Health and Recovery Services Administration (HRSA)

Family Planning Provider

Billing Instructions for:

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

ProviderOne Readiness Edition

[Chapter 388-532 WAC]

About This Publication

This publication supersedes all previous Department/HRSA *Family Planning Provider Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

> **Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected

Copyright Disclosure

How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

Table of Contents

Table of Contents (cont.)

Table of Contents (cont.)

Section F: Sterilization

Important Contacts

Note: This section contains important contact information relevant to family planning providers. For more contact information, see the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider	**Family Planning program manager**: Phone: 1-360-725-1664; or **TAKE CHARGE program manager**: Phone: 1-360-725-1652
TAKE CHARGE providers wanting to submit a change of address, phone number, or fax number	**Family Planning program manager**: Phone: 1-360-725-1664; or **TAKE CHARGE program manager**: Phone: 1-360-725-1652
Obtaining the TAKE CHARGE Application form, DSHS 13-781 (for clients)	To **download** Department forms, visit: http://www1.dshs.wa.gov/msa/forms/eforms.html scroll down to form # 13-781.
Obtaining information regarding the Family Planning program	**Visit the Family Planning Resources link on the Department/HRSA web site:** http://hrsa.dshs.wa.gov/familyplan/ **E-mail the Provider Relations unit:** providerinquiry@dshs.wa.gov **Contact the Family Planning program manager** Family Services Section PO Box 45530 Olympia, WA 98504-5530 Phone: 1-360-725-1664

<table>
<tr><th>Topic</th><th>Contact Information</th></tr>
<tr><td>Obtaining information regarding the TAKE CHARGE program</td><td>Visit the Family Planning Resources link on the Department/HRSA web site:
http://hrsa.dshs.wa.gov/familyplan/

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

Contact the TAKE CHARGE program manager:
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
Phone: 1-360-725-1652

TAKE CHARGE Eligibility Unit
PO Box 45531
Olympia, WA 98504-5531
Phone: 1-877-787-2119
Fax: 1-866-841-2267</td></tr>
<tr><td>Submitting the client's TAKE CHARGE application on-line</td><td>You must be registered with the Department to submit your client's TAKE CHARGE application on-line. To register with the Department, contact:

Family Planning Program Manager
Phone: 1-360-725-1664</td></tr>
<tr><td>Obtaining pharmacy information</td><td>Visit the Department/HRSA Pharmacy web site:
http://hrsa.dshs.wa.gov/pharmacy/</td></tr>
<tr><td>Finding out about payments, denials, claims processing, or Department managed care organizations</td><td rowspan="4">See the Department/HRSA Resources Available web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html</td></tr>
<tr><td>Electronic or paper billing</td></tr>
<tr><td>Finding Department documents (e.g., billing instructions, # memos, fee schedules)</td></tr>
<tr><td>Private insurance or third-party liability, other than Department managed care</td></tr>
</table>

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

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 the Department'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 the Department for the TAKE CHARGE program. [WAC 388-532-710]

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

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 Department 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]

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]

Department-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 the Department; and
- Been given special permission to bill for family planning laboratory services provided to self-referred clients enrolled in a Department managed care plan through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA).

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]

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]

Health and Recovery Services Administration (HRSA) - The administration within Department 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.

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

Medical Identification card(s) – See *Services Card*.

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.

Medicare - Health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD).

National Provider Identifier (NPI) – A system for uniquely identifying all Providers of health care services, supplies, and equipment.

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]

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system assigned number that uniquely identifies a single Client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

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]

Services Card – A plastic "swipe" card that replaces the paper Medical Assistance ID Card and will be issued when ProviderOne becomes operational. This card has a magnetic strip that gives providers the option to acquire and use swipe card technology as one method to access the most up-to-date client eligibility information. Some differences between the new plastic swipe card and the old paper Medical ID Card are:

- The Services Card will be issued one time, not on a monthly basis.
- The Services Card will only display the client's name and ProviderOne Client ID number.
- The Services Card will not display eligibility type, coverage dates, or managed care plans.
- The Services Card doesn't guarantee eligibility; providers will need to verify client identification and complete an eligibility inquiry.

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 - The Department'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 the Department to participate in TAKE CHARGE by:

- Being an approved Department 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]

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

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.

Reproductive Health Services

How Does the Department Define Reproductive Health Services?
[WAC 388-532-001]

The Department 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 the Department for reproductive health services provided to eligible clients, physicians, advanced registered nurse practitioners (ARNPs), licensed midwives, and Department-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)]

The Department covers limited, medically necessary reproductive health services for clients who are on a Benefit Service Package (BSP) that covers reproductive health services.

> **Note:** Refer to the *Scope of Coverage Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **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:

- The Department covers reproductive health services under Emergency Medical Only programs **only** when the services are directly related to an emergency medical condition.

- The Department pays Medicare premium copays, coinsurance, and deductibles for Qualified Medicare Beneficiary (QMB) clients only.

Which Reproductive Health Services May a Client Enrolled in a Department Managed Care Plan Receive Outside of the Plan? [Refer to WAC 388-532-100(2)]

Clients enrolled in a Department 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:

- A Department-Approved Family Planning Provider; or
- A Department-contracted local health department/STD-I clinic; or
- A Department-contracted provider who provides abortions; or
- A Department-contracted pharmacy (see the Department/HRSA *Prescription Drug Program Billing Instructions*) for:
  - ✓ Over-the-counter contraceptive supplies; and
  - ✓ Contraceptives and STD-I related prescriptions from a Department-approved Family Planning provider or Department-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 the Department/HRSA *Prescription Drug Program Billing Instructions)*

- **OTC contraceptives, drugs, and supplies**
(See the Department/HRSA *Prescription Drug Program Billing Instructions*)

- **Maternity-related services**
(See the Department/HRSA *Physician-Related Services Billing Instructions*)

- **Abortions**
(See the Department/HRSA *Physician-Related Services Billing Instructions*)

- **Sterilization** procedures that meet the requirements of the Department/HRSA *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.

Services for Women (cont.)

In addition to the reproductive health services listed in the Department/HRSA *Physician-Related Services Billing Instructions*, the Department 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; and
    - ➢ 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; and
    - ➢ 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 Gonorrhea (GC) and Chlamydia (CT) test must be sent to a laboratory enrolled as a Department provider 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, the Department 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.

Services for Women (cont.)

> **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.

- **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).

Services for Women (cont.)

- **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.

Services for Men

In addition to the reproductive health services listed in the Department/HRSA *Physician-Related Services Billing Instructions*, the Department 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 the Department/HRSA *Prescription Drug Program Billing Instructions*).

- **Sterilization** procedures that meet the requirements of the Department/HRSA *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 and Claim Forms* 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]

The Department does not cover the reproductive health services listed as noncovered in the Department/HRSA *Physician-Related Billing Instructions*. The Department 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: The Department pays providers for covered reproductive health services using the Department/HRSA Physician-Related Services Fee Schedule. This fee schedule may be viewed and downloaded at: http://hrsa.dshs.wa.gov/RBRVS/Index.html#P.

Billing

Department-Approved Family Planning Clinics that Dispense Contraception:

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

- **For services**: Bill the Department your *usual and customary fee* (the fee you bill the general public). The Department's payment is either your *usual and customary fee* or the Department's maximum allowable fee, whichever is less.
- If a Department 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 NPI 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 **the Department** 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 the Department 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 a Department managed care plan and who self-refer to a Department-Approved Family Planning Provider or Department-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 the Department's 60-day post pregnancy 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 Services Card. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Services Card.

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

To be paid by the Department for services provided to clients eligible for the Family Planning Only program, physicians, advanced registered nurse practitioners (ARNPs), and Department-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 the *Definitions & Abbreviations* 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).

The Department 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; and
    ➢ 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; and
    ➢ 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 enrolled as a Department provider 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 Section C 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.*

- **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 the Department/HRSA *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:

  ✓ 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?

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

Contraceptives and supplies that can be dispensed from a Department-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 Nitrofuran 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.

Over-the-counter, nonprescribed 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 using a Services Card.

Hormonal Contraceptives Dispensed from Department-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.

The Department'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 is only covered by the Family Planning Only program 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: The Department 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 the Department detailing the circumstances and conditions that caused the need for the inpatient services in order for the Department to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-04, CMS-1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to the Department. See the *Important Contacts* section.

Reimbursement

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

Fee Schedule: The Department limits reimbursement under the Family Planning Only program to visits and services listed on the *Family Planning Fee Schedule* 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 the Department your *usual and customary fee* (the fee you bill the general public). The Department's payment is either your *usual and customary fee* or the Department's maximum allowable fee, whichever is less.

- If a Department/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 NPI 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 **the Department** 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 the Department 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 noncontraceptive 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 a Department-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. The Department 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 in Section E. 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 Section E 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 a Department-Approved Family Planning Provider (see the *Definitions & Abbreviations* section);
- Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to the Department's TAKE CHARGE program guidelines; and
- Participate in the Department'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 Department 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 Department staff; and
- Referral for clients regarding available and affordable non-family planning primary care services.

Evaluation and Research Responsibilities

If requested by the Department, 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)]

The Department 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.

The Department pays for these services under the rules and fee schedules applicable to the specific services provided under the Department'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 Department 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 Services 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 the Department 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, the Department 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 Department 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 a Department-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 the Department.

- Application assistance in completing the document prior to submitting the TAKE CHARGE client application to the Department 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 Department-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, the Department 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.

3. If the client is a citizen and citizenship has not been previously determined by the Department, 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 Department 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 Department 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. The Department 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 Department 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 Services 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 the Department 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.

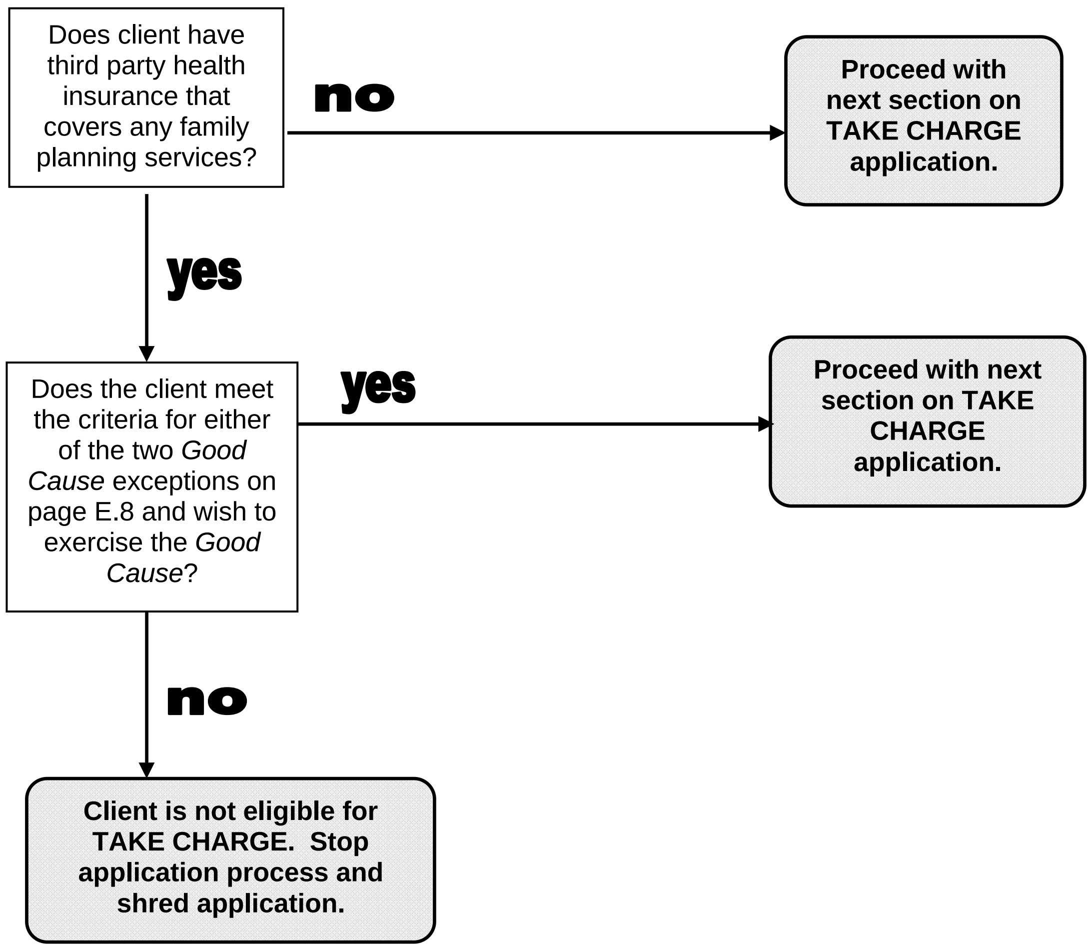
Active duty military:

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 13-789). This affidavit must be kept in client's chart until the Department 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:** The Department 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:

- The Department 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**: The Department 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:** The Department issues only one TAKE CHARGE Services 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 Department program that covers family planning services, the client is **no longer eligible** for TAKE CHARGE.

> **Do not** bill the Department 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 Services 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, the Department'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
- The Department needs more information in order to complete the eligibility determination (this will be indicated by a note in the comment box).

Eligibility Approved

If the Department approves eligibility, the client will receive a TAKE CHARGE Services Card in the mail, along with a TAKE CHARGE brochure.

In some instances, the Department mails the TAKE CHARGE Services 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 Services 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 the Department 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 Department 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 1-877-787-2119.

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.**

The Department 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; and
  - ➢ 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; and
  - ➢ 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 enrolled as a Department provider 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 Section C 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.*

- **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 bebilled 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 the Department/HRSA *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

<table>
<tr><th>Visit</th><th>Performed by</th><th>Billing codes</th></tr>
<tr><td rowspan="2">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.</td><td>ARNP, PA, MD</td><td>Preventive code 99394 – 99396 with modifier 52.</td></tr>
<tr><td>RN, LPN, medical assistant, certified nurse assistant or a trained and experienced health educator.</td><td>99211</td></tr>
<tr><td>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.</td><td>ARNP, PA, MD</td><td>Bill code G0101. Must be billed with a diagnosis from V25 series, excluding V25.3.</td></tr>
</table>

- **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.

Services for Men

The Department 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 the Department/HRSA *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 the Department to evaluate the reimbursement of the preventive codes. See Section E 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. The Department 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.

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.

- 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.

Component B: Assess and address other client personal considerations, risk factors, and behaviors that impact their use of contraception.

At a minimum, assess the following:

- 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).

Component C: Facilitate discussion of the male role in successful use of chosen contraceptive method, as appropriate (for himself or for his female partner).

- 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.

Component D: **Facilitate the client's contingency planning (the "back-up method") regarding the client's use of contraception, including planning for emergency contraception.**

- 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.

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.**

- 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 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	(Exact opposite of risk characteristics listed on the left.)

What Drugs and Supplies Are Paid Under the TAKE CHARGE Program?

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

Contraceptives and supplies that can be dispensed from a Department-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

Contraceptives and supplies that can be dispensed from a Department-approved Family Planning clinic.	**Family Planning-related drugs and supplies that can be dispensed from a pharmacy.**
	Cephalosporins – 3rdt generation Absorbable Sulfonamides Nitrofuran 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.

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 using a Services Card.

Hormonal Contraceptives Dispensed from Department-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.

The Department'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]

The Department 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.**

Inpatient Services: The Department 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 the Department a complete report of the circumstances and conditions that caused the need for the inpatient services in order for the Department to consider payment under WAC 388-501-0165. A complete report includes:

- A copy of the billing (UB-04, CMS-1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA at: 1-866-668-1214.

Reimbursement

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

Fee Schedule: The Department limits reimbursement under the TAKE CHARGE program to visits and services listed on the *Family Planning Fee Schedule* 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 the Department your *usual and customary fee* (the fee you bill the general public). The Department's payment is either your *usual and customary fee* or the Department's maximum allowable fee, whichever is less.
- If a Department-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.

> **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 NPI 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 **the Department** 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 the Department 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 noncontraceptive take-home drugs dispensed at a family planning clinic are not reimbursable.

Research and Evaluation Activities: The Department 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 the Department for TAKE CHARGE services without regard to their special rates and fee schedules. The Department does **not** pay FQHCs, RHCs, or Indian health providers under the encounter rate structure for TAKE CHARGE services.

Billing Timeline: The Department 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. The Department 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: The Department 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.

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 Department 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	FP	Adolescent (age 12 through 17)		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99385	FP	18-39 years		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99386	FP	40-64 years		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.

Comprehensive Family Planning Preventive Medicine Visits (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
99394	FP	Adolescent (age 12 through 17)		Established (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99395	FP	18-39 years		Established (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99396	FP	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] (*Seasonale* 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		The Department pays for a dispensing fee for each unit billed with S4993, J7303, J7304 and J3490. (Plan B).

Note: • The dispensing fee can be billed only for designated drugs which must be purchased and dispensed by a Department-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		
Injectables				
J1055		Medroxyprogesterone acetate inj for contraceptive use, 150 mg *(Depo-Provera)*		Allowed once every 67 days and only with V25, V25.02, V25.49, V25.9.
Intrauterine Devices (IUD)				
J7300		Intrauterine copper device *(Paragard)*		No Dispensing Fee Allowed
J7302		Levonorgestrel-releasing IUD *(Mirena)*		No Dispensing Fee Allowed
58300		Insertion of intrauterine device (IUD)		No Dispensing Fee Allowed
58301		Removal of intrauterine device (IUD)		No Dispensing Fee Allowed

Prescription Birth Control Methods (Continued)

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
Miscellaneous Contraceptives				
J7303		Contraceptive ring, each *(Nuvaring)*		Must be billed with S9430 (i.e., one unit of J7303 is entitled to one unit of S9430)
J7304		Contraceptive patch, each *(Ortho-Evra)*		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: The Department 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 CMS-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 Box19 on the CMS-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 CMS-1500 Claim Form and send in an invoice with your billing. Do not bill a dispensing fee for the device.

Note: The Department pays for Implanon (J7307) only once every three years, per client.

Unlisted Contraceptive Drugs and Supplies

> **Note:** The Department requires Department-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.

The Department has established coding requirements for the contraceptive drugs and supplies listed in the following tables.

Emergency Contraceptive Pills

Providers must bill the Department for emergency contraceptive pills as detailed below:

HCPCS Code	Modifier	Brief Description	Policy/ Comments
J3490	FP	Unlisted drug	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).

Non-Drug Contraceptive Supplies

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

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

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	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)	
55450		Ligation of sperm duct	
58600		Division of fallopian tube	
Laparoscopy			
58615		Occlude fallopian tube(s)	The Department pays for external occlusive devices **only** such as band, clip, or *Falope* ring. The Department does not pay for occlusive devices introduced into the lumen of the fallopian tubes. (i.e., *Essure*)
58670		Laparoscopy, tubal cautery	
58671		Laparoscopy, tubal block	The Department pays for external occlusive devices **only** such as band, clip, or *Falope* ring. The Department does not pay for occlusive devices introduced into the lumen of the fallopiantubes (i.e., *Essure*)

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	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 *Depo-Provera*.
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 *Depo-Provera*.
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 *Depo-Provera*.

Note: Radiology services must be performed by radiologists. The Department 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 Department managed care client. Only in this instance, with managed care clients, may a family planning provider bill the Department for laboratory services on a "pass-through" basis and only up to the amount billed by the laboratory.

Procedure Code	Modifier	Brief Description	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	
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	

Laboratory Services (Continued)

Procedure Code	Modifier	Brief Description	Policy/ Comments
87210		Smear, wet mount, saline/ink	
87270		Infectious agent antigen detection by immuno-fluorescent technique; chlamydia trachomatis	
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	

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 the Department pays directly to Department approved family planning clinics. All other covered drugs, must be obtained and billed by a pharmacy, see Section C. See numbered memoranda 06-06 for more NDC details.

Procedure Code	Modifier	Brief Description	Policy/ Comments
96372		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		Spectinomycn di-hcl inj, up to 2 g	
Oral Medication			
Q0144		Azithromycin dihydrate, oral, 1 g	
J3490	FP	Unlisted drugs	Use for: • Plan B only; and • Each 1 unit equals one treatment • Must be billed with S9430.

TAKE CHARGE Clients Only

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

Fee Schedule

You may view the Department/HRSA *Family Planning Fee Schedule* on-line at:

http://hrsa.dshs.wa.gov/RBRVS/Index.html#f

Billing and Claim Forms

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. The Department 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, discus 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

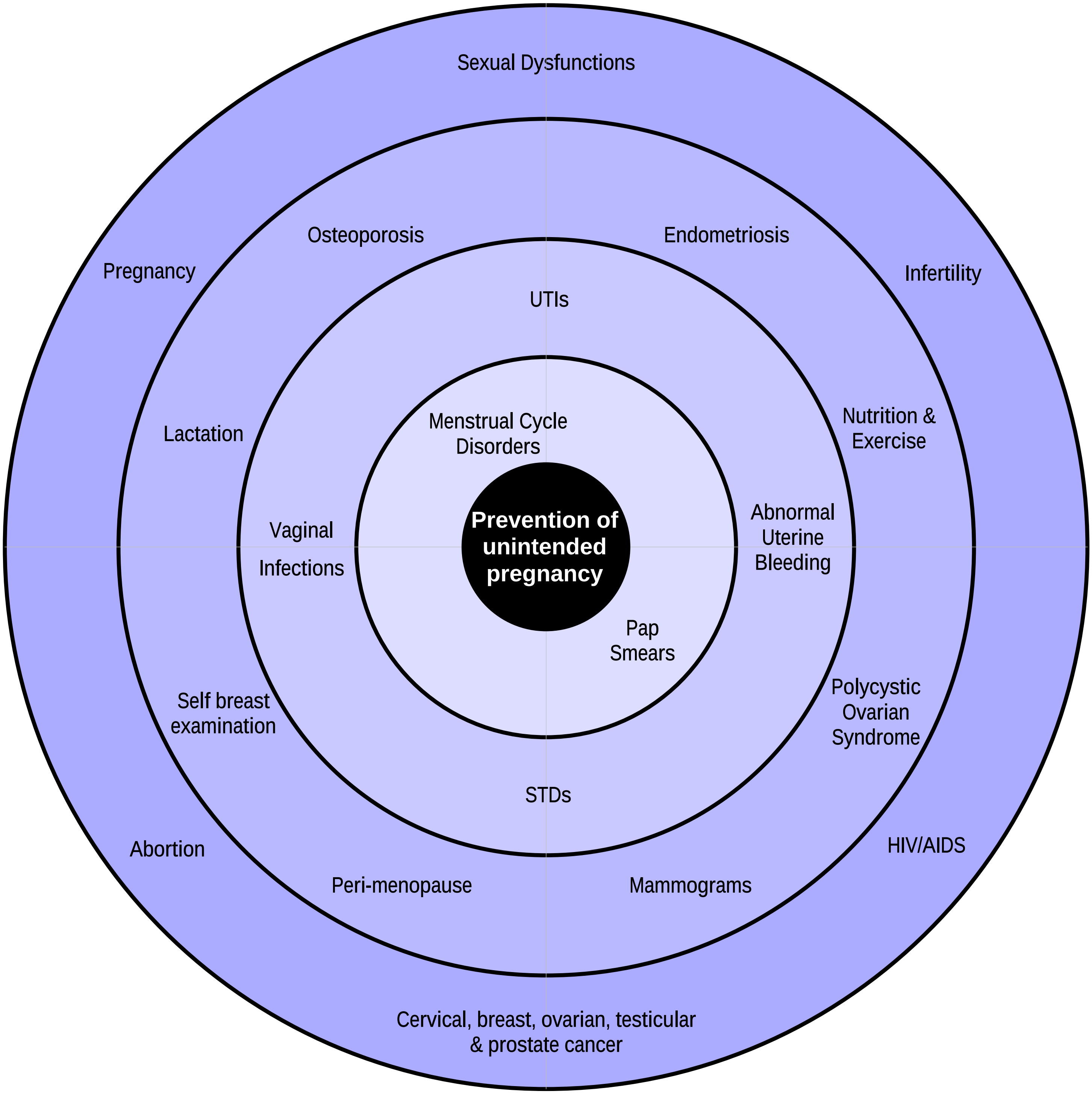
Client C comes into the clinic stating that she heard that her recent past partner "had something" and she wanted to be checked just to be sure. She is in a new relationship, using oral contraceptives and also using condoms for STD prevention. She is having no problems with her birth control method. 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 the Department 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 in Section B.

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 Section E.

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 Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

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 Additional Items must TAKE CHARGE Providers Keep in a Client's File [Refer to WAC 388-532-760]

In addition to the documentation requirements listed in WAC 388-502-0020, 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 Section F for how to obtain a copy of this form). For details about sterilization refer to the Department/HRSA *Physician-Related Services Billing Instructions*, or call Family Planning program manager 1-360-725-1664. 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 Services Card sent to and kept at the provider's office (if the client makes this request).

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The Department requires Department-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 CMS-1500 Claim Form, or in the *Comments* section of the electronic CMS-1500 Claim Form, when billing for an unlisted contraceptive identified by an EPA number.

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

What Are the Department's Reimbursement Requirements for Sterilizations? [Refer to WAC 388-531-1550(2)]

The Department 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:** The Department 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.

The Department 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. The Department does not accept any other forms attached to the claim. The Department pays after the procedure is completed.

The Department 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. The Department 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 the Department will pay the provider for the sterilization of a mentally incompetent or institutionalized client. The Department 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 the Department Waive the 30-Day Waiting Period? [WAC 388-531-1550(3) and (4)]

The Department 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.

The Department 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 *(***CMS-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 *(***CMS-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. *(***CMS-1500 Claim Form field 19:** *"NO SUBSTANCE ABUSE AT TIME OF DELIVERY.")*

The provider must note on the CMS-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 the Department *Not* Accept a Signed Sterilization Consent Form, DSHS 13-364? [Refer to WAC 388-531-1550(5) and (6)]

The Department 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 Department-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 the Department to pay your claim. The Department does not accept any other form.

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

The Department will deny a claim for a procedure received without the Sterilization Consent form, DSHS 13-364. The Department 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
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 the Department 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 CMS-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. The Department 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 the Department 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:

The Department 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 has: "didn't have consent form completed correctly."

Outpatient Claims

For hospitals that are paid either OPPS or Per Charges:

The Department 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 has: "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).
- The Department 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. *Examples: Clinic – ABC Clinic. Physician – Either doctor's name, or doctor on call at ABC Clinic.*
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)

8. Month/Day/Year:	Date of consent. Must be date that client was initially counseled regarding sterilization. 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. The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8. Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005. If less than 30 days, refer to page F.2/F.3: "When does the Department waive the 30 day waiting period?" and section IV of Sterilization Consent Form, DSHS 13-364.

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 the Department 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 *expected* 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
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ 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
Language

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

(10) ______________________ (11) ______________
Interpreter *Date*

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 that 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

DSHS 13-364 (Rev. 12/2002)

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.

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 18 years of age and was born on (3) August 1, 1984
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
Language

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 18 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, 2001
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 18 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 that 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, 2001
Physician's Signature *Date*

(24) Dr. Tim Lu
Physician's Printed Name