FEE COLLECTION POLICY

1. Delegate agencies must have a schedule of discounts (sliding fee scale) that is in compliance with the Title X Federal Regulations and provides for the following charges for family planning services for non-third party clients:
    a) No charge for a client whose income is at or below 100% of poverty.
    b) A schedule of discounts for clients with incomes between 101% and 250% of poverty.
    c) Full charge for clients whose income is above 250% of poverty. (Program Guidelines 6.3 (2-3), p.7-8)

2. Covered family planning services include routine family planning visits to initiate, continue or discontinue a contraceptive method. Additional covered family planning services may include, but are not limited to, provision of contraceptive methods and pregnancy testing and counseling. Some labs may also be covered by the family planning program.

3. Agencies must use the most recent Federal Poverty Guidelines to assess income level. The annual revision of the Federal Poverty Guidelines becomes available each spring.

4. Client income and family size must be documented in the client's financial chart or record. Computer files are considered part of the client's record (Program Guidelines 6.3 (4), p.8). A verbal or self-declaration of income is acceptable. Written income verification is also acceptable but not required. Agencies electing to ask for written income verification must complete formal income verification on all clients presenting for family planning services so that the process is fair and equitable for all clients. Client income and family size must be updated at least annually or as appropriate (Program Guidelines 6.3 (12), p.8). Delegates that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on client's self report (OPA Program Instruction Series, OPA 08-1,**http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-instructions/opa-08-01.html**).

    If delegate agencies choose to use written income verification, they cannot deny services or charge full fee for services to a client who fails to produce written income verification. In a case where a client does not have written income documentation, agencies must accept a verbal declaration and request that the client bring written documentation of income at their next visit.

5. Client eligibility for third party billing (i.e. insurance coverage) must be updated annually.

6. Adjustments to decrease or waive client charges based on extenuating circumstances are allowed. Collection of fees must be consistent with the client's ability to pay. Clients must not be denied services because of inability to pay current or past due amounts. (Program Guidelines 6.3, p.7)

7. Agencies must have a methodology for determining whether or not a minor is seeking "confidential" services (i.e., whether or not they are not receiving financial support from their family to pay for their family planning services). Minors presenting for services with parental consent**/support** or in the company of a parent/guardian must be queried about whether their parent/guardian is providing financial support for the visit. If so, the client may be charged as all others are: according to their family income and size. Minors should estimate family income if they are not certain of actual incomes. However, if a minor seeks "confidential" services, the minor must be income coded on the basis of the minor's income and family size (number of individuals supported by that income). Delegate agencies may not calculate an imputed value of room and board when determining the minor's income. (Program Guideline 6.3 (8), p.8; OPA Program Instruction Series 97-1)

8. Delegate agencies must provide clients with a statement at the time of service that details the full charges, discounts, amount paid, and the balance, if any, which the client is expected to pay. **It is not acceptable to only offer the client a copy of the statement or bill. Clients who are responsible for paying any fee for their family planning services must be routinely and directly provided a bill for such at the time of services.** (Program Guideline 6.3 (1 & 7), p.7-8)

9. Reasonable efforts to collect past due amounts, including the mailing of bills, must be undertaken, so long as client confidentiality is not jeopardized. Collections of past due amounts must not be done in a coercive manner. Delegates must have a centralized system to determine how much money is owed by clients and how long the debt is outstanding and not yet paid. (Program Guideline 6.3 (9), p.8)

10. In cases where a third party payer is responsible, bills must be submitted to that party. Bills to third parties must show total charges without applying any discount. Agencies must bill all third parties legally authorized or legally obligated to pay for services. (Program Guidelines 6.3 (1, 3 & 4), p.8)

    a) If a client with private insurance is willing to bill the insurance company, this is allowable. However, it is preferable for the agency to directly bill the insurance company. If the client is willing to bill the insurance company, the client should be given a copy of the statement showing what services were provided and what the client actually paid (e.g., a super bill).

    b) If a client has private insurance and is not willing to submit the bill, the agency must make efforts to determine if they are a covered provider and if so, submit the bill.

    c) If a client has private insurance and states that her/his plan does not cover family planning services, this must be documented. The agency is then not required to bill the third party.

    d) If the family planning agency is not a covered provider for a given insurance plan, direct billing is not required. However, the agency must have documents on file to show that they are not a covered provider. The agency must verify and document whether or not they are a covered provider with each new insurance plan and annually thereafter.

e) Agencies may elect to submit the bill at full fee to the insurance company and defer the charge to the client at the time of service. If the insurance company refuses all or part of the bill, the agency may charge the balance to the client after applying the discount according to the sliding fee scale.

f) When a contract is in place with an insurance carrier, the terms of the contract (co-pay requirements, acceptance of reimbursement as full payment, fees set by the third party, etc.) must be followed. If a client is in the zero pay category (less than 100% of the federal poverty level), and a co-pay is required, the client may not have money for the co-pay. In that case, the clinic can choose to waive the co-pay.

11. Donations by clients may be accepted under the following circumstances (Program Guidelines 6.3 (11), p.8):
    a) There is no schedule of donations.
    b) No bills are sent to clients for donations.
    c) No coercion is involved.
    d) No amount for a donation is suggested.
    e) Requests for donations are equitable. If agencies choose to request donations from clients, they must request them from all Title X clients, regardless of income level.

12. Most of the Colorado Title X Family Planning clinics receive funding from the Center for Disease Control and Prevention (CDC) sponsored Infertility Prevention Project (IPP), which the CDPHE STI/HIV Section administers to provide some assistance for Chlamydia and gonorrhea testing, treatment, and data collection. In consideration of this funding, Chlamydia tests must slide from full fee to zero for clients in the required populations (see Nursing Manual, STI Protocol, Section 2.11, Page 5). The azithromycin that delegate agency's receive from The Apothecary in Boulder is funded by the CDPHE STI/HIV Section. The policy of the CDPHE STI/HIV Section is that any azithromycin supplied through the grant is free to clients who are positive for Chlamydia, as well as their partners. Note that the drugs from The Apothecary are purchased through 340B pricing and must only be distributed to partners who have a record established with the delegate agency. For expedited partner therapy (drugs sent home with the infected client for a partner who is not a client of the clinic), drugs must be purchased at non-340B prices. Please refer to the Nursing Manual, STI protocol for more information about Expedited Partner Therapy and 340B drugs. Although delegate agencies may not charge for the azithromycin purchased through the STI/HIV Section, agencies may apply a sliding fee to any azithromycin purchased with the delegate agency's funds. Screening for gonorrhea is <u>not</u> a Title X requirement. However, if the agency uses a combined Chlamydia/gonorrhea test which provides both results, then the combination test must be charged as one on the sliding fee scale. Provision of treatment for gonorrhea is not a Title X requirement, therefore, delegate agencies can offer gonorrhea treatment at either a flat fee or according to the delegate agency's sliding fee scale.

FEDERAL POVERTY LEVELS/GUIDELINES

Federal poverty guidelines are issued each year in the *Federal Register* by the **U.S.** Department of Health and Human Services (HHS). The table is issued each year and is used to determine financial eligibility/sliding scale charges for certain federal programs, including Family Planning. The Administrative Consultant will issue the Federal poverty guidelines to delegate agencies each spring (usually in February or March when the current year's guidelines are issued) and it is expected that agencies will put the new guidelines into place within two weeks of receiving the information.

The most current guidelines can also be found at:
http://aspe.hhs.gov/poverty/index.shtml
or through the CDPHE Family Planning Program website:
http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618366665

INFORMING CLIENTS ABOUT SLIDING FEE SCALE POLICIES

The following information must be posted or provided to clients in writing:

- Fees for services are based on the client's income and family size and the client will be charged according to a fee scale.
- No one is denied services because of an inability to pay.
- Clients whose income is at or below 100% of poverty are not charged or billed for required services.
- Fees for minors requesting confidential services are based on their own income

The following page, "Dear Family Planning Client," summarizes the Title X requirements related to sliding fee scales as stated above and is for delegate agencies to use. The above fiscal information should be posted in agency clinics or given to clients in writing. The "Dear Family Planning Client" information sheets are available for downloading in English and Spanish from the CDPHE Family Planning program website at:
http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618366665. Agencies may also create their own documents to use in providing this information to clients.

Dear Family Planning Client,

We are pleased you have chosen to come to our clinic.

We want to provide you with low-cost, quality care.

A sliding fee scale, based on the cost of providing services, is used to determine your fee. The amount you are charged depends on how much money you earn and how many people you support.

Using a sliding fee scale allows us to provide care at much lower cost to you than other health care offices. No one will be denied birth control services because he or she can't pay.

If your income is at or below 100% of the federal poverty level, you will not be charged or billed for covered routine family planning clinic services related to your birth control method.

You may be billed for services that are not covered by the family planning program, and you are responsible for the costs of those services. This could include non-Title X services such as colposcopy, HIV testing, Chlamydia testing for clients not at risk, as well as complications resulting from Title X procedures, side effects from medications, etc.

If you are under 18, your fees are based only on the income available to you, which may or may not include your parent's income.

Family planning clinics receive some state and federal dollars to help pay for your care here. However, government funding has not kept up with our expenses.

Your donations are very important. They help keep our clinic open and this care available. We appreciate your donations, no matter how much you can give.

We will be happy to answer any questions you have about our services and fees.

DETERMINING FAMILY SIZE AND INCOME

Family Size

- Count all persons related by blood, marriage, or adoption living in the same household.

Income

- Count the gross income of each person in the family (as described above and in Section 1.1, Intro to Title X and CDPHE Family Planning Program)

- The following sources should be included when calculating gross income:

    - Salaries, wages, tips
    - Business profits
    - Royalties or commissions
    - Assistance from relatives or friends
    - Workers' compensation
    - Veterans' payments
    - Social Security cash benefits
    - Public assistance (Aid to Families with Dependent Children, Temporary Assistance for Needy Families (TANF) supplemental security income, non-Federally funded General Assistance or General Relief money payments)
    - Training stipends
    - Alimony
    - Military family allotments or other regular support from an absent family member or someone not living in the household
    - Pensions or annuities (including military retirement pay)

BILLING FOR SERVICES USING CPT AND DIAGNOSIS CODES

Introduction

Current Procedural Terminology (CPT) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by health care providers. Each procedure or service is identified with a five-digit code.[1] Such coding was devised to assure consistency among providers, standard reporting, and more accurate reimbursement for services (from third party insurers, including Medicaid).

All claims submitted to third party insurers for family planning services must also include an appropriate diagnosis code from the *International Classification of Diseases, Clinical Modifications* (ICD-9-CM) coding structure.

In order to be reimbursed by third party insurers, all claims must have (at a minimum) an appropriate CPT and ICD-9-CM code. This can be illustrated using a Patient Encounter Form or super bill *(sample is attached at the end of this section).*

It may be challenging initially to appropriately assign and link procedure code (CPT) and diagnosis (ICD-9-CM) code, this guide is intended to assist in this effort. To obtain additional resources other than this guide, including Medicaid maximum allowable rates, please contact the Administrative Consultant in the CDPHE Family Planning Program at (303) 692-2493.

*CPT code describes the services provided.	*ICD-9-CM describes the reason for the service.

Payment Guidelines

Upon receipt of appropriate documentation, the Colorado Department of Health Care Policy and Financing will base reimbursement by Medicaid on maximum allowable fees set for family planning services. Payment is subject to conditions, exclusions, and limitations set forth by the department. The payment of services shall be the lower of the following:

1) the amount specified in the department's fee schedule (maximum allowable reimbursement information for specific services available from the CDPHE Family Planning Program upon request)
2) the agency's usual and customary fee (in the case of the sliding fee schedule, the full fee charge for the service)

Note: When billing Medicaid for family planning services, CPT codes must include the family planning modifier "-FP" (Example: 99212-FP).

Private third party insurers have similar payment reimbursement policies as well. Please contact the insurance company for more information on its specific policy.

For additional information on Medicaid reimbursement, please visit the Provider Services and Billing Manuals sections of the Colorado Department of Health Care Policy and Financing's website.
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485906

[1] *Current Procedural Terminology, CPT 2011,* Chicago: AMA Press, 2010.

FAMILY PLANNING CPT CODES

Previously, Medicaid only approved the Evaluation and Management (E/M) Office Visit codes for family planning billing (99201-99204 for new clients and 99211-99214 for established clients). However, now family planning clinics can bill using the Preventive Medicine Services codes. These codes are age-based and are inclusive of the initial or periodic comprehensive exam, counseling, anticipatory guidance, and risk factor reduction interventions.

The actual definition is: "Initial [or periodic] comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of laboratory/diagnostic procedures…"

99384: Initial (new) adolescent 12 – 17 years
99385: Initial (new) 18 – 39 years
99386: Initial (new) 40 – 64 years
99394: Periodic (established) adolescent 12 – 17 years
99395: Periodic (established) 18 – 39 years
99396: Periodic (established) 40 – 64 years

These codes better describe the types of services family planning clinics provide in the form of initial and annual exams.

The family planning service codes listed in the Evaluation and Management (E/M) Services Guidelines as Office or Other Outpatient Services should be used for those services that are more "medical" in nature, frequently termed "revisits." Visits for STI evaluation, UTIs, Depo reinjections, repeat Pap tests, or other problems would be better described using the Evaluation and Management Office codes (99201-99204 for new or 99211-99214 for established clients). The descriptions for the levels of these E/M services recognize seven components, six of which are used in defining the level of services.[2] The components are:

- *History**
- *Examination**
- *Medical decision making**
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Please note, when counseling dominates more than 50% of the time spent with the physician or midlevel provider (face-to-face in the office), then time may be the determining factor for the level of E/M services. The extent of the counseling must be documented in the client's record.

*The first three components are considered the *key* components in selecting the level of service.

[2] *Current Procedural Terminology, CPT 2011,* Chicago: AMA Press, 2010.

Definitions

- *New Patient:* A patient who has not yet received any professional services from the agency's family planning program within the past three years.

- *Established Patient:* A patient who has received professional services from the agency's family planning program within the past three years.

If a patient is new to the health center or has been a health center patient but has not received family planning services in the previous three years, the patient should be considered a new patient for family planning. If the patient is a health center patient and has received family planning services in the previous three years, the patient should be considered an established family planning client.

Preventive Patient Visit Codes

CPT CODE	DESCRIPTION
99384	Initial comprehensive preventive medicine visit for adolescent for ages 12-17 years • Initial family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.
99385	Initial comprehensive preventive medicine visit for ages 18 – 39 years. • Initial family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.
99386	Initial comprehensive preventive medicine visit for ages 40 - 64 years. • Initial family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.
99394	Periodic comprehensive preventive medicine visit for adolescent (age 12-17 years) • Annual family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.
99395	Periodic comprehensive preventive medicine visit for ages 18 – 39 years • Annual family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.
99396	Periodic comprehensive preventive medicine visit for ages 40 – 64 years • Annual family planning visit to include age and gender appropriate history, exam, counseling, anticipatory guidance, risk factor reduction interventions, lab and diagnostic procedures.

For revisits or visits of a more medical nature consider the following series of codes:

NOTE: A midlevel or physician must see the client to bill all of these codes except 99211.

New Patient Visits

CPT CODE **DESCRIPTION**

99201 New Patient Focused Visit

Presenting problems are self-limited or minor. Physicians typically spend 10 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making
    - Example: Counseling and treatment of male contact to positive Ct/GC

99202 New Patient Expanded Visit

Presenting problems are low to moderate. Physicians typically spend 20 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Straightforward medical decision making
    - Example: Initial evaluation of new client with UTI

99203 New Patient Detailed Visit

Presenting problems are of moderate severity. Physicians typically spend 30 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- A detailed history;
- A detailed examination; and
- Medical decision making of low complexity
    - Example: Initial evaluation of female with STI or vaginitis

99204 New Patient Comprehensive Visit

Presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:

- A comprehensive history
- A comprehensive examination; and
- Medical decision making of moderate complexity
    -
    - **Medicaid does not reimburse family planning clinics for this code**
    - Example: Initial evaluation of pelvic/testicular pain to rule out PID/epididymitis

* All visits listed above include counseling and/or coordination of care, including anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.

NOTE: Time spent face-to-face with patients is physician time. It is expected that another healthcare provider (nurse practitioner or registered nurse) may spend more time with patient than time noted above.

Established Patient Visits

CPT CODE DESCRIPTION

99211 Established Patient Minimal Visit

Usually, the presenting problems are minimal and may not require the presence of a physician or midlevel provider. Typically, a total of 5 minutes are spent with patient.

- Example: Depo injection, blood pressure recheck established client.

99212 Established Patient Focused Visit

Presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making
  - Example: Brief medical visit by mid-level or physician provider for evaluation of vaginitis or STI

99213 Established Patient Expanded Visit

Presenting problems are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:

- An expanded problem focused history;
- An expanded problem focused examination; and
- Medical decision making of low complexity
  - Example: Evaluation of established client by mid-level or physician provider with pelvic/testicular pain to rule out PID/epididymitis

99214 Established Patient Detailed Visit

Presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with patient.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:

- A detailed history;
- A detailed examination; and
- Medical decision making of moderate complexity
  - **Medicaid does not reimburse family planning clinics for this code**
  - Example: Evaluation of lower quadrant pain to rule out ectopic pregnancy

* All visits listed above include counseling and/or coordination of care, including anticipatory guidance, risk factor reduction, interventions, and the ordering of appropriate laboratory and diagnostic procedures.

NOTE: Time spent face-to-face with patients is physician time. It is expected that another healthcare provider (nurse practitioner or registered nurse) may spend more time with patient than time noted above.

Preventive Counseling Visits

When a face-to face visit is for the purpose of promoting health, preventing illness or risk factor reduction, it may be more appropriate to use the following counseling codes. This one set of codes is used for both new and established clients. These services can be provided by any qualified health care professional.

CPT CODE	DESCRIPTION
99401	Preventive Medicine Counseling *Provided to an individual; approximately 15 minutes* • Example: 3 month method evaluation with no problems and not requiring a physical exam
99402	Preventive Medicine Counseling *Provided to an individual; approximately 30 minutes* • Example: Pregnancy testing and options counseling • Example: 'Delayed exam' for initiating a contraceptive method

In general, counseling codes include the visit. An additional visit code should not be charged, See "Modifiers" below for when an additional visit can be charged.

Procedure Codes

CPT CODE	DESCRIPTION
11981	Insertion, **non-biodegradable drug delivery implant**
11982	Removal, **non-biodegradable drug delivery implant**
11983	Removal **with** reinsertion, **non-biodegradable drug delivery implant**
57170	Diaphragm fitting (with instructions)
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)

In general the procedure codes include the visit. An additional visit code should not be charged. See "Modifers" below for when an additional visit can be charged.

Modifiers

Modifiers are added to visit/procedure CPT codes to provide additional billing explanation. The most common modifiers that will be used in family planning clinics are listed below.

-25: Distinct E/M service by same provider on same day*

This modifier can be used when a second E/M service is provided by the same provider on the same day. The second visit CPT code must be significant and separately identifable. In other words, it must be for a service unrelated to the first code and must be substantiated by documention in the chart. The modifier should be attached to the second (additional) visit CPT Code.

-51: Multiple procedures (similar operation)*

This modifier can be used to indicate when additional procedures are done on the same day. For example, if an IUD is removed and an implant is inserted. The code with the highest Relative Value Unit (RVU) or charge should be reported first and the modifer should be added to the less valuable procedure.

-53: Discontinued procedure

This modifier can be used to indicate when a procedure was attempted, but unsuccessful.

*Agencies should check with the third parties being billed to determine whether or not they will pay for additional visits/procedures on the same day.

**Some third party payers will only pay for one discontinued procedure for the client per year.

Contraceptive Supplies

CPT CODE	DESCRIPTION
A4266	Diaphragm
A4267	Condom, male
A4268	Condom, female*
A4269	Spermicide (e.g. foam, gel) - each*
J1055	Contraceptive injectable - per three-month dose (i.e. Depo Provera)
J7300	Intrauterine device, copper T380A (Paragard)
J7302	Intrauterine device, levonorgestrel releasing, LNG-IUS (Mirena)
J7303	Hormone releasing vaginal ring (i.e. Nuvaring) - each
J7304	Hormone containing patch (i.e. Ortho Evra) - each
J7307	Etonogestrel implant, 68 mg. (**Nexplanon**)
S4993	Oral contraceptives (per cycle), all brands, including Plan B

For implantable contraceptives, IUDs, Depo-Provera, etc, charge CPT code for procedure and CPT code for device/supply.
*Medicaid does not cover female condoms or spermicide

NOTE: If the cost of the contraceptive supply is less than the maximum allowable rate listed on the Medicaid Fee Schedule, the provider must submit the claim for the actual cost.

Other Supplies

CPT CODE	DESCRIPTION
J3490	Medications related to family planning services. *If billing this code to insurance, including Medicaid, the name of the medication must be specified. Including, but not limited to:* -Metrogel -Monistat -Monistat Dual Pack -Sultrin -Terazol 3, Terazol 7, Terazol Cream
J0696	-Rocephin
Q0144	-Zithromax

Lab Codes (for labs typically done in the clinic)

Note: labs that are not performed in the clinic are not billed to third parties by the clinic. The lab performing the test(s) should bill insurance for the test(s).

CPT CODE	DESCRIPTION
81000	Urinalysis, non-automated with microscopy (by dipstick or tablet reagent)
82948	Glucose, blood reagent strip
85013	Spun MicroHematocrit
85018	Hemoglobin (Hgb)
86701	Rapid HIV 1
87210	Smear, Wet Mount, or
Q0111	Smear, Wet Mount with preparations
99000	Handling and/or conveyance of specimen for transfer from clinic to a laboratory (e.g., Chlamydia or Pap smear specimens)
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick)

Other Procedure Codes – Female Genital System

CPT CODE	DESCRIPTION
56501	Destruction of lesion(s) on vulva, any method, simple
56605	Biopsy of vulva or perineum, one lesion
+56606	Each separate additional lesion
57061	Destruction of vaginal lesions, any method, simple
57420	Colposcopy of entire vagina, with cervix if present
57421	Colposcopy of entire vagina, with cervix if present, with biopsy
57452	Colposcopy of the cervix including upper/adjacent vagina
57454	Colposcopy of the cervix including upper/adjacent vagina, with biopsy
57511	Cryocautery of the cervix, initial or repeat
58100	Endometrial sampling, separate from colposcopy procedure
+58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (add on to code for primary procedure - colposcopy)

Other Procedure Codes – Male Genital System

CPT CODE	DESCRIPTION
00921	Anesthesia for vasectomy, unilateral or bilateral
54050	Destruction of lesion(s) on penis (e.g. condyloma, papilloma) chemical
54056	Destruction of lesion(s) on penis- cryosurgery
55250	Vasectomy, unilateral or bilateral (includes post-op semen examination)

ICD-9-CM DIAGNOSIS CODES

As previously mentioned, ICD-9-CM codes describe the reason for the visit. All claims submitted to third party insurers for family planning services must include an appropriate diagnosis code from the *International Classification of Diseases, Clinical Modifications* (ICD-9-CM) coding structure as well as a CPT code. The codes most likely to be used in family planning clinics, corresponding to the appropriate CPT code include:

Diagnosis Codes

ICD-9-CM CODE	DESCRIPTION
V25	Encounter for contraceptive management
V25.0	General counseling and advice
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures (eg. fitting diaphragm, prescription of spermicide)
V25.03	Encounter for emergency contraceptive counseling and Prescription
V25.04	Counseling and instruction in natural family planning to avoid pregnancy
V25.09	Other counseling and advice for contraceptive management
V25.1	Insertion of intrauterine contraceptive
V25.11	Insertion of intrauterine device (IUD)
V25.12	Removal of intrauterine device (IUD)
V25.13	Removal and reinsertion of intrauterine device (IUD)
V25.2	Sterilization (interruption of fallopian tubes or vas deferens)
V25.4	Surveillance of previously prescribed contraceptive method(s)
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine contraceptive device surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Other contraceptive method surveillance
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management (e.g. postvasectomy sperm count)
V25.9	Unspecified contraceptive management

Other Diagnosis Codes

ICD-9-CM CODE	DESCRIPTION
939.2	Foreign body in vagina (e.g. forgotten tampon)

When the reason for the visit (ICD-9-CM code) is other than contraceptive in nature (example – follow up to abnormal Paps, vaginitis, etc.), other ICD-9 codes may need to be used to file insurance claims. The above list is not meant to be an exhaustive list. Please refer to the resource referenced below for more complete coding information.

More information and/or resources on CPT and ICD-9-CM Coding Can be Purchased From:
American Medical Association
Phone: (800) 621-8335
Website: https://catalog.ama-assn.org/Catalog/home.jsp

Please visit the Centers for Medicare and Medicaid web site for information about the transition form ICD-9 codes to ICD-10 codes, effective October 1, 2013. https://www.cms.gov/ICD10/

SUPER BILL

The following is a sample super bill. This type of form can be used to bill third party insurers. For this reason, the form does not include services such as labs which are sent off-site for processing. These labs are usually billed directly to the third party insurer by the laboratory. If agencies wish to use the super bill as a statement of all services provided to the client, they would need to add items such as off-site labs (Pap test, Chlamydia, gonorrhea, etc.) and other medications and supplies (antibiotics, Cycle Beads, BBT thermometers, etc.) for which the agency cannot bill third parties.

This form can be downloaded from the CDPHE Family Planning Program at:
http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618366665

<Insert new super bill >

INSERT NAME OF AGENCY
COMPLETE ADDRESS, PHONE NUMBER, FAX NUMBER

Date of Service:	**Clinic Presented at:**		
Last Name:	**First Name:**	**Middle Initial:**	**Gender:** ☐ Female ☐ Male
Birth Date:	**Age:**	**Phone Number:**	**Alt. Phone Number:**
Address:	**City:**	**State:**	**Zip:**
Medicaid: ☐ No ☐ Yes	**If yes, enter number:**		
Health Insurance: ☐ No ☐ Yes	**If yes, enter Insurance Company:**		**Insurance Phone Number:**
Policy Holder's Name:	**Policy Number:**	**Group Number:**	

New Patient Preventive Visit (Initial):		
99384	Age 12 – 17 years - Adolescent	
99385	Age 18 – 39 years	
99386	Age 40 – 64 years	
Established Patient Preventive Visit (Annual):		
99394	Age 12 – 17 years - Adolescent	
99395	Age 18 – 39 years	
99396	Age 40 – 64 years	
New Patient Medical Visit:		
99201	Focused Exam	
99202	Expanded Visit	
99203	Detailed Visit	
Established Patient Medical Visit:		
99211	Minimal Visit	
99212	Focused Exam	
99213	Expanded Visit	
Individual Counseling		
99401	Counseling 15 minutes	
99402	Counseling 30 minutes	
Procedures:		
11981	Insertion, **non-biodegradable drug delivery implant**	
11982	Removal, **non-biodegradable drug delivery implant**	
11983	Removal/reinsertion, **non-biodegradable drug delivery implant**	
57170	Diaphragm fitting (with instructions)	
58300	Insertion of intrauterine device (IUD)	
58301	Removal of intrauterine device (IUD)	
Contraceptive Supplies:		
A4266	Diaphragm	
A4267	Condom, male	
A4268	Condom, female	
A4269	Spermicide	
J1055	Contraceptive injectable	
J7300	Intrauterine device, Paragard	
J7302	Intrauterine device, Mirena	
J7303	Hormone releasing vaginal ring (Nuva Ring - each)	
J7304	Hormone containing patch (Evra - each)	
J7307	Etonogestrel Implant, 68 mg. (Implanon)	
S4993	Oral contraceptives/**Emergency contraception** (per cycle)	
Lab Codes:		
81000	Urinalysis, non automated	
81025	**Urine pregnancy test**	
82270	Fecal Occult Blood Screening	
82948	Glucose, blood reagent strip	
85013	Spun Microhematocrit	
85018	Hemoglobin	
86701	Rapid HIV 1	
87210	Smear, Wet Mount	
Q0111	Smear, Wet Mount with prep	
99000	Lab handling	
36415	Venipuncture (blood draw)	
36416	Collection of capillary blood specimen (finger stick)	

Other Codes – Female Genital System:		
56501	Destruction of lesion/s on vulva, simple	
56605	Biopsy of vulva or perineum, one lesion	
+56606	Each separate additional lesion	
57061	Destruction of vaginal lesions, simple	
57420	Colposcopy of the entire vagina, with cervix if present	
57421	Colposcopy of the entire vagina, with cervix if present, with biopsy	
57452	Colposcopy of the cervix, including upper/adjacent vagina	
57454	Colposcopy of the cervix, including upper/adjacent vagina, with biopsy	
57511	Cryocautery of the cervix, initial or repeat	
+58110	Endometrial sampling in conjunction with colposcopy	
Other Codes – Male Genital System:		
00921	Anesthesia for vasectomy, unilateral or bilateral	
54050	Destruction of lesions on penis, chemical	
54056	Destruction of lesion/s on penis - cryosurgery	
55250	Vasectomy, unilateral or bilateral	
Other Supplies:		
	<List all other therapeutics you carry here; These cannot be billed to Medicaid>	

Diagnosis Codes:		
	Encounter for contraceptive management:	
V25.0	General counseling and advice	
V25.01	Prescription of oral contraceptives	
V25.02	Initiation of other contraceptive device	
V25.03	Encounter for emergency contraceptive counseling and prescription	
V25.04	Counseling/instruction Natural Family Planning	
V25.09	Other counseling and advice for contraceptive management	
V25.11	Insertion of intrauterine device (IUD)	
V25.12	Removal of intrauterine device (IUD)	
V25.2	Sterilization - Vasectomy	
V25.4	Surveillance of previously prescribed contraceptive method/s	
V25.40	Contraceptive surveillance, unspecified	
V25.41	Contraceptive pill surveillance	
V25.42	Intrauterine contraceptive device surveillance	
V24.43	Implantable subdermal contraceptive surveillance	
V25.49	Other contraceptive method surveillance	
V25.5	Insertion of implantable subdermal contraceptive	
V25.8	Other specified contraceptive management	
V25.9	Unspecified contraceptive management	
939.2	Tampon Removal	
	List other diagnosis codes used	

Income Level	**1 2 3 4 5**
Today's Charges	**$**
Discounted Charge	**$**
Amount Paid	**$**
Balance Due	**$**
Donation	**$**

Patient Signature: _____

Form rev. 7/2012