C

C Family Planning

Family planning services are services provided to prevent or delay pregnancy.

C.1 Eligible Individuals

Eligible individuals are those females of childbearing age 10 through 55 years of age and males of any age who may be sexually active and meet the criteria for Medicaid eligibility. Family planning services **do not require a referral** for recipients in Medicaid's managed care programs.

Reimbursement will be made only for eligible Medicaid recipients. Eligibility should be verified **prior to rendering** services to **ANY** Medicaid recipient.

SOBRA-eligible Medicaid women are covered for family planning services through the end of the month in which the 60th postpartum day falls.

Plan First

The Plan First program is an 1115 Research and Demonstration waiver approved by the Centers for Medicare and Medicaid Services that extends family planning coverage for women ages 19 through 55. Please refer to the section, Plan First, for additional information.

C.1.1 Authorization for Recipient Services

The recipient must have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary on the part of the recipient and without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. **A recipient consent for services must be obtained at each Family Planning visit. A sign-in logbook may be used after the initial consent form has been signed.**

Age of Consent

Family planning services are available to:

- Females, any age, after onset of menses. If age 14 or over, no parental or other consent is required.
- Males, any age. If age 14 or over, no parental or other consent is required.
- If a child is under the age of 14, whether they are sexually active or not, parental consent is required.

C.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

C.2.1 Family Planning Visits

The following services are covered services when provided by Family Planning providers.

Initial Visit (99205-FP)

The initial visit is the first time a recipient receives family planning services. An initial visit is limited to one per provider per recipient per lifetime.

The initial visit requires the establishment of medical records, an in-depth evaluation of an individual including a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, and issuance of supplies or prescription. Counseling in the family planning setting is interactive and includes education. Counseling/education topics must be based on patient need and on protocol requirements.

PT+3 Teaching Method

All family planning counseling must utilize the **PT+3 teaching method**, after the provider has received training. The acronym, PT+3, means:

P = Personalize the PROBLEM,
T = "TAKLE" the problem
- T = set a Therapeutic Tone,
- A = Assess the knowledge level of the patient,
- K = provide Knowledge
- L = Listen for feedback,
- E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

At all points during the counseling and education process, the patient must be given the information in such a way as to encourage and support the exercise of choice. In order to support informed choice, certain informational elements should be offered. Due to the constraint of time, the topics are listed in order of priority. Priority One includes those topics that MUST be DISCUSSED with the patient. Priority Two includes those topics that can be presented to the patient in a written document, with verbal follow-up. Priority Three includes those topics that can be presented in written format only, with follow-up occurring should the patient need/desire further clarification.

At all times, the PT+3 method of teaching/counseling should be used so that time is targeted toward individual patient need.

Priority One Topics:

1. Patient expressed needs or problems
2. Contraception:
    a. Listing of the various options
    b. How to use
    c. Side effect management
3. Prevention of STDs including HIV
4. Breast self-exam or testicular self-exam

Priority Two Topics

1. Explanation of any screening or lab testing done
2. Services offered
3. Telephone number of office or instructions about accessing emergency care
4. Folic Acid

Priority Three Topics

1. Need for Mammogram
2. Anatomy and physiology

Billable laboratory services **for the initial and annual visits include:**

- Hemoglobin or hematocrit,
- Urinalysis,
- PAP smear,
- STD/HIV test, and
- Pregnancy testing.

Since a family planning visit may be the only medical encounter a female has, **performing the listed laboratory tests is encouraged at the initial and annual visits.** Pregnancy testing is covered during any visit where clinical indication is present and evaluation is needed. Any laboratory procedure performed within the past 30 days with available results need not be repeated. A pap smear may be accepted if done within the past 6 months and is considered normal.

The **physical assessment** is another integral part of the initial family planning visit. The following services, at a minimum, **must** be provided during the initial visit:

- Height, blood pressure, and weight check
- Thyroid palpation
- Breast and axilla examination accompanied by instruction for self-breast examination
- Abdominal examination and liver palpation
- Auscultation of heart and lungs
- Pelvic evaluation to include bimanual and recto-vaginal examination with cervical visualization
- Examination of extremities for edema and varicosity
- Testicular, genital, and rectal examination for males.

Annual Visit (99214-FP)

The annual visit is the re-evaluation of an established patient requiring an update to medical records, interim history, complete physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling using PT+3 teaching method, and adjustment of contraceptive management as indicated. An annual visit is **limited to one per calendar year**.

The services listed below must be provided during the annual visit:

- Updating of entire history and screening, noting any changes
- Counseling and education, as necessary, using the PT+3 teaching method
- Complete physical assessment as outlined in the “Initial Visit” requirements
- Laboratory tests as outlined under “Initial Visit”
- Issuance of supplies or prescription.

Periodic Revisit (99213-FP)

The periodic revisit is a follow-up evaluation of an established patient with a new or existing family planning condition. Four periodic visits are available per calendar year. These visits are available for multiple reasons such as contraceptive changes, issuance of supplies, or contraceptive problems (e.g. breakthrough bleeding or the need for additional guidance). Providers may utilize the appropriate **V254** diagnosis code, “Surveillance of previously prescribed contraceptive methods,” for a visit related to a contraceptive problem.

The following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure
- Interim history
- Symptom appraisal as needed

Documentation of any treatment/counseling including administration/issuance of contraceptive supplies.

NOTE:
Family Planning visits are not payable after sterilization.

Home Visit (99347-FP)

The home visit is a brief evaluation by a medical professional in the home of an established patient and is for the purpose of providing contraceptive counseling (using the PT+3 teaching method) and administration/**issuance of supplies** as indicated. The home visit is for postpartum women during the 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is limited to one per 60-day postpartum period.

To qualify for reimbursement for the home visit:

- Medical professionals who are licensed to administer medications such as oral contraceptives or to give injections must provide the home visit.
- The home visit must include: brief medical histories: family, medical, contraceptive, and OB/GYN, blood pressure and weight check, contraceptive education and counseling using the PT+3 teaching method assuring that the patient:
  - understands how to use the method selected,
  - how to manage side effects/adverse reactions,
  - when/whom to contact in case of adverse reactions, and the importance of follow-up.
  - scheduling of a follow-up visit in the clinic if needed
  - issuance or prescription of contraceptive supplies as appropriate.

The patient must give her signed consent for this visit.

Extended Family Planning Counseling Visit (99212-FP)

The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The extended family planning counseling visit is performed in conjunction with the 6-week postpartum visit in the office/clinic setting. The counseling services are those provided **above and beyond the routine contraceptive counseling that is included in the postpartum visit.** The purpose of this additional counseling time is to take full advantage of the window of opportunity that occurs just after delivery when the physical need for pregnancy delay is at a peak**.** Extended family planning counseling is limited to once during the 60-day post-partum period, and is not available for women who have undergone a sterilization procedure.

Services required:

- Contraceptive counseling and education
- STD/HIV risk screening and counseling
- Issuance of contraceptive supplies.

NOTE:

In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP.

STD/HIV Risk Screening and (Pre-HIV test) Counseling (99401, Diagnosis Code V259)

STD/HIV screening, counseling, and testing is necessary to identify infected persons who will benefit from medical treatment and to support and encourage all persons to practice responsible sex. Patients who contract ANY type of STD are at greater risk of contracting HIV and those who are HIV+ and contract any type of STD have a much greater chance of transmitting HIV. The best way to prevent HIV is to prevent an STD. For this reason, emphasis is being placed on STD/HIV screening and counseling in lieu of HIV testing only. The HIV pre-test counseling code will be used even though this activity is performed in conjunction with STD risk counseling. Document on the form provided in the Attachment section.

Basic requirements of STD/HIV screening and counseling are:

1. Determine degree of risk
2. Intervene with confrontation and counseling
3. Test for STDs and HIV as clinically indicated
4. Document using the form provided
5. Screen for risk at the initial and annual visit or as clinically indicated.

Requirements Detailed:

- Determine degree of risk.
- Screen for STD/HIV risk using the screening tool provided. See Attachments for a reproducible copy.
- Intervene with confrontation and counseling.
    a. Risk Level I - No risk factors identified. Minimal counseling required.
    b. Risk Level II - At Risk – Due to exposure to blood or blood products only. limited counseling required.
    c. Risk Level III - One or more risk factors present: Prevention Counseling required using the PT+3 method.
- Test for STDs and HIV as indicated by screening results and clinical symptoms.
- Document using the form provided.
- Screen for risk at the initial and annual visit or as clinically indicated.

At a minimum, screening for STD/HIV risk is to be done at these visits, however screening and offering STD and HIV testing should be done as necessary or appropriate.

Please note that the pre-test counseling may be billed regardless of whether the counseling session results in the drawing of blood or of STD testing.

STD/HIV Post-Test Counseling (99402, Diagnosis Code V259)

Post-test counseling is performed to provide the patient with test results. When STD testing results in a positive finding, the patient should be called in and told of test results and treated immediately. A plan of notification of partners with treatment should be developed. Counseling should focus on immediate treatment and future prevention efforts.

Post-test counseling for HIV testing, if negative, should emphasize and reinforce the HIV prevention message imparted during the pre-test counseling session. If positive results are obtained, this counseling visit should focus on

- the meaning of the test result,
- assisting with the emotional consequences of learning the result,
- providing a referral for and stressing the importance of getting into medical care as soon as possible,
- developing a plan to prevent transmission of HIV,
- developing a plan for notification of partners, and
- justification, if needed, for a second post-test counseling visit.

Should a second post-test visit be necessary, requirements for this second session are the same as those above. Forms for documentation of HIV testing and post-test counseling are available in reproducible form in the Attachment section.

NOTE:

Counseling is limited to two counseling services per recipient each calendar year and must be performed in conjunction with a family planning visit. This means Medicaid will pay for a total of two counseling services. The recipient can have two services of 99401; or two services

of 99402 or one service of 99401 and one service of 99402 in the same calendar year. Once two counseling services (99401 or 99402) are paid for the recipient for the year, Medicaid will not pay for additional counseling services for that calendar year.

C.2.2 Family Planning Protocols-Clinical

Visits	*INIT*	*AN*	*PER*	*EXT/C*	*HOME*
Consent For Services	*X*	*X*	*X*	*X*	*X*
History					
Family	X	X			X
Med/Surg/OB-GYN	X	X			X
Contraceptive	X	X			X
STD/HIV screening	X	X			X
Interim		X	X		
Blood Pressure	**X**	**X**	**X**		**X**
Weight	**X**	**X**	**X**		**X**
Physical Exam					
Skin/General appearance	X	X	CI		
Eyes/ENT	X	X	CI		
Head/Neck/Thyroid	X	X	CI		
Nodes	X	X	CI		
Heart/Lungs	X	X	CI		
Breast/SBE	X	X	CI		
Abdomen	X	X	CI		
Extremities/Back	X	X	CI		
External genitalia	X	X	CI		
Glands	X	X	CI		
Vagina	X	X	CI		
Cervix	X	X	CI		
Uterus size/shape	X	X	CI		
Adnexa	X	X	CI		
Recto-vaginal	X	X	CI		
Rectum	X	X	CI		
Laboratory					
HGB or HCT	CI	CI	CI		
Urinalysis	CI	CI	CI		
Pap smear	X	X			
STD tests including HIV	CI	CI	CI		
Pregnancy testing	CI	CI	CI		

C.2.3 Family Planning Protocols – Educational

		INIT	AN	Per	EXT/C	Home
Counseling Using PT + 3 Teaching Method						
Priority One	*Patient expressed needs or problems*	X	X	X	X	X
	Contraceptives: **** Listing of the various options* ****How to use* **** Side effect management*	CI	CI	CI	CI	CI
	Prevention of STDs including HIV	X	X	CI	CI	CI
	Breast self-exam or testicular self-exam	X	X	X	X	X
Priority Two	*Explanation of any screening or lab testing done*	X	X	X	X	X
	Services offered	X	X			
	Telephone number of office or instructions regarding the accessing of emergency care	X	X	X	X	X
	Folic Acid	X	X			
Priority Three	*Need for Mammogram*	X	X			
Optional	Anatomy and physiology	CI	CI	CI	CI	CI

***Topic priority explanations: Priority One** includes those topics that MUST be discussed with the patient. All patient concerns fall in this area. **Priority Two** includes those topics that can be presented to the patient in a written document, with verbal follow-up. **Priority Three** includes those topics that can be presented in written format only, with verbal clarification done if needed or desired by the patient. At all times, if the patient wants to discuss a topic, the opportunity should be provided.

C.3 Sterilization

Counseling services involving complete information regarding male/female sterilization procedures shall be provided for the individual or couple requesting such services. These counseling services may be provided during any contraceptive visit to the office/clinic. Counseling and education should use the PT+ 3 teaching method. Full information concerning alternative methods of contraception will be discussed with the recipient.

NOTE:

The recipient is to be made aware that sterilization is considered permanent and irreversible and Medicaid does not cover the reversal of a voluntary sterilization. A "Consent to Sterilization" is a **required form**. The sterilization consent form is included with a sterilization booklet given to the recipient.

Counseling related to sterilization **must** include:

- Assessment of base knowledge level of the reproductive process/sterilization procedure.
- Instruction as needed.
- Listing and discussion of all reversible contraceptive methods.
- Information stressing that the sterilization procedure is considered irreversible.
- Complete explanation of the sterilization procedures using charts or body models.
- Complete information concerning possible complications and failure rates.
- Information regarding the relative merits of male versus female sterilization given to both partners, if possible.
- Information explaining that sterilization does not interfere with sexual function or pleasure.

The counselor shall in no way coerce or “talk the patient into being” sterilized.

C.3.1 Contraindications to Sterilization

The following conditions shall be considered contraindications for voluntary sterilization:

- The recipient has physical, mental, or emotional conditions that could be improved by other treatment.
- The recipient is mentally incompetent or institutionalized, regardless of age.
- The recipient is suffering from temporary economic difficulties that may improve.
- The recipient or couple feels that they are not yet ready to assume the responsibilities of parenthood.
- The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

NOTE:

If sterilization is not desired, alternate methods of contraception must be discussed.

C.3.2 General Rules

Surgical procedures for male and female recipients as a method of birth control are covered services under the rules and regulations as stated in the *Alabama Medicaid Agency Administrative Code,* Chapter 14, Rule No. 560-X-14-.04, and as set forth below.

a. The recipient must be eligible for Medicaid at the time the procedure is performed.
b. The recipient is at least 21 years old at the time informed consent is obtained.
c. The recipient is mentally competent.
d. The recipient has voluntarily given informed consent in accordance with all requirements.
e. At least 30 days, but not more than 180 days, have passed between the date of signed informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.
f. A recipient may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days prior to EDC (expected date of delivery). If the recipient decides to be sterilized, the provider must be responsible for referring the recipient to the proper medical source and for ensuring that the recipient is accepted by that resource. In addition, the provider shall:
g. Inform the recipient that, in accordance with federal regulations, a 30-day waiting period is required between the time the consent form is signed and the procedure is performed.
h. Provide information and instructions concerning the need for follow-up, particularly for male recipients.
i. Provide appropriate post-operative semen analysis for vasectomy recipients.

NOTE:

Payment is not available for the sterilization of a mentally incompetent or institutionalized individual. Federal regulations prohibit Medicaid coverage of sterilization for anyone less than 21 years of age.

The provider must submit a copy of the recipient's signed sterilization consent form to HP. HP will NOT pay any claims to ANY provider until a correctly completed appropriate form is on file at HP.

All blanks on the consent form **must be** appropriately **completed** before Medicaid pays the provider for the sterilization procedure. The only exception is the "Race and Ethnicity," and the "Title of the person obtaining consent" designation which is optional.

NOTE:

When the claim for the sterilization procedure is submitted to HP, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 21 days, for the approved consent form. After the 21st day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

The sterilization consent forms shall be completed as follows.

a. The counselor must thoroughly explain the sterilization procedure to the recipient:
b. The "Consent to Sterilization" must be signed by the person to be sterilized at least 30 days prior to the procedure date. The birth date must indicate the person to be at least 21 years of age on the date the signature was obtained.
c. The person obtaining consent (counselor) and the title for that person (e.g., M.D., D.O., R.N., L.P.N., C.R.N.P., C.N.M.W.), if applicable, must be indicated on the consent form.
d. The counselor's original signature with date, as well as the recipient's signature with date, shall reflect that at least 30 days, but not more than 180 days, have passed prior to the procedure being performed. The counselor signs and dates the consent form after the recipient signs the consent form and prior to the procedure. The counselor may sign the consent form on the same date as the recipient if the counselor signs after the recipient.
e. If no interpreter is used, this section of the form must be marked as "Not Applicable" (N/A). If the "Interpreter's Statement" is signed and dated, please complete the "in_____ language" line also. The recipient and interpreter must sign and date the consent form on the same date.

f. Procedure recorded in the "Physician's Statement": It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure. However, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form. Example: "Bilateral tubal ligation" listed in the recipient's section and "postpartum tubal ligation" listed under the physician's section is acceptable.

NOTE:

The physician's statement must be signed or initialed by an individual clearly identified as a physician. The signature or initials are not acceptable if they are rubber stamped, unless the physician has initialed the stamp. The physician must date the certification on the same date he or she signs it.

g. Each copy of the consent form (Form 193) is used in the correct manner. Upon completion, the forms should be dispensed according to the following procedure:

    a. Original – Patient

    b. Copy 2 – HP

    c. Copy 3 - Patient's permanent record

C.3.3 Referrals

Family planning providers shall be responsible for referring the recipient to the proper resource, and for ensuring that the recipient is accepted by the resource to which they are referred, in the following circumstances:

a. Medical/GYN problems indicated by history, physical examination, or laboratory and clinical tests, including the removal of Norplant capsules

b. Pregnancy related services.

C.3.4 Family Planning Drugs

Medically approved pharmaceutical supplies and devices, such as oral contraceptive pills, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

C.4 Plan First

Plan First operates under an 1115 Research and Demonstration waiver granted by the Centers for Medicare and Medicaid Services (CMS). The Alabama Medicaid Agency initiated this program to extend family planning and birth control services to an expanded eligibility group in Alabama who qualify for prenatal care through Medicaid's SOBRA program.

Under Plan First, eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera shot, vaginal ring and contraceptive patch doctor/clinic visits (for family planning only), and tubal ligations. Plan First does not cover any other medical services, and women who have been previously sterilized are not eligible for participation in this program.

NOTE:

Pain medication prescribed after a tubal ligation **is not** covered for a Plan First recipient.

NOTE:

If for medical reasons, a **Plan First recipient** requires an **inpatient stay** for sterilization, **prior approval** must be requested by the physician and approved by Medicaid prior to performing the sterilization. Please contact the Plan First Program Manager at (334) 353-5263 for prior approval of an inpatient stay.

C.5 Eligible Individuals

Eligible individuals are females of childbearing age between 19 through 55 years of age who meet the eligibility criteria described below. These women are identified on the Eligibility Master File with an aid category of 50.

As always, providers are responsible for verifying eligibility and coverage via PES or AVRS systems.

Eligible recipients fall into three categories; however, there is no difference in benefits. The income limit for each of these groups must not exceed 133% of the federal poverty level. The three groups are described below:

Group 1

Women 19 through 55 years of age who have SOBRA-eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer yes to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 2

SOBRA poverty level pregnant women 19 through 55 years of age are automatically eligible for family planning services after 60 days postpartum without a separate eligibility determination if they meet all eligibility criteria. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 3

Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. An eligibility determination will be completed using poverty level eligibility rules and standards. Client declaration of income will be accepted unless there is a discrepancy. Client declaration of income will be accepted. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the client's declaration and the income reported through data matches, the client will be required to provide documentation and resolve the discrepancy. Eligibility is redetermined every 12 months.

C.6 Plan First Provider Enrollment

Participation in Plan First is open to any provider who wishes to be Medicaid enrolled and executes a Plan First agreement. Only those Plan First enrolled providers are able to service Plan First eligibles. Providers can be clinics, private physicians, nurse midwives, nurse practitioners, or physician assistants. Providers are bound by the requirements in the Appendix C of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology, 1996; and the approved 1115 Research and Demonstration Waiver.

In addition to enrolling as a Medicaid provider through HP, the provider must complete a Plan First agreement.

Clinics and clinic-based providers (Health Departments, FQHCs, and RHCs) are enrolled as one group. Individual providers within these groups are not required to individually enroll. Plan First recipients have the option of using any provider within these groups.

A provider who contracts with Alabama Medicaid as a Plan First provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Plan First related claims. A specialty of 700 is added to the provider file for those enrolling in Plan First. In order for claims to process for Plan First recipients, this specialty code must be present on the provider file.

Providers that perform only tubal ligations do not have to enroll as a Plan First provider. This includes surgeons and anesthesiologists as well as outpatient surgery centers.

If you have further questions regarding this program or if you wish to enroll, please call the Plan First Program Manager at (334) 353-5263. Recipients may call the Plan First hotline toll-free at 1 (888) 737-2083 for more information.

C.6.1 Network List

The Alabama Medicaid Agency maintains a listing of all providers who have enrolled to provide services to Plan First eligibles. The list contains the provider's address and phone number and is sorted by the provider's county of practice. The list is made available to all Plan First care coordinators and staff of the Plan First toll free hotline, and will also be available to any other party who may be assisting women in locating a Plan First provider. The list is available online at the Alabama Medicaid web site (www.medicaid.alabama.gov) as well as in printed form.

Confidentiality

Providers agree that any information obtained through this program is confidential and will not be disclosed directly or indirectly except for purposes directly connected with the conduct of this program. The informed, written consent of the individual must be obtained for any disclosure.

Availability of Records

The provider shall make available for review and audit by authorized representatives of the Alabama Medicaid Agency at all reasonable times, the medical records pertaining to the services rendered to program recipients.

C.7 Plan First Benefits and Limitations

Services covered are the same as current Medicaid family planning services unless otherwise noted. See Section C.2 for a listing of these. Please note; however, that **Plan First is for women only ages 19 through 55** services for male family planners are not a part of the Plan First program.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Effective 11/1/2009, women on Plan First have a new option of obtaining oral contraceptives, the contraceptive ring or the contraceptive patch at a Medicaid-enrolled community/outpatient pharmacy. This is in addition to the contraceptive products already available at the pharmacy such as depo and diaphragms. In order to fill a prescription at a community/outpatient pharmacy, the Plan First recipient must have received the prescription from a private provider. A 30-day supply is the maximum that may be dispensed at one time.

NOTE:
Plan First recipients seeing providers at a Federally Qualified Health Center (FQHC) or the health department will continue to receive the oral contraceptives, contraceptive patch or vaginal ring from the FQHC or health department provider. A 12-month supply of contraceptives may be dispensed at one time.

Providers with questions may contact the Plan First Program Manager at (334) 353-5263.

C.7.1 Care Coordination

Medicaid will reimburse for care coordination services provided to a Plan First recipient. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allow for enhanced contraceptive education, encouragement to continue with pregnancy spacing plans and assistance with the mitigation or removal of barriers to successful pregnancy planning. These services must be provided by licensed social workers or registered nurses associated with the Department of Public Health. Services are available to all Plan First recipients, regardless of the service provider. Should care coordination services be needed, a referral can be made by calling the local health department and asking for the Plan First Care Coordinator.

As mentioned above, the goal of care coordination is to form a partnership with the patient to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A bio-psychosocial assessment and development of case plan for all patients who accept care coordination.
- Counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified in the assessment, such as substance abuse or domestic violence.
- Referrals and follow up to ensure appointments are kept, including subsequent family planning visits.
- Answers to general questions about family planning.
- Low-literacy family planning education based on the PT+3 model.

- Consultation with providers regarding problems with the selected family planning method.

The care coordinator will work diligently with family planning providers to ensure that patients receive care coordination services in a timely manner. All Plan First patients are eligible to receive an initial risk assessment to determine if and what type of care coordination services is needed.

C.7.2 Patient Choice/Consent for Service

As with any family planning visit, the recipient must have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. **Recipients are required to give written consent prior to receiving family planning services.**

C.8 Cost Sharing (Co-payment)

Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services.

There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

Plan First Claims Information

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Claims for family planning services - See sections C.10, Completing the Claim form and C.10.2 and C.10.4 for diagnosis and procedure codes. Service requirements per visit are detailed in Section C.2.2, Family Planning Protocol - Clinical.

Non-enrolled providers who are billing for a tubal ligation or a tubal ligation with a family planning visit can file an electronic or paper claim to HP in order to receive reimbursement. The approved Plan First tubal codes are 58600, 58615, 58670, and 58671. The Plan First family planning visit codes are 99205-FP (initial), 99214-FP (annual), or 99213-FP (periodic). In addition to these codes, the diagnosis code V25.9 must be used as well **as a secondary modifier of 56**.

If the sterilization is **not** performed, the non-enrolled provider must use the V25.9 diagnosis code and a secondary modifier of 56 with procedure code 99205-FP, 99214-FP or 99213-FP.

For information about Third Party Liability, please refer to Section 3.3.6, Third Party Liability.

Quality Assurance Overview

As with any waiver, there is a requirement for Quality Assurance monitoring and complaint/grievance resolution.

The Waiver has four major goals:

- To assure accessibility of family planning services to eligible clients,
- To assure that client assessments include the assessment and care plan appropriate for the risk level,

- To assure that the family planning encounters provided through enrolled providers follows the guidelines in the Appendix C, Plan First, of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology, 1996; and
- To ensure that an effective complaint and grievance system is in place for both providers and recipients.

The Waiver has provisions for UAB to assist in providing outcome and summary reports to support effectiveness of the Program. This will enable comparisons between different sectors of populations and historical data.

Through referral from a Plan First Provider, the Waiver has approved Care Coordinators to assist patients who are assessed to be at high risk of an unintended pregnancy. The Care Coordinators will make and follow a plan to aid the high-risk patients in avoiding unintended pregnancies through improved compliance and informed decisions about Family Planning services.

The Alabama Medicaid Agency is responsible for Quality Assurance, Complaint and Grievance Resolution, and Utilization Monitoring. In order to accomplish these Waiver requirements, the Agency will implement several monitoring functions as outlined below:

- Utilization reports from claims data to monitor trends and utilization,
- Monitor Care Coordinator activity via summary reports
- Review Summary Reports, UAB
- Coordinate complaints and grievances to acceptable resolution.

C.9 Services Other Than Family Planning

Services **required** to manage or treat medical conditions/diseases whether or not such procedures are also related to preventing or delaying pregnancy are **not** eligible as family planning. Many procedures that are done for “medical” reasons also have family planning implications.

- Sterilization by hysterectomy is not a family planning covered service.
- Abortions are not covered as a family planning service. Refer to Chapter 28, Physician's Program, for details about abortions.
- Hospital charges incurred when a recipient enters the hospital for sterilization purposes, but then opts out of the procedure cannot be reimbursed as a family planning service.
- Removal of an IUD due to a uterine or pelvic infection is not considered a family planning service, and is not reimbursable as such.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions are not considered family planning services.
- Diagnostic or screening mammograms are not considered family planning services.
- Medical complications requiring treatment (for example, perforated bowel) caused by or following a family planning procedure are not a covered family planning service.
- Any procedure or service provided to a woman who is known to be pregnant is not considered a family planning service.
- Removal of contraceptive implants due to medical complications are not family planning services.

C.10 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

- Providers who bill Medicaid claims electronically receive the following benefits:
- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

C.10.1 Time Limit for Filing Claims

Medicaid requires all claims for family planning to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

C.10.2 Diagnosis Codes

V2501	Prescription of Oral Contraceptives
V2502	Initiation of other contraceptive measures – fitting of diaphragm, prescriptions of foams, creams, or other agents
V2509	Other – Family planning advice
V2511	Encounter for insertion of intrauterine contraceptive device
V2512	Encounter for removal of intrauterine contraceptive device
V2513	Encounter for removal and reinsertion of intrauterine contraceptive device Encounter for replacement of intrauterine contraceptive device
V252	Sterilization- Admission for interruption of fallopian tubes or vas deferens
V2540	Contraceptive surveillance, unspecified
V2541	Contraceptive Pill
V2542	Intrauterine contraceptive device – Checking, reinsertion, or removal of intrauterine device
V2543	Implantable subdermal contraceptive
V2549	Other contraceptive method
V255	Insertion of implantable subdermal contraceptive (Norplant)
V258	Other specified contraceptive - management post vasectomy sperm count
V259	Unspecified contraceptive management
V7241	Pregnancy examination or test, negative result

NOTE:

All claims filed for Plan First recipients must utilize one of the family planning diagnosis codes noted above. This includes claims filed for lab services. Diagnosis codes that are used and not listed above will cause the claim for a Plan First recipient to deny.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4 or 5 digits). Do not use decimal points in the diagnosis code field.

C.10.3 Family Planning Indicator References

Providers must complete the Family Planning Indicator, as applicable. “Y or “N” are the only valid indicators, when filing electronic claims.

C.10.4 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

NOTE:

Family planning visits do not count against the recipient's office visits when the procedure codes listed below and the appropriate family planning indicator are used.

Code	Procedure Description
99420	Low Risk assessment; use with modifier 22 for high-risk assessment*. For Plan First patients only – to be billed only by health departments.*
99403	Care coordination*. For Plan first patients only – to be billed by health departments only.*
99402	STD/HIV Post-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. See note box below. (Must use diagnosis code V259)
99401	STD/HIV Risk Screening and HIV Pre-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. See note box below. (Must use diagnosis code V259)
88305	Level IV Surgical Pathology, gross and microscopic examination
88304	Level III Surgical Pathology, gross and microscopic examination
88302	Surgical pathology, gross and microscopic examination
88300	Level I Surgical Pathology, gross examination only
89300	Semen analysis; presence and/or motility of sperm *(not applicable for Plan First)*
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision.
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal

Code	Procedure Description
88162	Cytopathology, any other source
88161	Cytopathology, any other source
88160	Cytopathology, smears, any other source
88155	Cytopathology, slides, cervical or vaginal
88154	Cytopathology, slides, computer assisted
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)
88152	Cytopathology, slides, cervical or vaginal
88150	Cytopathology, manual screening under physician supervision
88148	Cytopathology, screening by automated system with manual rescreening
88147	Cytopathology smears, screening by automated system under physician supervision
88143	Cytopathology, manual screening & rescreening under physician supervision
88142	Cytopathology, cervical or vaginal, automated thin layer preparation
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88108	Cytopathology, concentration technique, smears and interpretation
87850	Neisseria gonorrhea
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique
87660	Trichomonas vaginalis, direct probe technique
87622	Papillomavirus, human, quantification
87621	Papillomavirus, human, amplified probe technique
87620	Papillomavirus, human, direct probe technique
87592	Neisseria gonorrhea, quantification
87591	Neisseria gonorrhea, amplified probe technique
87590	Neisseria gonorrhea, direct probe technique
87539	HIV-2, quantification
87538	HIV-2, amplified probe technique
87537	HIV-2, direct probe technique
87536	HIV-1, quantification
87535	HIV-1, amplified probe technique
87534	HIV-1, direct probe technique
87533	Herpes virus-6, quantification
87532	Herpes virus-6, amplified probe technique
87531	Herpes virus-6, direct probe technique
87530	Herpes simplex virus, quantification
87529	Herpes simplex virus, amplified probe technique
87528	Herpes simplex virus, direct probe technique
87512	Gardnerella vaginalis, quantification
87511	Gardnerella vaginalis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique.
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types

Code	Procedure Description
87177	Smear, primary source, with interpretation, wet and dry mount for ova and parasites, concentration and identification
87164	Dark field examination, any source; includes specimen collection
87110	Culture, chlamydia
87081	Culture, bacterial, screening only, for single organisms
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86689	HTLV or HIV antibody
86593	Syphilis
86592	Syphilis
85032	Manual cell count (erythrocyte, leukocyte or platelet) each
85027	Blood count; RBC only
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85018	Blood count; hemoglobin
85014	Blood count; other than spun hematocrit
85013	Blood count; spun microhematocrit
85009	Blood count; differential WBC count, buffy coat
85008	Blood count; manual blood smear examination without differential parameters
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
84703	HCG qualitative
84702	HCG quantitative
81025	Urine pregnancy test
81020	Urinalysis; two or three glass test
81015	Urinalysis microscopic only
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81003	Urinalysis; automated without microscopy
81002	Urinalysis; non-automated without microscopy
81001	Urinalysis; automated with microscopy
81000	Urinalysis by dip stick or tablet reagent
74740	Hysterosalpingography, radiological supervision and interpretation
58671	Tubal ligation by laparoscopic surgery
58670	Tubal ligation by laparoscopic surgery
58615	Tubal ligation by suprapubic approach
58611	Tubal ligation done in conjunction with a c-section (*Not applicable for Plan first)*
58605	Tubal ligation by abdominal approach (postpartum) (*Not applicable for Plan first)*
58600	Tubal ligation by abdominal incision
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (by Prior Approval only; **See note box below procedures)
A4264	Intratubal occlusion device (by Prior Approval only; **See note box below procedures)
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58301	IUD removal
58300	IUD insertion
57170	Diaphragm – fitting with instructions
55450	Vasectomy (*Not applicable for Plan first)*
55250	Vasectomy (*Not applicable for Plan first)*
11980	Subcutaneous hormone pellet implantation(implantation of estradiol and/or testosterone beneath the skin)
11977	Removal with reinsertion, implantable contraceptive capsules (Implanon)
11976	Implanon– implant removal
11975	Insertion, implantable contraceptive capsules (Implanon)
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.

Code	Procedure Description
J1056	Lunelle
J1055	Depo-Provera – 150mg/ml – Limited to one injection *every 70 days*
J3490	Depo – Subq Provera 104 – Limited to one injection *every 70 days*
J7302	Mirena IUD (limited to one every 5 calendar years)) Exceptions are in NOTE box below
J7304	Ortho Evra Patch (To be used for billing by Plan First Private Providers) TPL exempt applicable until current office supplies exhausted
J7304-FP	Ortho Evra Patch (For Health Department Billing Only) TPL exempt
J7304-SE	Ortho Evra Patch (For FQHCs, PRHCs, IRHCs Billing only) applicable until current office supplies exhausted
J7303	Vaginal Ring (This code is Not applicable for Plan First billing)
J7303-FP	Vaginal Ring (For Health Department billing only and is covered for Plan First)
99205-FP	Initial visit
99214-FP	Annual visit
99213-FP	Periodic visit
99347-FP	Home visit – Limited to one per 60 day post-partum period. (Not applicable for Plan First)
S4993-FP	Birth control pills (For Health Department billing only)
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
99212-FP	Extended contraceptive counseling visit (May be billed alone or in conjunction with the postpartum visit – Limited to one service during the 60 day postpartum period.) (Not applicable for Plan First.)
S4993	Birth control pills (To be used for billing by Plan First Private Providers) applicable until current office supplies exhausted (Refer to ALERT dated 8/21/2006).
S4993-SE	Birth Control Pills (For FQHCs, PRHCs, IRHCs Billing only) applicable until current office supplies exhausted
J7307	Etonogestrel (contraceptive) implant system, including implants and supplies also known as Implanon Effective 1/1/2008, J7307 replaces S0180
J7300	Mechanical (Paragard) IUD
S4989	Hormonal (Progestasert) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
36415-90	Routine venipuncture for collection
36416-90	Collection of capillary blood specimen (eg, finger, heel, ear stick)

NOTE:

The Essure method of sterilization is restricted to Prior Approval and also requires a sterilization consent form. The limitations are as follows:

This procedure must be performed in an outpatient setting and the patient must meet one of the following criteria:

Morbid obesity (BMI of 45 or greater); or

Abdominal mesh that mechanically interfaces with laparoscopic tubal ligation sterilization procedures; or

Permanent colostomy with documented adhesions; or

Multiple abdominal/pelvic surgeries with documented severe adhesions; or

Artificial heart valve requiring continuous anticoagulation; or

Other severe medical problems that would be a contraindication to laparoscopic tubal ligation procedures based on medical documentation submitted.

Effective January 1, 2010, Medical providers will use two procedures to bill for the Essure. A4264 will be used for reimbursement of the device and 58565 will be used for reimbursement of the procedure. The outpatient facility will **only** bill 58565 for the surgical procedure.

NOTE:

Once a sterilization claim is processed for a Plan First recipient, the Medicaid eligibility is ended. Therefore, a claim for the Essure related follow-up procedures (58340 and 74740) would deny due to no eligibility. The performing provider should submit the claims for procedures 58340 and 74740 for administrative review to:

Alabama Medicaid Agency

Plan First Program Manager

501 Dexter Avenue

Montgomery, AL 36103

The claims will be researched and a lump sum payment will be made to the provider if there is a paid claim on file for the Essure procedure.

NOTE:

Effective 1/1/2010, the Mirena IUD was restricted to 1 every 5 years. Medicaid recipients **must meet** the following criteria to receive the Mirena IUD within the 5 year limit:

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.

3. Mirena IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Mirena IUD.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Medical Services Division
P.O. Box 5624
Montgomery, AL 36103-5624

C.11 Attachments

- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form
- Plan First Patient Contraceptive Order Form

These handouts are available through the Communications Division (334-353-4099)

- How to do a Breast Self-Exam (Handout)
- Folic Acid for Women for healthy babies (Handout)
- Birth Control Method Sheets (Handout)
- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form

NOTE:

Please go to the Alabama Medicaid Agency web site to access the Alabama Medicaid Product Catalog for any forms that you may need to order. The web address is www.medicaid.alabama.gov.

Patient Name_____ Sex: M F Today's Date _____

STD/HIV Risk Screening and Intervention Tool

Questions/Risk Factors	YES	NO
1. Have you had a blood transfusion or received any blood products prior to 1985? ***Blood exposure?***		
2. Have you ever had a job that exposed you to blood or other body fluids? Like a nursing Home or a day care or hospital? Doctor's office? Funeral Home? ***Occupational exposure?***		
3. Your medical history tells me that you (do or do not have) the free bleeding disease called Hemophilia. Is that correct? ***Has Hemophilia?***		
4. Has the use of alcohol or any other drug ever caused you to do things sexually that you Normally would not do? ***Risky use of alcohol or non-IV drugs****?*		
5. Have you **ever** put drugs of any type into your veins? ***Ever an IV drug user?***		
6. Have you ever had any type of infection of the sex organs? ***History of STDs?***		
7. Think about the first time you had sex. (Since your last HIV test?) Have you had sex With more than one partner since then? What about your current partner? ***Multiple Sex Partners***?		
8. Some women and some men use sex to get things they need. Have you ever had to do this?		
9. Have you ever been hit, kicked, slapped, pushed or shoved by your partner? ***History of Abuse?***		
10. Some women/men prefer sex with men, some with women and some with both. What type of partner do you prefer? **Circle One: Man Woman Both**		
11. **As far as you know,** have you ever had sex with someone who		
a. was a free bleeder or Hemophiliac?		
b. had HIV or AIDS or an STD?		
c. was a man who had sex with men?		
d. used IV drugs or put drugs into their veins?		
e. was a prostitute - either male or female?		
NOTE: For screening after a previous negative HIV test, ask, "Since your last HIV test ..."		

Documentation instructions and explanations:

1. **Yes or No.** Blood transfusion prior to 1985 places the person at risk for HIV/AIDS.
2. **Yes or No**. Any profession that exposes the patient to body fluids creates a risk for HIV/AIDS.
3. **Yes or No**. Yes, if the patient has Hemophilia; No, if does not have the disease. Hemophilia itself does not create risk for HIV, but the use of blood and blood products by the patient does create risk for HIV/AIDS.
4. **Yes or No.** Use of alcohol or non-IV drugs in a setting/manner that results in sexual risk taking places a person at risk for both STDs and HIV.
5. **Yes or No.** IV drug use is a risk factor for HIV specifically.
6. **Yes or No**. A history of any STD places the patient at risk for another STD including HIV/AIDS.
7. **Yes or No.** Having more than one partner places a patient at risk for both STDs and HIV, unless the partners were prior to 1978.
8. **Yes or No**. Exchanging sex for anything places a person at risk for both HIV and STDs.
9. **Yes or No.** Any type of abuse or coerciveness that the patient has experienced places the patient at risk for both HIV and STDs
10. **Circle** the appropriate choice. Male homosexuality and/or male bisexuality are risk factors for HIV/AIDS.
11. **a-e. Yes or No.** Any Yes answer is considered a risk factor for both STDs and HIV/AIDS.

Intervention Documentation: Circle the intervention taken

Level I: - No risk factors identified – No counseling required. Offer "STDs – Don't…" Handout – because "sometimes we change". HIV testing w/counseling is optional – at patient request.

Level II: Risks are related to blood products exposure ONLY – Recommend HIV test. Inform of need for and explain universal precautions. Use "STDs – Don't… " handout.

Level III: Any other risk factor present - significant risk exists. Recommend strongly the HIV test. Test for other STDs as CI. Provide prevention counseling about need for change in (specifically identified) habits and importance of protected sex. Use "STDs – Don't…" handout. Provide skill training in use of condom and in negotiation skills.

Remember: All patients should be given information the handout, "Facts about HIV and HIV testing."

Form 189 Alabama Medicaid Agency

Documentation of HIV testing:

❑ ***HIV Testing Done*** ❑ ***NO HIV Test drawn***

IF Patient declined, why? Circle One

* I am not at risk,
* Do not want to know,
* Other

Follow-up Notes:

Signature/title of counselor _____ **Date** _____

HIV Post Test Counseling

HIV Test Results: Date _____

❑ **HIV positive**

- ○ Test results explained
- ○ Provided emotional assistance related to test result
- ○ Explained need to notify partners/contacts
- ○ Offered options for partner notification
- ○ Stressed need for transmission prevention
- ○ Explained need for early medical evaluation & treatment

❑ **HIV Negative**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

❑ **Indeterminate**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

Referrals made:

- ❑ Mental Health_____
- ❑ Partner notification services _____
- ❑ Other Health Care Provider_____
- ❑ Social Services_____
- ❑ Retesting
- ❑ Other_____

Retest Results (Date) _____

Positive Negative Indeterminate

Follow-up Notes:

Additional Post- test counseling

Reason:

Points covered:

Signature/title of counselor _____ **Date** _____

Form 189 Alabama Medicaid Agency

Checklist for Consent Form Completion

Sterilization Claim & Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to HP. Providers other than performing surgeon should not submit a copy of consent form to HP. Receipt of multiple consent forms slows down the consent from review process and payment of claims. Therefore, please do not forward copies of completed consent forms to other providers for submission to HP.

When the claim for the sterilization procedure is submitted to HP, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 21 days, for the approved consent form. After the 21st day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

Sterilization Consent Form

Clarification of the completion of the sterilization consent form reflecting CMS regulations and Alabama Medicaid policy (refer to the current Appendix C of the Alabama Medicaid Provider Manual and 42CFR50 Revised October 1, 2001):

a) All blanks on the consent form must be appropriately completed before the State may pay the provider for sterilization procedure. The only exception is the Race, Ethnicity, and Title of person obtaining consent, which is optional.

b) The "Consent to Sterilization" must be signed by the person to be sterilized at least thirty days prior to the procedure date. The birth date must indicate the person to be at least twenty-one (21) years of age on the date the signature was obtained.

c) The interpreter, if one is used, must sign and date the consent the same day the recipient signs. In instances where the interpreter signs any date other than the date recorded by the recipient, the claim will be denied. If no interpreter is used, this section of the form must be marked as "not applicable" (N/A). If the Interpreter's Statement is signed and dated, please complete the "form of language" line also.

d) When it is not known in advance which specific physician will perform the procedure, it is acceptable to list a generic description of the physician, i.e. "staff physician, on-call physician, OB/GYN physician". When using a generic description and not a specific physician's name, the patient is to be informed that the physician on call or on duty will perform the procedure. The name of the provider facility (hospital, surgical center, etc.) or provider physician's group must also be entered in the same blank containing the generic physician description when the generic physician description is used. The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery and signs the "Physician's Statement".

e) Signature of person obtaining consent: The individual obtaining consent must sign after the recipient (may sign the same day as the recipient, as long as the recipient signs first) but prior to the procedure in order to properly document informed consent. In instances where the person obtaining consent does not sign prior to the procedure date, (date-wise – not time) the claim will be denied. In other words, denial will occur if the date of the signature of the person obtaining consent and the procedure date is the same or any date after the procedure date.

f) Procedure recorded in physician's statement: It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure; however, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form.

Most frequent causes of claims having to be returned for correction:	**Reasons consent forms and associated claims will be denied:**
1. Patient's date of birth not the same on the claim and consent form.	1. Missing recipient signature
2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.	2. Missing or invalid date of recipient signature, including less than 30 days prior to procedure
3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.	3. Recipient under age 21 on date consent form was signed
4. All blanks not appropriately completed.	4. Missing signature of person obtaining consent
5. Physician's stamp signature not initialed by physician.	5. Missing or invalid date of person obtaining consent, including date of procedure, or any later date
6. Date of sterilization not the same on the claim and on the consent form	6. Missing interpreter signature (if one was used)
7. Legibility of dates and signatures.	7. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used)
8. Facility name not on the consent form.	

*** As a reminder if these guidelines are not followed, HP will deny the consent form. ***

Checklist for Consent Form Completion

Sterilization Claim & Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to HP. Providers other than performing surgeon should not submit a copy of consent form to HP. Receipt of multiple consent forms slows down the consent from review process and payment of claims. Therefore, please do not forward copies of completed consent forms to other providers for submission to HP.

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a) All blanks on the consent form must be appropriately completed before the State may pay the provider for sterilization procedure. The only exception is the Race, Ethnicity, and Title of person obtaining consent, which is optional.

g) The "Consent to Sterilization" must be signed by the person to be sterilized at least thirty days prior to the procedure date. The birth date must indicate the person to be at least twenty-one (21) years of age on the date the signature was obtained.

h) The interpreter, if one is used, must sign and date the consent the same day the recipient signs. In instances where the interpreter signs any date other than the date recorded by the recipient, the claim will be denied. If no interpreter is used, this section of the form must be marked as "not applicable" (N/A). If the Interpreter's Statement is signed and dated, please complete the "form of language" line also.

i) When it is not known in advance which specific physician will perform the procedure, it is acceptable to list a generic description of the physician, i.e. "staff physician, on-call physician, OB/GYN physician". When using a generic description and not a specific physician's name, the patient is to be informed that the physician on call or on duty will perform the procedure. The name of the provider facility (hospital, surgical center, etc.) or provider physician's group must also be entered in the same blank containing the generic physician description when the generic physician description is used. The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery and signs the "Physician's Statement".

j) Signature of person obtaining consent: The individual obtaining consent must sign after the recipient (may sign the same day as the recipient, as long as the recipient signs first) but prior to the procedure in order to properly document informed consent. In instances where the person obtaining consent does not sign prior to the procedure date, (date-wise – not time) the claim will be denied. In other words, denial will occur if the date of the signature of the person obtaining consent and the procedure date is the same or any date after the procedure date.

k) Procedure recorded in physician's statement: It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure; however, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form.

Most frequent causes of claims having to be returned for correction:	**Reasons consent forms and associated claims will be denied:**
9. Patient's date of birth not the same on the claim and consent form.	8. Missing recipient signature
10. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.	9. Missing or invalid date of recipient signature, including less than 30 days prior to procedure
11. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.	10. Recipient under age 21 on date consent form was signed
12. All blanks not appropriately completed.	11. Missing signature of person obtaining consent
13. Physician's stamp signature not initialed by physician.	12. Missing or invalid date of person obtaining consent, including date of procedure, or any later date
14. Date of sterilization not the same on the claim and on the consent form	13. Missing interpreter signature (if one was used)
15. Legibility of dates and signatures.	14. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used)
16. Facility name not on the consent form.	

*** As a reminder if these guidelines are not followed, HP will deny the consent form. ***

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