintended pregnancy. Check the box next to "I am less than 19 years of age..." on the application; **or**

If a victim or a survivor of domestic violence is covered under their spouses' insurance and wishes to maintain confidentiality regarding his or her use of family planning services, consider that health insurance is not available to the client to prevent unintended pregnancy. Check the box next to "I am a domestic violence survivor..." to avoid billing or other information being sent to the applicant's home address. See page E.8.

Exceptions to Third-Party Insurance Coverage (Good Cause) Continued:

When you bill for family planning services for either exception above, do not indicate on the claim form that the client has other insurance, in order to preserve confidentiality.

Note: If the client wishes to maintain confidentiality regarding the use of family planning services, you must have some way of reaching the client.

Full Time Students Age 19-23:

Under the terms of the original waiver, these young adults could be covered under their parents' insurance and still be eligible for TAKE CHARGE if they were seeking confidential family planning services.

Under the terms and conditions of the extended waiver, these students, who are still covered under their parents' insurance are no longer eligible for TAKE CHARGE. Please refer them to other programs such as Title X or other state Social Service programs.

For these clients enrolled in TAKE CHARGE prior to November 1, 2006, providers must bill the client's third-party insurance before billing the state for the unpaid balance of the claim, unless the client meets the previous exceptions.

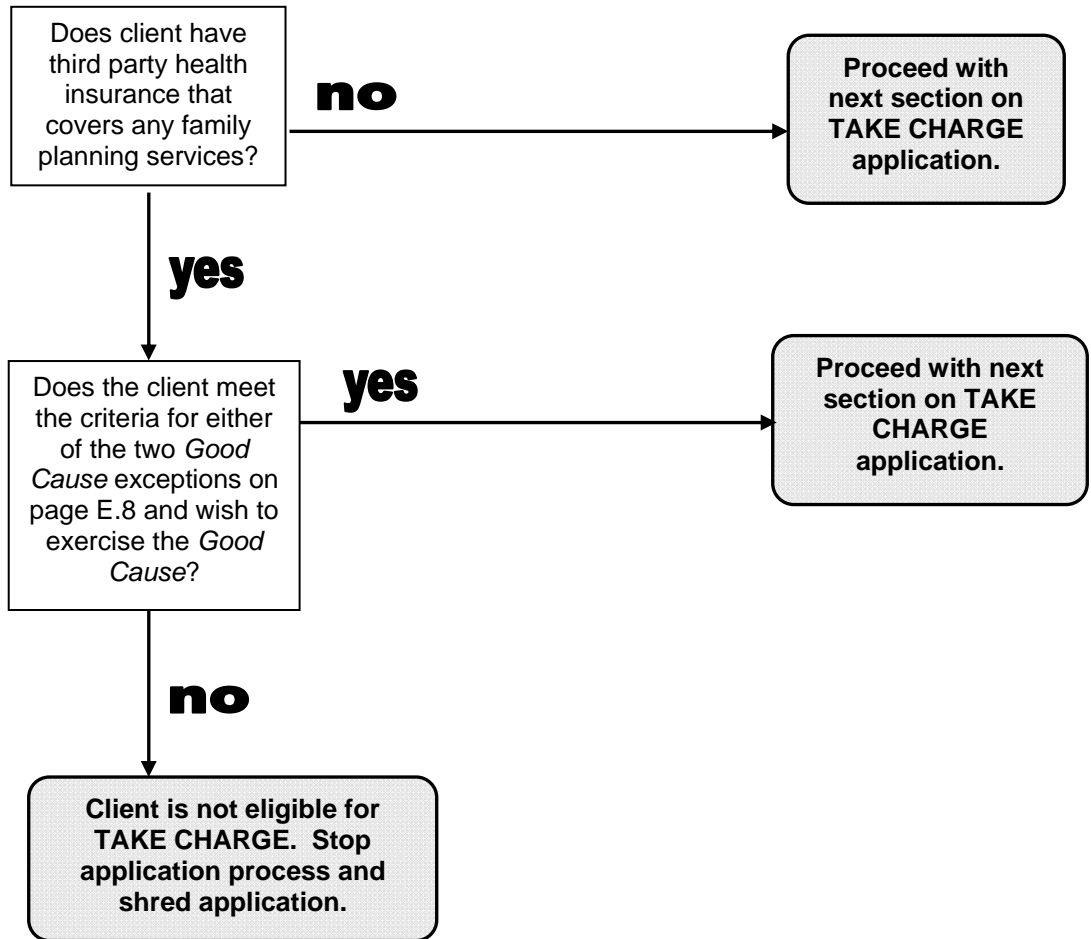
Active duty military:

Clients on active duty in any branch of the military are not eligible for TAKE CHARGE because they have comprehensive medical coverage.

Incarcerated clients:

Incarcerated clients, including those in Work Release programs, are not eligible for TAKE CHARGE because their healthcare needs are covered by the jail/prison. They are prohibited by Medicaid rules from receiving Medicaid benefits.

TAKE CHARGE Eligibility for Clients with Health Insurance



Citizenship Requirement

U.S. citizens or U.S. nationals qualify for TAKE CHARGE. All clients must sign an affidavit claiming citizenship **and** provide a photo ID unless citizenship and identity can be established by the following documents: Keep copies of these documents with the client's TAKE CHARGE application.

The following documents provide proof of citizenship and identity:

- U.S. passport; or
- Certificate of Naturalization; or
- Certificate of Citizenship; or
- Tribal membership card with photo.

These documents provide proof of citizenship only:

- An official state/county U.S. birth certificate; or
- Other certification of birth issued by the Department of State; or
- U.S. citizen ID card; or
- Final adoption decree in the U.S.; or
- Evidence of civil service employment by the U.S. government before June 1976; or
- Official military record of service that shows a U.S. place of birth.

Note: A "hospital" birth certificate is considered by the federal government to be a souvenir and does not meet the federal requirement.

These documents provide proof of identity only:

- A current state driver's license with individual's photo; or
- A state identity card with individual's photo; or
- A U.S. American Indian/Alaska Native tribal document; or
- Military identification card (non-active or dependent) with individual's photo; or
- School identification card.

Note: **Only for children** under the age of 16, make a note in the chart if no photo identification is available.

If the client does not have proof of U.S. citizenship with them when enrolling in TAKE CHARGE, then the provider must have the client complete an affidavit of U.S. citizenship (DSHS form #13-789). This affidavit must be kept in client's chart until HRSA requests this information.

The provider must make a copy of the client's legal, permanent U.S. Citizenship and Immigration Services (USCIS) paperwork and the date the client permanently entered the U.S. The USCIS paperwork must be faxed to the TAKE CHARGE Eligibility Unit for eligibility determination at 866.841.2267. The provider must keep a copy of these documents and the photo ID with the client's application.

Illegal or undocumented persons are not eligible for TAKE CHARGE.

Residency Requirements

- The applicant for TAKE CHARGE services must reside in the state of Washington (e.g., not residing in Oregon or Idaho).
- Out-of-state college students attending school in Washington State who do not plan to remain in Washington when school is complete are not considered permanent Washington residents and do not qualify for TAKE CHARGE.
- For Washington residents attending school out-of-state, the Code of Federal Regulations (CFR) states that students meet residency requirements if they:
 - √ Are attending college out-of-state;
 - √ Primarily reside in Washington; and
 - √ Intend to return to Washington.
- Foreign students or visiting foreign nationals are not considered legal permanent residents; they are temporarily in Washington State and are not eligible for TAKE CHARGE.

Ethnicity and Race

- Please have the client complete both the questions in this section.
- If the client feels uncomfortable answering these two questions, have the client indicate “prefer not to answer.”
- If the client indicates “other” under race, please have the client specify their race in the space provided.

Note: HRSA is gathering this information to assist in providing coverage for all populations in order to reduce health disparities.

Please do not make assumptions about the race or ethnicity of the client. This information is for the client to self-report.

Income Requirements and Family Size:

- HRSA uses the Medical Income and Resource Standards based on the Federal Poverty Level (FPL), updated each April, to determine whether the applicant meets the eligibility requirement of 200 percent of FPL or below. Open the TAKE CHARGE online database, click **Help**, then select the **Federal Poverty Level (FPL)** link to view the table.
- Clients below 185% of the FPL, should be referred to their local CSO to find out if they are eligible for a more comprehensive social service program or another program(s) that would more fully meet their reproductive health needs.

It is to both providers' and clients' advantage for the client to have expanded coverage beyond family planning.

Adolescents

- For adolescents 17 years of age or younger, use the client's income to determine income eligibility regardless of the parents' income.
- If the client reports "0" income, the client must explain on the application how they meet their basic needs; i.e. food, clothing, shelter, and other necessities.

Example of explanation for "0" income:

- "Parents support me"
- "Boyfriend supports me"

For single clients

Use their gross income to determine potential financial eligibility.

For married clients

Use both the client's and spouse's incomes to determine potential financial eligibility, entering both incomes separately.

Note: Remind all clients that their reported **gross** income will be verified.

How do I finalize the TAKE CHARGE Application Process?

Review the information entered on the completed TAKE CHARGE Client application for accuracy, completeness, and potential eligibility.

- Using the online database, submit the TAKE CHARGE Client application to the TAKE CHARGE Eligibility Unit (see the *Important Contacts* section). **Exception:** HRSA may make a special consideration for a provider who needs to submit client applications via fax.
- The completed initial or recertification application must be entered into the TAKE CHARGE application database no later than 20 business days from the date the client signs the application.
- You must keep the signed TAKE CHARGE Client application in the client's file.
- For all clients claiming qualified aliens status you must retain a copy of the client's USCIS paperwork, date that the client permanently entered the U.S., and a copy of the client's photo identification with the client's application.
- U.S. citizenship, you must retain the citizenship affidavit or proof of citizenship and a copy of their photo identification with their application.
- A valid SSN is required for all TAKE CHARGE applicants. You will not be able to enter a TAKE CHARGE application online without a valid SSN.

Note: HRSA issues only one TAKE CHARGE Medical ID card per client: and this card is good for one year from the beginning of the month of eligibility. At the end of the eligibility year, the client may reapply for services. The client may reapply every 12 months until the TAKE CHARGE program ends or the client is no longer eligible. If a client enrolls in another HRSA program that covers family planning services, the client is **no longer eligible** for TAKE CHARGE.

Do not bill HRSA for application assistance if any part of the application is incomplete.

All of the following documents must be completed or obtained in order to bill for TAKE CHARGE application assistance:

- TAKE CHARGE application; and
- Either proof of citizenship or signed affidavit, qualifying USCIS documents; and
- Copy of photo identification; and, if applicable,
- The client's signed and dated request to have their Medical ID card sent to and kept at the provider's office (if the client makes this request).

Checking for TAKE CHARGE Eligibility

Once the provider enters the client's application into the TAKE CHARGE database, HRSA's TAKE CHARGE Eligibility Unit determines eligibility.

Checking the Status of a Client Application

The provider uses the TAKE CHARGE database to check the status of the client application. (**Note:** Eligibility status may take 20 to 45 days to appear in the database). The database will indicate one of three things:

- ✓ Eligibility approved;
- ✓ Eligibility denied; or
- ✓ HRSA needs more information in order to complete the eligibility determination (this will be indicated by a note in the comment box).

Eligibility Approved

If HRSA approves eligibility, the client will receive a TAKE CHARGE Medical ID card in the mail, along with a TAKE CHARGE brochure.

In some instances, HRSA mails the TAKE CHARGE Medical ID card to the provider instead of the client. In this instance, make a copy of the card for the client's chart and **forward the Medical ID card and brochure to the client within 7 business days** unless the client has confidentiality reasons (see note, below). This ensures that the client has easy and immediate access to the TAKE CHARGE provider or pharmacy of their choice.

Note: If the client specifically requests, in writing, that the card **not** be forwarded to them for confidentiality reasons, the provider must document this in the application and chart. A copy of the client's request must be kept in the chart.

Eligibility Denied

If HRSA denies eligibility, the provider must inform the client of the eligibility denial.

Application Needs More Information

If there is a note in the client's application comment box requesting more information, the provider **must** obtain the requested information from the client and send it to the HRSA TAKE CHARGE Eligibility unit. The application cannot be processed for final eligibility determination until the necessary information is obtained or the CSO records are changed to accurately reflect client information.

If you have questions regarding the department's comments/questions in the comment box, please call the Eligibility Unit at 877.787.2119.

What services are covered? [Refer to WAC 388-532-740]

Every female Medicaid client needing contraception and an annual exam is eligible for one comprehensive family planning preventive medicine visit every 12 months, if it is provided by a TAKE CHARGE provider. A Medicaid client who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning preventive medicine visit.

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.

HRSA covers all of the following TAKE CHARGE services for women:

- An initial or annual comprehensive family planning preventive medicine visit is allowed with a family planning diagnosis, once every 11-12 months.

The comprehensive family planning preventive medicine visit includes the following:

- A clinical breast examination and a pelvic examination;
 - Client-centered counseling that incorporates anticipatory guidance and risk factor reduction intervention regarding the prevention of unintended pregnancy; and
 - May include a pap smear according to current clinical guidelines.
-
- For women between the ages of 13 and 25, this visit may also include routine Gonorrhea (GC) and Chlamydia (CT) testing and treatment.

If the provider is an Infertility Prevention Project (IPP) provider, the GC and CT test must be sent to a laboratory with a Medicaid provider number instead of the non-Medicaid IPP laboratory.

For providers who have a delayed pelvic examination protocol, these services may be divided between two visits. See pages C.19 for more information about billing for a delayed pelvic examination.

Refer to CPT codes 99384 – 99386 and 99394 – 99396 for services provided at the annual comprehensive family planning preventive medicine visit. *Only TAKE CHARGE providers can bill these preventive codes for Family Planning Only clients.*

HRSA-Approved Family Planning Providers

- **Cervical, vaginal, and breast cancer screening examination**, once every 11-12 months as medically necessary. The screening HCPCS code G0101 should be billed with ICD-9-CM diagnosis codes within the V25 series, excluding V25.3. The examination must be:
 - √ Provided according to the current **clinical guidelines**; and
 - √ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3).

Note: The annual comprehensive family planning preventive medicine visit cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) **or an office visit.**

- One session of **application assistance** per client, once every 12 months.
- An office visit directly related to a family planning problem when medically necessary.
- **FDA-approved prescription and nonprescription contraceptives** as provided in Chapter 388-530 WAC, including, but not limited to, the following items:
 - √ Birth control patch;
 - √ Birth control pills;
 - √ Birth control vaginal ring;
 - √ Diaphragm and cervical cap and cervical sponge;
 - √ Emergency contraception.
 - √ Injectable and implantable hormonal contraceptives;
 - √ Intrauterine devices (IUDs);
 - √ Male and female condoms;
 - √ Spermicides (foam, gel, suppositories, and cream); and

Note: Pap smears, while not technically related to any contraceptive method, may be provided according to the current standard of care and schedule. **Providers must have and follow** a Pap smear protocol based on the guidelines of a nationally recognized organization such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF).

- Sterilization procedures that meet the requirements found in these billing instructions and *HRSA's Physician-Related Billing Instructions*, if the services are:
 - √ Requested by the TAKE CHARGE client; and
 - √ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered if performed more than one day prior to the surgery, when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days but no longer than 180 days prior to surgery.

- **Delayed Pelvic Visits**

Many clinics have protocols for clients who wish to initiate contraception and delay their pelvic exam. TAKE CHARGE providers may provide other components of the physical exam, contraceptive counseling, contraception, and schedule the pelvic examination for a subsequent visit. See the following tables for appropriate billing procedures for delayed pelvic visits.

Delayed Pelvic Visits – New Client

Visit	Performed by	Billing codes
First clinic visit for an initial or annual gynecological visit that includes detailed history, physical exam (excluding pelvic exam) counseling, contraceptive choice and contraceptive start.	ARNP, PA, MD	Preventive code 99384 – 99386 with modifier 52.
Subsequent (Different date of service than initial visit) This visit includes the initial/annual women’s pelvic and breast exam (may also include Pap smear) and evaluation of client’s satisfaction and compliance with chosen birth control method.	ARNP, PA, MD	Bill code G0101. Must be billed with a diagnosis from V25 series, excluding V25.3

Delayed Pelvic Visits – Established Client

Visit	Performed by	Billing codes
First clinic visit for an initial or annual gynecological visit that includes detailed history, physical exam (excluding pelvic exam) counseling, contraceptive choice and contraceptive start.	ARNP, PA, MD	Preventive code 99394 – 99396 with modifier 52.
	RN, LPN, medical assistant, certified nurse assistant or a trained and experienced health educator.	99211
Subsequent (Different date of service than initial visit) This visit includes the initial/annual women’s pelvic and breast exam (may also include Pap smear) and evaluation of client’s satisfaction and compliance with chosen birth control method.	ARNP, PA, MD	Bill code G0101. Must be billed with a diagnosis from V25 series, excluding V25.3.

HRSA-Approved Family Planning Providers

- **Screening and treatment for STD-I**, including laboratory tests and procedures **only** when the screening and treatment are:
 - √ A part of the comprehensive family planning preventive medicine exam for women 13-25 years of age **(GC and CT only); or**
 - √ Performed in conjunction with and at the initial or annual comprehensive family planning preventive medicine visit and have a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3); **and**
 - √ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.
- **Education and/or supplies** for FDA-approved contraceptives, natural family planning, and abstinence.

HRSA-Approved Family Planning Providers

HRSA offers all of the following TAKE CHARGE services for **men**:

Men who are specifically seeking family planning services such as sterilization, and/or contraceptive supplies (such as condoms and spermicides) for the purposes of preventing unintended pregnancy may be enrolled in TAKE CHARGE.

Note: TAKE CHARGE offers very limited services to men. Unless related to and necessary for sterilization, no office visits or physical exams are covered. No STD screening or treatment is covered unless related to and necessary for a sterilization procedure. HIV counseling and testing are not covered under TAKE CHARGE.

- One session of application assistance once every 12 months for those male clients specifically seeking family planning services.
- FDA-approved nonprescription contraceptives including spermicides and male and female condoms.
- Education and counseling for risk reduction for those male clients whose female partners are at risk for unintended pregnancy. (See pages C.21 – C.25 for the parameters for this service.)
- Sterilization procedures that meet the requirements found in these billing instructions and HRSA's *Physician-Related Services Billing Instructions*, if the service is:
 - Requested by the TAKE CHARGE client; and
 - Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered if performed more than one day prior to the surgery when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days, but no longer than 180 days prior to the surgery.

Education and Counseling for Risk Reduction (ECRR)

The cornerstone of the TAKE CHARGE program is client-centered education and counseling service designed to strengthen decision making skills and support a client's safe, effective and successful use of the chosen contraceptive method.

For Women

Prior to November 1, 2006, ECRR was a stand alone service with a separate billing code. The service is now offered as part of the annual comprehensive family planning preventive medicine visit. This comprehensive family planning preventive medicine visit focusing on the prevention of unintended pregnancy should be client centered. There are some women who have a history of consistent and effective use of their contraceptive method. If, at the time of their visit, all indications are that they will continue to use contraceptives successfully, then these clients will need **minimal** counseling.

Some clients are generally very satisfied and successful with their chosen method but may have an occasional problem or lapse with their method that could result in them being at moderate risk for unintended pregnancy. These clients at **moderate** risk, need some counseling and help with strategizing about back-up methods.

There are other **high-risk** clients who have significant problems that interfere with their ability to use contraceptives consistently, effectively or successfully. These clients are at significantly increased risk for an unintended pregnancy and often need lengthy counseling and referrals for psycho-social issues that complicate their lives and their ability to use contraception.

The reimbursement for the annual comprehensive family planning preventive medicine visit that includes education and risk reduction counseling for unintended pregnancy is the same regardless of the risk of unintended pregnancy. For clients at high-risk of contraceptive failure and unintended pregnancy, bill using the modifier SK to enable HRSA to evaluate the reimbursement of the preventive codes. See page E.1 in the [Billing](#) section for more information about the annual comprehensive family planning preventive medicine visit.

ECRR as part of the annual comprehensive family planning preventive medicine visit must be provided by one of the following TAKE CHARGE providers:

- Physician;
- Advanced Registered Nurse Practitioner (ARNP);
- Physician Assistant; or
- Registered Nurse, Licensed Practical Nurse or a trained and experienced health educator or medical assistant or certified nursing assistant when used for assisting and augmenting the above listed clinicians.

Note: The counseling intervention must be clearly documented in the client's chart, with detailed information that would allow for a meaningful, well-informed, follow-up visit.

For Men

Men who are seeking family planning services and whose female sexual partners are at moderate to high-risk for unintended pregnancy are eligible for one session of ECRR once every 12 months.

Men whose partners have had a tubal ligation are using an IUD, *Depo-Provera* or *Implanon* are not eligible for ECRR services.

ECRR is not to be billed automatically for every male seen by a TAKE CHARGE provider. The reimbursement should not be used to cover the cost of providing other reproductive health services for men, including STD counseling, testing and treatment, which are not covered by TAKE CHARGE. HRSA will closely monitor the provision of this service to men.

1. Education and counseling for risk reduction is offered as a stand-alone counseling session, once every 12 months.

Bill this service using CPT code 99401 **with a FP modifier.**

Note: The only office visit that can be billed on the same day as ECRR is the initial preoperative sterilization visit. TAKE CHARGE offers very limited services to men.

2. ECRR must be appropriate and individualized to the client's needs, age, language, cultural background, risk behaviors, and psychosocial history.
3. ECRR must be provided by one of the following TAKE CHARGE providers:
 - ✓ Physician;
 - ✓ Advanced Registered Nurse Practitioner (ARNP);
 - ✓ Physician Assistant; or
 - ✓ Registered Nurse, Licensed Practical Nurse or a trained and experienced health educator or medical assistant or certified nursing assistant when used for assisting and augmenting the above listed clinicians.

Note: The counseling intervention must be clearly documented in the client's chart with detailed information that would allow for a meaningful, well-informed follow-up visit.

Components

Five critical components are a part of the ECRR intervention. Integrate these five components into the counseling process by following the client's lead. Individual components may overlap with the other components. For high-risk clients, you must have addressed and documented all of the components by the close of the client/provider interaction.

<p>Component A: Help the client (male or female) critically evaluate which contraceptive method is most acceptable and which method they can most effectively be used.</p> <ul style="list-style-type: none"> • Focus first on the client's choice of method; • Assess and clarify knowledge, assumptions, misinformation, and myths about their chosen method(s); • Describe method benefits, including non-contraceptive benefits; • Address potential side effects and health risks; • Provide written materials that are culturally sensitive, clear, relevant, and easy to understand; and • Provide a telephone number to call if the client has questions.
<p>Component B: Assess and address other client personal considerations, risk factors, and behaviors that impact their use of contraception.</p> <p>At a minimum, assess the following:</p> <ul style="list-style-type: none"> • History of abuse; • Current exploitation or abuse; • Current living situation; • Need for confidentiality; and • Make community referrals as necessary (e.g., domestic violence shelters and hotlines, food bank, mental health, substance abuse, other primary care needs).
<p>Component C: Facilitate discussion of the male role in successful use of chosen contraceptive method, as appropriate (for himself or for his female partner).</p> <ul style="list-style-type: none"> • With both female and male clients, assess and address partner issues (e.g., attitudes about birth control methods and how much the partner will be involved); • Reinforce male involvement in pregnancy prevention; and • Discuss male's role in supporting a partner's use of an individual method, as appropriate.
<p>Component D: Facilitate the client's contingency planning (the "back-up method") regarding the client's use of contraception, including planning for emergency contraception.</p> <ul style="list-style-type: none"> • Address side effects of the client's chosen method, and make sure the client knows what to do if there are side effects; • Discuss back-up methods with the client; • Provide information about access to emergency contraception as it relates to errors or problems with the chosen method; and • Provide a telephone number for the client to call with questions or concerns.
<p>Component E: When medically necessary, schedule follow-up appointments for birth control evaluation at or before 3 months, or as appropriate for the method chosen.</p> <ul style="list-style-type: none"> • Address questions about method use and follow-up appointment, as needed; • Reinforce positive contraceptive and other self-protective behaviors; and • Follow up on any community referrals, as necessary.

Determining if a client is at increased risk for unintended pregnancy

Clients can have just one factor in their life that can put them at increased risk for pregnancy, but most often risk factors occur in clusters. Below is a list (not all-inclusive) of some of the factors as they relate to the previously described components that would give indicate a client will likely need some in-depth education and counseling to support the safe, effective and successful use of the chosen contraceptive method.

When charting both the client’s history and counseling intervention, make sure that the chart is detailed and thorough. This will facilitate a more meaningful and effective follow-up at the client’s next visit, whether you see the client again or another provider sees the client.

Risk by Component

1. Method

At Risk	Not at Risk
Ambivalent about using birth control	Has successful method and wants to continue
Ambivalent about having sex	Already knowledgeable and motivated
Fearful/concerned about side effects	Easy access (teen clinic nearby or at school)
Trouble reading/understanding written materials	Easy to use
No partner support	Goal oriented and will not let anything get in the way (e.g. college, business venture, etc.)
Pattern of no follow-through previous birth control methods	Confident; self-assured
Wants method that has contraindications (e.g., smoker wants pill)	Fear driven
Younger teens	
Doesn’t believe she can get pregnant (or that he can get pregnant)	
Ambivalent about preventing pregnancy	

2. Partner

At Risk	Not at Risk
Multiple partners	Involved partner/interested
Lack of communication	Supportive partner
Abusive partner	Communicative partner
Drug-using partner	Monogamous or long term partner
Controlling partner	Trustworthy
Unsupportive/uninvolved partner	Responsible
Apathetic	Partner comes to appointment
Partner not willing to help with cost	Impotent
	Information seeking
	Partner uses consistent method
	Offers financial support

3. Personal Considerations

At Risk	Not at Risk
Low literacy level/education level	Stable living environment
Transportation issues/other access issues	No negative history of abuse
Confidentiality of method	Determination/intent not to become pregnant
Substance abuse	Good support system
Abusive relationship	Positive peer pressure
History of sexual abuse	
Relationship status (length, etc)	
Inability to meet basic needs	
Living conditions	
Low self-esteem	
No life goals (goals for future)	
Apathetic about future	
Mental health issues	
Maturity level	
Age at first intercourse	
Number of pregnant	
Cultural beliefs	
Negative peer pressure	
Family history of teen pregnancy	

4. Back-up

At Risk	Not at Risk
Mental illness	(Exact opposite of risk characteristics listed on the left.)
Developmental delays	
Substance abuse	
Transportation issues/other access issues	
Uncooperative partner	
Has to seek contraception in secret	
Personal/religious beliefs, (i.e., emergency contraception)	
Has misinformation	
Allergies	
Ambivalence, about sex/contraception	
Assertive	

What drugs and supplies are paid under the TAKE CHARGE Program?

HRSA pays for the family planning-related drugs and contraceptives within the following therapeutic classifications:

Contraceptives and supplies that can be dispensed from a HRSA-approved Family Planning clinic.	Family Planning-related drugs and supplies that can be dispensed from a pharmacy.
Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, sponge, spermicides, vaginal film, creams. Azithromycin	Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, spermicides, vaginal film, creams. Vaginal antifungals Vaginal Sulfonamides Vaginal Antibiotics Tetracyclines Macrolides Antibiotics, misc. other Quinolones Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Absorbable Sulfonamides Nitrofurans Derivatives Antifungal Antibiotics Antifungal Agents Anaerobic antiprotozoal – antibacterial agents
	* Antianxiety Medication – Before Sterilization Procedure Diazepam Alprazolam
	* Pain Medication – After Sterilization Procedure Acetaminophen with Codeine #3 Hydrocodone Bit/ Acetaminophen Oxycodone HCl/Acetaminophen 5/500 Oxycodone HCl/ Acetaminophen

* Selected drugs are copied from Numbered Memorandum [05-05](#) HRSA.

HRSA-Approved Family Planning Providers

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, etc.) may also be obtained in a 30-day supply through a pharmacy or a family planning provider with a Medical ID card.

Hormonal Contraceptives Dispensed from HRSA-Approved Family Planning Clinics:

For fee-for-service clients, hormonal contraception must be dispensed at a minimum of three cycles/months. A maximum of 13 cycles may be dispensed on the same day. If the hormonal contraception is dispensed for less than three months/cycles, there must be documentation in the chart stating the reason the why only one or two cycles were dispensed.

Hormonal Contraceptive Prescriptions filled at the pharmacy.

HRSA's Point-of-Sale system currently cannot fill a contraception prescription for more than a three month supply at one time. We are working on system changes to allow refills for up to a 12 month supply. Until further notice, you must dispense three months/cycles unless the prescriber writes a prescription for less than three months/cycles.

Managed care clients will receive their hormonal contraceptives according to the terms set by their managed care plans.

Note: All services provided to TAKE CHARGE clients **must** have a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3). All services related to sterilization must be billed with the sterilization diagnosis code V25.2

What services are *not* covered? [WAC 388-532-750]

HRSA does not cover medical services under the TAKE CHARGE program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning; and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

Abortions are not covered under the TAKE CHARGE program.

Other pregnancy-related services are not covered under the TAKE CHARGE program.

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. **All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.**

HRSA-Approved Family Planning Providers

Inpatient Services: HRSA does not cover inpatient services under the TAKE CHARGE program. However, inpatient costs may be incurred as a result of complications arising from covered TAKE CHARGE services. If this happens, providers of TAKE CHARGE related inpatient services must submit to HRSA a complete report of the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0165. A complete report includes:

- A copy of the billing (UB-92, 1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Benefits and Care Management at 360.586.1471.

Reimbursement

[Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA limits reimbursement under the TAKE CHARGE program to visits and services listed on the Fee Schedule (see section D) that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (i.e., ICD-9-CM diagnosis code within the V25 series); and
- Are medically necessary for the clients to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Department-Approved Family Planning Clinics that Dispense Contraception:

Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services:** Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment is either your *usual and customary fee* or HRSA's maximum allowable fee, whichever is less.
- If a HRSA fee schedule lists a drug or item as “actual acquisition cost,” the provider must bill its actual acquisition cost and not a usual and customary fee or maximum allowable fee.

For drugs purchased under the Public Health Services (PHS) Act: Providers must comply with Pharmacy Services WAC 388-530-1425.

HRSA-Approved Family Planning Providers

WAC 388-530-1425

(1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid HRSA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under the Public Health Service (PHS) Act and paid by **HRSA** are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs.

- **For other contraceptives, drugs, drug supplies and devices not purchased under Public Health Services Act:** Bill HRSA your usual and customary fee. Reimbursement is your usual and customary fee or the department's maximum allowable fee, whichever is less. [Refer to WAC 388-530-1050]
- Any non-contraceptive take-home drugs dispensed at a family planning clinic are not reimbursable.

Research and Evaluation Activities: HRSA limits reimbursement for TAKE CHARGE to selected research sites.

FQHC/RHC: Federally qualified health centers (FQHCs), rural health clinics (RHCs), and Indian health providers who choose to become TAKE CHARGE providers must bill HRSA for TAKE CHARGE services without regard to their special rates and fee schedules. HRSA does **not** pay FQHCs, RHCs, or Indian health providers under the encounter rate structure for TAKE CHARGE services.

Billing Timeline: HRSA requires TAKE CHARGE providers to meet the billing requirements of WAC 388-502-0150 (billing time limits). In addition, billing adjustments related to the TAKE CHARGE program must be completed no later than two years after the demonstration and research program terminates. HRSA will not accept any new billings or any billing adjustments that increase expenditures for the TAKE CHARGE demonstration and research program after the cut-off date in this WAC.

Third-Party Liability: HRSA requires a provider under WAC 388-501-0200 to seek timely reimbursement from a third party when a client has available third party resources. See page E.8 for exceptions to this requirement.

Family Planning Services Coverage Table

Note: For billable codes and fees for Reproductive Health Services, refer to the *Physician-Related Billing Instructions*. Only the provider who rendered the services is allowed to bill for those services, except in the case where a client self-refers outside the DSHS Managed Care Plan for family planning services.

Office Visits

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
99201		Office/outpatient visit, new		
99202		Office/outpatient visit, new		
99203		Office/outpatient visit, new		
99204		Office/outpatient visit, new		
99211		Office/outpatient visit, est		
99212		Office/outpatient visit, est		
99213		Office/outpatient visit, est		
99214		Office/outpatient visit, est		
G0101		CA screen; pelvic/breast exam		

Comprehensive Family Planning Preventive Medicine Visits

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
99384		Adolescent (age 12 through 17)		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99385		18-39 years		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99386		40-64 years		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.

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Coverage Table
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Comprehensive Family Planning Preventive Medicine Visits (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
99394		Adolescent (age 12 through 17)		Established (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99395		18-39 years		Established (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99396		40-64 years		Established (female) patient - Once every 11-12 months. Only TAKE CHARGE providers can bill.

Prescription Birth Control Methods

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
Oral Contraceptives				
S4993		Contraceptive pills for birth control		[1 unit = each 30-day supply] (<i>Seasonale</i> should be billed as 3 units.) Must be billed with S9430 (i.e., one unit of S4993 is entitled to one unit of S9430).
S9430		Pharmacy compounding and dispensing services		DSHS pays for a dispensing fee for each unit billed with S4993, J7303, J7304 and J3490. (Plan B).

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Coverage Table
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HRSA-Approved Family Planning Providers

Note:

- The dispensing fee can be billed only for designated drugs which must be purchased and dispensed by a DSHS-Approved Family Planning Provider.
- The dispensing fee can be billed only for drugs **purchased** by the provider. Any drug provided free of charge (e.g., samples, obtained through special manufacturer agreements, etc.) is not reimbursable. A dispensing fee in these cases is not reimbursable either.
- The dispensing fee can be billed on a unit-by-unit basis only with codes S4993, J7303, J7304, and J3490 (Plan B). For example, if the provider dispenses 12 units of S4993 and 1 unit of J3490 (Plan B), then the dispensing fee (S9430) would be billed for 13 units. The number of billed units for S9430 must be **billed on the same day of service and always** equal the number of units dispensed by the provider for codes S4993, J7303, J7304 and/or J3490 (Plan B).

Cervical Cap/Diaphragm

A4261		Cervical cap for contraceptive use		
A4266		Diaphragm		
57170		Fitting of diaphragm/cap		

Implant

11976		Removal of contraceptive capsule		
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Injectables

J1055		Medroxyprogesterone acetate inj for contraceptive use, 150 mg (<i>Depo-Provera</i>)		Allowed once every 67 days and only with V25, V25.02, V25.49, V25.9.
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Intrauterine Devices (IUD)

J7300		Intrauterine copper device (<i>Paragard</i>)		No Dispensing Fee Allowed
J7302		Levonorgestrel-releasing IUD (<i>Mirena</i>)		No Dispensing Fee Allowed
58300		Insertion of intrauterine device (IUD)		No Dispensing Fee Allowed
58301		Removal of intrauterine device (IUD)		No Dispensing Fee Allowed

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Coverage Table
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Prescription Birth Control Methods (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
Miscellaneous Contraceptives				
J7303		Contraceptive ring, each (<i>Nuvaring</i>)		Must be billed with S9430 (i.e., one unit of J7303 is entitled to one unit of S9430)
J7304		Contraceptive patch, each (<i>Ortho-Evra</i>)		Must be billed with S9430 (i.e., one unit of J7304 is entitled to one unit of S9430) One patch = one unit.

Non-Prescription Over-the-Counter (OTC) Birth Control Methods

Procedure Code	Modifier	Description	EPA/PA	Policy/Comments
A4267		Male Condom, each		
A4268		Female Condom, each		
A4269		Spermicide (e.g. foam, sponge), each		e.g. includes gel, cream and vaginal film

Note: DSHS pays for most FDA-approved family planning products and supplies.

Implanon (HCPCS code J7307)

Procedure Code	Diagnosis Code	Description	EPA/PA	Policy/Comments
11981	V25.5	For the insertion of the device		Enter the NDC in Box 19 on the 1500 Claim Form and send in an invoice with your billing. Do not bill a dispensing fee for the device.
11982	V25.43	For removal of the device.		Enter the NDC in Box 19 on the 1500 Claim Form and send in an invoice with your billing.
11983	V25.43	For removal of the device with reinsertion on the same day		Enter the NDC in Box 19 on the 1500 Claim Form and send in an invoice with your billing. Do not bill a dispensing fee for the device.

Note: DSHS pays for Implanon only once every three years, per client.

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Coverage Table
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Unlisted Contraceptive Drugs and Supplies

When billing for a contraceptive drug or contraceptive supply that does not have a dedicated HCPCS or CPT code, providers must bill DSHS for the contraceptive using DSHS’s Expedited Prior Authorization (EPA) process.

The EPA process allows DSHS to use a nine-digit EPA number to identify, track, and appropriately pay for an unlisted contraceptive. The nine-digit EPA number must be listed in the “Prior Authorization Number” field of the claim form (for example, Box 23 of a 1500 Claim Form).

The first five digits of all DSHS EPA numbers are **87000**. The last four digits of the EPA number identify the exact contraceptive supplied.

Note: DSHS requires DSHS-approved Family Planning providers to list the 11-digit National Drug Code (NDC) number in the appropriate field on the claim form (see numbered memorandum 06-06 for details) when billing for **ALL** drugs administered in or dispensed from the family planning clinic.

Family Planning Clinics may no longer bill DSHS for an unlisted contraceptive drug or supply using J3490 or J3490-FP *without an EPA number*. If DSHS has not yet established an EPA number for a particular contraceptive drug or supply, contact the Family Planning or TAKE CHARGE program manager to have an EPA number established for the new product. (See *Important Contacts* on page iv.)

DSHS has established coding and EPA number requirements for the contraceptive drugs and supplies listed in the following tables.

Emergency Contraceptive Pills

Providers must bill DSHS for emergency contraceptive pills as detailed below:

HCPCS Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
J3490	FP	Unlisted drug	870001252	Use for Plan B only. Each 1 unit equals one treatment. Must be billed with S9430 (i.e., one unit of J3490 is entitled to one unit of S9430).

HRSA-Approved Family Planning Providers

Non-Drug Contraceptive Supplies

Providers must bill DSHS for unlisted non-drug contraceptive supplies as detailed below:

HCPCS Code	Modifier	Brief Description	EPA/PA	Policy/Comments
T5999	FP	Unlisted supply	870001253	Use for cycle beads only. Each 1 unit equals one set of cycle beads.
99071	FP	Unlisted supply	N	Use for natural family planning booklet only. Each 1 unit equals one booklet.
A4931	FP	Reusable, oral thermometer	870001254	Use for: Basal thermometer only. Each 1 unit equals one thermometer.

Note: Do **not** use these EPA numbers when billing for any contraceptive or drug other than those listed in the table above.

Sterilization Procedures

A properly completed Sterilization Consent Form, DSHS 13-364, **must** be attached to any claim submitted with any of the following procedure codes. Go to the link below to download form DSHS 13-364. http://www1.dshs.wa.gov/pdf/ms/forms/13_364a.pdf .

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
00840	As needed	Anesthesia for intraperitoneal procedures in lower abdomen		
00851	As needed	Anesthesia for intraperitoneal procedure/tuballigation		
55250		Removal of sperm duct(s)		

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HRSA-Approved Family Planning Providers

Sterilization Procedures (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
55450		Ligation of sperm duct		
58600		Division of fallopian tube		
Laparoscopy				
58615*		Occlude fallopian tube(s)		DSHS pays for external occlusive devices only such as band, clip, or <i>Falope</i> ring. DSHS does not pay for occlusive devices introduced into the lumen of the fallopian tubes. (i.e., <i>Essure</i>)
58670		Laparoscopy, tubal cautery		
58671*		Laparoscopy, tubal block		DSHS pays for external occlusive devices only such as band, clip, or <i>Falope</i> ring. DSHS does not pay for occlusive devices introduced into the lumen of the fallopian tubes (i.e., <i>Essure</i>)

Note: Sterilization procedures and any initial visits must be billed with ICD-9-CM diagnosis code V25.2.

Radiology Services

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
77080		Dual energy x-ray absorptiometry (DXA)		See Fee Schedule in Physician-Related Services Billing Instructions (BI) Covered only for clients according to standards of care for clients using or considering <i>Depo-Provera</i> .
77081		Radius, wrist-heel		See Fee Schedule in Physician-Related Services BI Covered only for clients according to standards of care for clients using or considering <i>Depo-Provera</i> .

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Coverage Table
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Radiology Services (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
76830		Ultrasound, transvaginal		
76830	26	Professional Component		
76830	TC	Technical Component		
76856		Ultrasound, pelvic, complete		
76856	26	Professional Component		
76856	TC	Technical Component		
76857		Ultrasound, pelvic, limited		
76857	26	Professional Component		
76857	TC	Technical Component		
76977		Ultrasound bone density measurement and interpretation, peripheral site(s)		See Fee Schedule in Physician-Related Services BI Covered only for clients according to standards of care for clients using or considering <i>Depo-Provera</i> .

Note: Radiology services must be performed by radiologists. DSHS pays radiologists for these services.

Laboratory Services

A family planning provider may bill for laboratory services only when the provider actually performs lab tests unless the client is a self-referred DSHS managed care client. Only in this instance, with managed care clients, may a family planning provider bill DSHS for laboratory services on a “pass-through” basis and only up to the amount billed by the laboratory.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
36415		Drawing blood venous		Payment limited to one draw per day.
36416		Drawing blood capillary		
80061		Lipid profile		
80076		Hepatic function panel		
81000		Urinalysis, nonauto w/scope		

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HRSA-Approved Family Planning Providers

Laboratory Services (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
81001		Urinalysis, auto w/scope		
81002		Urinalysis nonauto w/o scope		
81003		Urinalysis, auto, w/o scope		
81025		Urine pregnancy test		
82120		Amines, vaginal fluid, qualitative		
82465		Assay, bld/serum cholesterol		
83718		Lipoprotein, direct measurement; high density cholesterol (HDL)		
84132		Potassium; serum		
84146		Prolactin		
84443		Thyroid stimulating hormone (TSH)		
84703		Chorionic gonadotropin assay		
85013		Hematocrit		
85014		Hematocrit		
85018		Hemoglobin		
85025		Automated hemogram		
85027		Automated hemogram		
86255		Fluorescent antibody, screen		
86255	26	Professional Component		
86631		Chlamydia antibody		
86632		Chlamydia igm antibody		
86692		Hepatitis, delta agent		
86706		Hep b surface antibody		
87110		Chlamydia culture		
87140		Cultur type immunofluoresc		
87147		Culture type, immunologic		
87210		Smear, wet mount, saline/ink		
87270		Infectious agent antigen detection by immunofluorescent technique; chlamydia trachomatis		

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Laboratory Services (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
87320		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative; chlamydia trachomatis		
87340		Hepatitis b surface ag, eia		
87490		Chylmd trach, dna, dir probe		
87491		Chylmd trach, dna, amp probe		
87590		N.gonorrhoeae, dna, dir prob		
87591		N.gonorrhoeae, dna, amp prob		
87800		Detect agnt mult, dna, direc		
87810		Chylmd trach assay w/optic		
88141		Cytopath, c/v, interpret		
88142		Cytopath, c/v, thin layer		
88143		Cytopath, c/v, thin lyr redo		
88147		Cytopath, c/v, automated		
88148		Cytopath, c/v, auto rescreen		
88150		Cytopath, c/v, manual		
88152		Cytopath, c/v, auto redo		
88153		Cytopath, c/v, redo		
88154		Cytopath, c/v, select		
88164		Cytopath tbs, c/v, manual		
88165		Cytopath tbs, c/v, redo		
88166		Cytopath tbs, c/v, auto redo		
88167		Cytopath tbs, c/v, select		
88174		Cytopath, c/v auto, in fluid		
88175		Cytopath, c/v auto fluid redo		
88300		Level 1 surgical pathology, gross examination only		
88302		Tissue exam by pathologist, level II		
88302	26	Professional Component		
88302	TC	Technical Component		

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Injectable Drugs and Injection Fee

(These drugs are given in the family planning clinic. These are not take-home drugs or drugs obtained by prescription through a pharmacy.) The following table contains the names of the only drugs that DSHS pays directly to DSHS approved family planning clinics. All other covered drugs, must be obtained and billed by a pharmacy, see page C.20. See numbered memoranda 06-06 for more NDC details.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/Comments
96372		Ther/proph/diag inj, sc/im (Specify substance or drug)		May not be billed with an office visit.
90772		Ther/proph/diag inj, sc/im (Specify substance or drug)		May not be billed with an office visit.
J0456		Azithromycin inj, 500 mg		
J0580		Penicillin g benzathine inj		
J0690		Cefazolin sodium inj, 500 mg		
J0694		Cefoxitin sodium inj, 1 g		
J0696		Ceftriaxone sodium inj, 250 mg		
J0697		Sterile cefuroxime inj, 750 mg		
J0698		Cefotaxime sodium inj, per gram		
J0710		Cephapirin sodium inj, up to 1 g		
J1055		Medroxyprogesterone acetate inj (Depo-Provera)		Allowed once every 67 days.
J1890		Cephalothin sodium inj, up to 1 g		
J2460		Oxytetracycline inj, up to 50 mg		
J2510		Penicillin g procaine inj, to 600,000 u		
J2540		Penicillin g potassium inj, to 600,000 u		
J3320		Spectinomycin di-hcl inj, up to 2 g		
Oral Medication				
Q0144		Azithromycin dihydrate, oral, 1 g		
J3490	FP	Unlisted drugs	870001 252	Use for: Plan B only; and Each 1 unit equals one treatment Must be billed with S9430.

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Coverage Table
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TAKE CHARGE Clients Only

HCPCS Code	Modifier	Brief Description	EPA/PA	Policy/Comments
T1023	FP	Intake Assessment		(Use for application assistance) <i>Only for TAKE CHARGE clients</i> Once every 12 months
99401	FP	PT education noc individ		(Use for Male contraceptive counseling – ECRR) <i>Only for TAKE CHARGE clients.</i> Once every 12 months

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Coverage Table

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Billing

What if a provider has more than one provider number?

When your agency has more than one provider number, the following table outlines which number to use for billing Family Planning Services for fee-for-service (FFS) clients and self-referred HRSA managed care enrollees.

Type of Service	Reproductive Health Services Clients	Family Planning Only Clients	TAKE CHARGE Clients	Self-Referred HRSA Managed Care Enrollees
Family Planning	Family Planning number or Medical number	Family Planning number or Medical number	Family Planning number	Family Planning number
Sexually Transmitted Disease (STD-I) <i>(limited coverage for Family Planning Only and TAKE CHARGE clients)</i>	Family Planning number or Medical number	Family Planning number or Medical number	Family Planning number	Family Planning number
Abortion	Medical number	Not covered	Not covered	Medical number
Other: menopause, abnormal Pap, precancerous conditions, etc.	Medical number	Not covered	Not covered	Refer client to Primary Care Provider

What must I consider when billing?

The purpose of the Family Planning Only and the TAKE CHARGE program is to prevent unintended pregnancies. All services provided under these programs must be related to the prevention of unintended pregnancy.

Documentation in the client’s chart must reflect that the majority of the time was spent with the client with the focus of family planning (ICD-9-CM V25 series diagnosis codes – excluding V25.3). See next page for examples of clinic visit scenarios.

Note: Billing adjustments related to the TAKE CHARGE program must be completed no later than two years after the demonstration and research program terminates. HRSA will not accept any new billings or any billing adjustments that increase expenditures for the TAKE CHARGE demonstration and research program after the cut-off date in this WAC. [Refer to WAC 388-532-780(5)]

Clinic Visit Scenarios

Example A

Client A has chosen to use an IUD. It is the standard of practice to screen for Chlamydia/Gonorrhea prior to IUD insertion. This STD screening (and treatment if necessary) **would** be covered under TAKE CHARGE as it is not medically safe to insert an IUD into a potentially infected uterus.

Example B

Client B has been a client at your clinic for several years. She has been an inconsistent condom and oral contraceptive user and at high-risk for unintended pregnancy. She decides to try the *Nuvaring* and has been using it safely, effectively and successfully for six months. She comes into the clinic with complaints of spotting and bleeding especially after intercourse, and believes it is caused by the hormones in the ring. She wants to quit the ring and go back to condoms. She mentions something about her new boyfriend and how he won't be too happy about having to use condoms. You are concerned that the bleeding may be caused by Chlamydia/Gonorrhea and not her hormonal contraceptive AND that she will again be at risk for pregnancy with a method that she didn't previously use well. You test her for Chlamydia/Gonorrhea, treat her presumptively, explain the importance of her partner getting treated and tested as well, discuss the importance of condoms for STD prevention, and continue her with the *Nuvaring*.

Her office visit, lab tests and treatment **would be** covered because your thorough charting makes the link to the safe, effective and successful use of her birth control method.

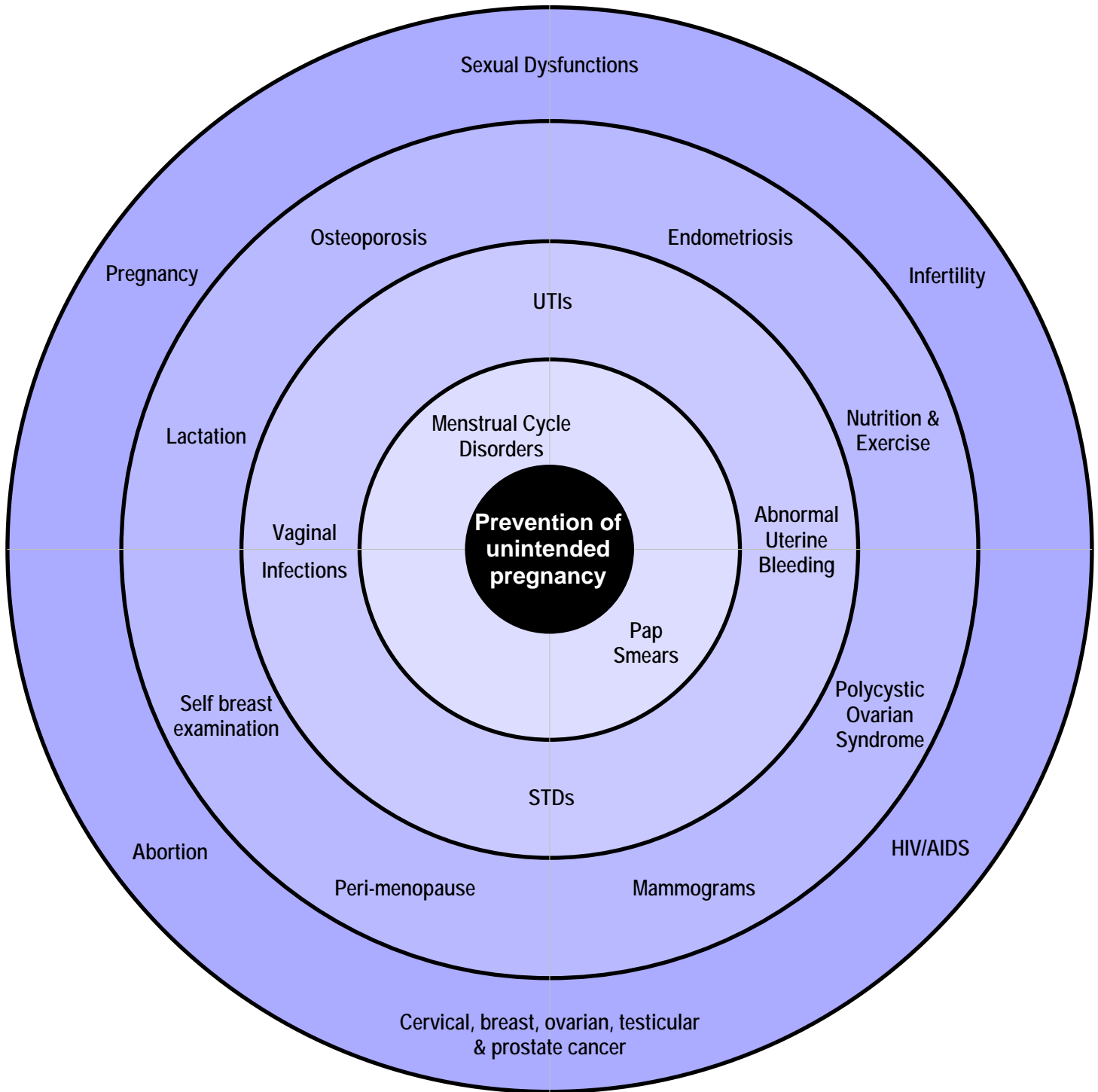
Example C

Client C comes into the clinic stating that she heard that her recent past partner "had something" and she wanted to be checked just to be sure. She is in a new relationship, using oral contraceptives and also using condoms for STD prevention. She is having no problems with her birth control method. She just wants to be screened for STDs. This visit would **not** be covered under TAKE CHARGE or Family Planning Only.

Example D

Client D was taken off hormonal contraceptives when she was diagnosed with severe mononucleosis. She was jaundiced and her liver was enlarged during the acute phase of her illness. She is not happy using condoms, has had unprotected sex a couple of times and wants to resume her oral contraceptive use. You order lab work to determine that her liver function has returned to normal before restarting her on pills. This visit and labs tests **would be** covered under TAKE CHARGE and Family Planning Only. Again, your thorough charting of this clients history and current presenting issues is your justification for requesting payment from HRSA for these services.

Aiming for the Bull's Eye Preventing Unintended Pregnancy



Frequently Asked Questions

If a client changes from TAKE CHARGE coverage to full scope Medicaid coverage, are they covered under the TAKE CHARGE program?

No, the client now is eligible for Reproductive Health Services. See Reproductive Health Services on page B.1.

Are prostate cancer screenings, digital rectal examinations, and prostate-specific antigen tests (PSA) covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Prostate cancer screenings are covered under Reproductive Health Services with the following procedure codes and diagnoses:

- Males are covered for procedure code G0103 for prostate-specific antigen test (PSA) with diagnosis code V76.44 (special screening for malignant neoplasms prostate).
- Digital rectal exam (procedure code G0102) is bundled into the reimbursement for the office visit.

These prostate cancer screenings **are not** covered under the Family Planning Only program (which is for women only) or under TAKE CHARGE.

Are mammograms covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Mammograms are covered for clients under Reproductive Health Services for women 40 years of age or older (one screening mammogram is covered annually).

Mammograms **are not** covered under the Family Planning Only program or TAKE CHARGE.

Are abortions covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Abortions are covered for clients under Reproductive Health Services. Bill for these services with your medical number, not your family planning number. See page E.1.

Abortions **are not** covered under the Family Planning Only program or TAKE CHARGE.

Note: If a Family Planning Only or TAKE CHARGE client becomes pregnant, refer her to her local Community Services Office to determine if she qualifies for medical services under another program.

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

Initial Claims

- HRSA requires providers to submit an **initial claim** to HRSA and obtain an ICN within 365 days from any of the following:
 - √ The date the provider furnishes the service to the eligible client;
 - √ The date a final fair hearing decision is entered that affects or has an impact on the particular claim;
 - √ The date a court orders HRSA to cover the services; or
 - √ The date DSHS certifies a client eligible under delayed¹ certification criteria.

Note: If HRSA has recouped a managed care plan's premium, causing the provider to bill HRSA, the billing time limit is 365 days from the date the plan recouped the payment from the provider.

- HRSA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:
 - √ DSHS certification of a client for a retroactive² period; or

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

² **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

HRSA-Approved Family Planning Providers

- √ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.
- HRSA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

Resubmitted Claims

- Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above. When rebilling, send a copy of the original Remittance and Status Report along with the claim. Be sure to cross out any lines that have already been paid.

- The time periods listed above do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, **must not bill a client or a client's estate** when:
 - √ The provider fails to meet these listed requirements; and
 - √ HRSA does not pay the claim.

What fee should I bill HRSA for services?

For services, bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment is either your usual and customary fee or HRSA's maximum allowable rate, whichever is less.

When can I bill the client?

See HRSA's *General Information Booklet* or WAC 388-502-0160 for information on billing the client.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claims are denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's web site at <http://maa.dshs.wa.gov/LTPR> or by calling the Coordination of Benefits at 800.562.6136.

Note: See the following for circumstances when TAKE CHARGE clients might have a *good cause* exception to billing third party insurance.

Billing Note: For those clients enrolled before November 1, 2006 that have third-party insurance, you must bill their insurance before billing HRSA.

TAKE CHARGE Third-Party Liability and *Good Cause*

[Refer to WAC 388-532-790]

The following TAKE CHARGE applicants may request an exemption of available third party coverage due to *good cause*:

- 18 years of age and younger seeking confidential services who depend on their parents' medical insurance; or
- Domestic violence victims.

Under the TAKE CHARGE program, *good cause* means that use of the third party coverage would violate his or her privacy because the third party:

- Routinely or randomly sends verification of services to the third party subscriber and that subscriber is other than the applicant; and/or
- Requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to another party.

If either of these conditions apply, the applicant is considered for TAKE CHARGE without regard to the available third party family planning coverage.

Note: Clients must make this self-declaration on the TAKE CHARGE client application in order to qualify for this exception.

What records must be kept? [Refer to WAC 388-502-0020]

All HRSA providers

Enrolled providers (including HRSA-approved Family Planning providers) must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - √ Patient's name and date of birth;
 - √ Dates of service(s);
 - √ Name and title of person performing the service, if other than the billing practitioner;
 - √ Chief complaint or reason for each visit;
 - √ Pertinent medical history;
 - √ Pertinent findings on examination;
 - √ Medications, equipment, and/or supplies prescribed or provided;
 - √ Description of treatment (when applicable);
 - √ Referrals for additional treatments, procedures, or consultations;
 - √ X-rays, tests, and results;
 - √ Plan of treatment and/or care, and outcome; and
 - √ Specific claims and payments received for services.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the U.S. Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

TAKE CHARGE providers [Refer to WAC 388-532-760]

In addition to the documentation requirements listed previously, TAKE CHARGE providers must keep the following records:

- TAKE CHARGE client application;
- Either proof of citizenship or signed affidavit, qualifying USCIS documents;
- Copy of photo identification;
- Chart notes that reflect that the primary focus and diagnosis of the visit was family planning;
- Contraceptive methods discussed with the client;
- Notes on any discussions of emergency contraception and needed prescription(s);
- The client's plan for the contraceptive method to be used, or the reason for no contraceptive method and plan;
- Documentation for the education, counseling and risk reduction (ECRR) service, if provided;
- Documentation of referrals to or from other providers;
- A form signed by the client authorizing release of information for referral purposes, as necessary;
- A copy of the completed Sterilization Consent Form, DSHS 13-364, as necessary (see page F.10 for how to obtain a copy of this form). For details about sterilization refer to HRSA's current *Physician-Related Services Billing Instructions*, or call Family Planning program manager 360.725.1664. Click link to download the DSHS 13-364 http://www1.dshs.wa.gov/pdf/ms/forms/13_364a.pdf; and
- The clients signed and dated request to have their Medical ID Card sent to and kept at the provider's office (if the client makes this request).

Fee Schedule

You may view **HRSA-Approved Family Planning Providers Fee Schedule** on-line at

<http://maa.dshs.wa.gov/RBRVS/Index.html>

For a paper copy of the fee schedule:

- **Go to:** <http://www.prt.wa.gov/> (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby** → **Search by Agency** → **Department of Social and Health Services** → **Health and Recovery Services Administration** → desired document; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Telephoned or faxed orders may take up to 2 weeks to fill.)

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Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing, including vasectomies and tubal ligations.

Note: HRSA does **not** pay for hysterectomies performed solely for the purpose of sterilization. Refer to HRSA's *Physician-Related Services Billing Instructions* for information on hysterectomies.

What are HRSA's reimbursement requirements for sterilizations? [Refer to WAC 388-531-1550(2)]

HRSA covers sterilization when all of the following apply:

- The client has **voluntarily** given informed consent;
- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

Note: HRSA pays providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system. All other managed care clients must obtain their sterilization services from their managed care provider.

HRSA pays providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for a sterilization procedure only when the completed federally-approved Sterilization Consent form, DSHS 13-364, is attached to the claim.

To download the form, click link (see below) and scroll down to 13-364 <http://www1.dshs.wa.gov/msa/forms/eforms.html>. HRSA does not accept any other forms attached to the claim. HRSA pays after the procedure is completed.

HRSA pays providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. HRSA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before HRSA will pay the provider for the sterilization of a mentally incompetent or institutionalized client. HRSA requires both of the following to be attached to the claim form:

- Court orders that include the following:
 - √ A statement that the client is to be sterilized; **and**
 - √ The name of the client's legal guardian, who will be giving consent for the sterilization.
- Sterilization Consent Form, DSHS 13-364, signed by the client's legal guardian.

When does HRSA waive the 30-day waiting period?

[WAC 388-531-1550(3) and (4)]

HRSA does not require the 30-day waiting period, but does require at least a 72-hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

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HRSA waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a Sterilization Consent form, DSHS 13-364. One of the following circumstances must apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (**1500 Claim Form field 19: “NOT ELIGIBLE 30 DAYS BEFORE DELIVERY”**); or
- The client did not obtain medical care until the last month of pregnancy (**1500 Claim Form field 19: “NO MEDICAL CARE 30 DAYS BEFORE DELIVERY”**); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**1500 Claim Form field 19: “NO SUBSTANCE ABUSE AT TIME OF DELIVERY.”**)

The provider must note on the 1500 Claim Form in field 19 or on the backup documentation, which of the above waiver condition(s) has been met. Required language is shown in parenthesis above. Providers who bill electronically, must indicate this information in the *Comments* field.

When does HRSA *not* accept a signed Sterilization Consent Form, DSHS 13-364? [Refer to WAC 388-531-1550(5) and (6)]

HRSA does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client’s state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent form, DSHS 13-364 is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent form, DSHS 13-364, to attach to their claim.

You must use Sterilization Consent form, DSHS 13-364, in order for HRSA to pay your claim. HRSA does not accept any other form.

To **download** DSHS forms, visit: <http://www1.dshs.wa.gov/msa/forms/eforms.html>
Scroll down to form number 13-364.

To **have a hard copy sent** to you, contact:
DSHS Forms Management Phone: 360.664.6047 or Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity desired;
- Your name and your office name; and
- Your full mailing address.

HRSA will deny a claim for a procedure received without the Sterilization Consent form, DSHS 13-364. HRSA will deny a claim with an incomplete or improperly completed Sterilization Consent Form. Submit the claim and completed Sterilization Consent form, DSHS 13-364, to:

**HRSA Division of Medical Benefits and Care Management
PO Box 45530
Olympia WA 98504-5530**

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent form, DSHS 13-364. Then send in the form with the electronic claims ICN.

Who completes the Sterilization Consent Form, DSHS 13-364?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page F.2: "When does HRSA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.
- If the initial Sterilization Consent form sections I, II, and III are completed by one physician and a different physician performed the surgery:
 - ✓ Complete another Sterilization Consent form entering the date it was completed; and
 - ✓ Submit both Sterilization Consent form with your claim.

Frequently Asked Questions on Billing Sterilizations

Physician 1500 Claim Forms

1. **If I provide sterilization services to TAKE CHARGE or Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?**

The scope of coverage for TAKE CHARGE and Family Planning Only clients is limited to contraceptive intervention only. HRSA does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are noncovered and will not be paid.

Note: Remember you must submit all sterilization claims with the **completed**, federally approved Sterilization Consent Form.

If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or C-Section delivery, how do I bill?

CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent form for payment.

If you do not have the consent form or it wasn't completed properly or the client was sterilized prior to the 30 days waiting period (client doesn't meet the criteria for HRSA to waive the 30 day waiting period) then the sterilization line on the claim will be denied and the other line items on the claim will be processed for possible payment.

2. **How will my Inpatient or Outpatient claim be paid when there are several services on the claim including a *non-payable sterilization procedure*?**

Inpatient Claims

For hospitals that are paid either DRG or RCC:

HRSA is unable to exclude the sterilization service and pay the rest of the claim. Therefore, the entire claim is denied. **The hospital should submit a bill, excluding the sterilization diagnosis, procedure and associated sterilization costs from the bill.** The hospital should document in their claim file the reason the sterilization was not billed such as: "didn't have consent form completed correctly."

Outpatient Claims

For hospitals that are paid either OPPS or Per Charges:

HRSA is unable to exclude the sterilization service and pay the rest of the claim. Therefore, the entire claim is denied. **The hospital should re-bill, exclude the sterilization diagnosis, procedure and associated sterilization costs from the bill.** The hospital should document in their claim file the reason the sterilization was not billed such as: "didn't have consent form completed correctly."

How to Complete the Sterilization Consent Form, DSHS 13-364?

- All information on the Sterilization Consent Form, DSHS 13-364, must be legible.
- All blanks on the Sterilization Consent Form, DSHS 13-364, must be completed *except* race, ethnicity, and interpreter’s statement (unless needed).
- HRSA does not accept “stamped” or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form, DSHS 13-364:

Section I: Consent to Sterilization	
Item	Instructions
1. Physician or Clinic:	Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization. This may be different than performing physician if another physician takes over. <i>Examples: Clinic – ABC Clinic. Physician – Either doctor’s name, or doctor on call at ABC Clinic.</i>
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent Form, DSHS 13-364.
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn’t have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent Form, DSHS 13-364. Must be signed in ink.

(Continued next page)

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8. Month/Day/Year:	<p>Date of consent. Must be date that client was initially counseled regarding sterilization.</p> <p>Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). Note: This is true even of shorter months such as February.</p> <p>The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8.</p> <p>Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005.</p> <p>If less than 30 days, refer to page F.2/F.3: "When does HRSA waive the 30 day waiting period?" and section IV of Sterilization Consent Form, DSHS 13-364.</p>
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Section II: Interpreter's Statement

Item	Instructions
9. Language:	Must specify language into which sterilization information statement has been translated.
10. Interpreter:	Must be interpreter's name. Must be interpreter's original signature in ink.
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent

Item	Instructions
12. Name of individual:	Must be client's first and last name. Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	Instructions
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent Form, DSHS 13-364.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page F.2/F.3: "When does HRSA waive the 30 day waiting period?" and section IV of the Sterilization Consent Form, DSHS 13-364.
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be <i>expected</i> date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who actually performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent Form, DSHS 13-364(x).
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":
 - a. Section I: Consent to Sterilization: "**I am at least 21...**"
 - b. Section III: Statement of Person Obtaining Consent: "**To the best of my knowledge... is at least 21...**"
 - c. Section IV: Physician's Statement: "**To the best of my knowledge... is at least 21...**"



SAMPLE STERILIZATION CONSENT FORM NEEDING CLIENT STATEMENT FORM

NOTE: 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.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) Dr. Tim Lu
Physician or Clinic

When I first asked 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 Aid to Families with Dependent Children (AFDC) 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 that I will be sterilized by an operation known as a

(2) tubal ligation The discomforts, risks, and
Specify type of operation

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 (30) 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) August 1, 1971
Month Day Year

I (4) Jane Doe hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) Dr. Tim Lu
Physician

by a method called (6) tubal ligation My consent
Specify type of operation

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) August 20, 2001
Signature Month Day Year

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

- American Indian or Alaska Native
- Black (not of Hispanic origin)
- Hispanic
- Asian or Pacific Islander
- White (not of Hispanic origin)

SECTION II: 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 this consent. I have also read him/her the consent form in (9) _____ language and explained

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter Date

DSHS 13-364 (Rev. 12/2002)

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Jane Doe signed the consent form, I
Name of Individual

explained to him/her the nature of the sterilization operation.

(13) tubal ligation the fact that it is intended to be
Specify type of operation

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 understand the nature and consequences of the procedure.

(14) _____ (15) August 20, 2001
Signature of person obtaining consent Date

(16) US Clinic
Facility

(17) PO Box 123, Anywhere, WA 98000
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) Jane Doe (19) October 1, 2002
Name of Individual to be sterilized Date of sterilization operation

I explained to him/her the nature of the sterilization operation

(20) tubal ligation The fact that it is intended to be
Specify type of operation

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 delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

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

- Premature delivery
Individual's expected date of delivery (21) _____
- Emergency abdominal surgery (describe circumstances)

(22) _____ (23) October 1, 2002
Physician's Signature Date

(24) Mary Williams
Physician's Printed Name

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STERILIZATION CONSENT FORM FOR A CLIENT 18 TO 20 YEARS OF AGE

NOTE: 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.

<p>SECTION I: CONSENT TO STERILIZATION</p> <p>I have asked for and received information about sterilization from</p> <p>(1) <u>Dr. Tim Lu</u> <small>Physician or Clinic</small></p> <p>When I first asked 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 Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.</p> <p>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.</p> <p>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 that I will be sterilized by an operation known as a</p> <p>(2) <u>tubal ligation</u> The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.</p> <p>I understand that the operation will not be done until at least thirty (30) 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.</p> <p>I am at least 21 16 years of age and was born on (3) <u>August 1, 1984</u> <small>Month Day Year</small></p> <p>I (4) <u>Jane Doe</u> hereby consent of my own free will to be sterilized by (5) <u>Dr. Tim Lu</u> <small>Physician</small></p> <p>by a method called (6) <u>tubal ligation</u> My consent expires 180 days from the date of my signature below.</p> <p>I also consent to the release of this form and other medical records about the operation to:</p> <ul style="list-style-type: none"> • 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. <p>I have received a copy of this form.</p> <p>(7) _____ (8) <u>August 20, 2001</u> <small>Signature Month Day Year</small></p> <p>You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check):</p> <p><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black (not of Hispanic origin)</p> <p><input checked="" type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> White (not of Hispanic origin)</p> <p>SECTION II: INTERPRETER'S STATEMENT</p> <p>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 this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.</p> <p>(10) _____ (11) _____ <small>Interpreter Date</small></p>	<p>SECTION III: STATEMENT OF PERSON OBTAINING CONSENT</p> <p>Before (12) <u>Jane Doe</u> signed the consent form, I explained to him/her the nature of the sterilization operation.</p> <p>(13) <u>tubal ligation</u> the fact that it is intended to be a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.</p> <p>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.</p> <p>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.</p> <p>To the best of my knowledge and belief, the individual to be sterilized is at least 21 16 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.</p> <p>(14) _____ (15) <u>August 20, 2001</u> <small>Signature of person obtaining consent Date</small></p> <p>(16) <u>US Clinic</u> <small>Facility</small></p> <p>(17) <u>PO Box 123, Anywhere, WA 98000</u> <small>Address</small></p> <p>SECTION IV: PHYSICIAN'S STATEMENT</p> <p>Shortly before I performed a sterilization operation upon</p> <p>(18) <u>Jane Doe</u> (19) <u>October 1, 2001</u> <small>Name of individual to be sterilized Date of sterilization operation</small></p> <p>I explained to him/her the nature of the sterilization operation</p> <p>(20) <u>tubal ligation</u> 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 benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 16 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.</p> <p>(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)</p> <p>(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.</p> <p>(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)</p> <p><input type="checkbox"/> Premature delivery Individual's expected date of delivery (21) _____</p> <p><input type="checkbox"/> Emergency abdominal surgery (describe circumstances)</p> <p>(22) _____ (23) <u>October 1, 2001</u> <small>Physician's Signature Date</small></p> <p>(24) <u>Dr. Tim Lu</u> <small>Physician's Printed Name</small></p>
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DSHS 13-364 (Rev. 12/2002)

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Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006**, HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at: <http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html> or request a paper copy from the Department of Printing (see Important Contacts section).

HRSA requires HRSA-approved Family Planning providers to list the National Drug Code (NDC) number **on all drug claims** and the amount of drug given to the client in Box 19 of the 1500 Claim Form, or in the *Comments* section of the electronic 1500 Claim Form, when billing for an unlisted contraceptive identified by an EPA number.

The following 1500 claim form instructions relate to *HRSA-Approved Family Planning Providers Billing Instructions*. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:
800.562.3022

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