

## MEMORANDUM

**To:** Local Health Directors  
Directors of Nursing  
Family Planning Coordinators  
Communicable Disease Coordinators

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**Subject:** Coding and Billing follow up family planning encounters

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In March 2011, guidelines for coding, documentation and billing of follow up services (i.e., repeat Pap test, STD testing and follow up, etc) were distributed to local health departments through the Public Health Nursing & Professional Development (PHN&PD) Unit. Through these guidelines, family planning clinics can provide better continuity of care for their clients. However, questions have been raised by several local health departments as to specifics on how to code and bill for these services. A joint meeting including a nurse and administrative consultant from the PHN&PD Unit, the STD/HIV Nurse Consultant from the Communicable Disease branch, two Regional Women's Health Nurse Consultants, Cheryl Kovar, the state Family Planning Nurse Consultant and Joy Reed was held to discuss some specific scenarios. Please find below the scenarios and our recommendations for coding and billing.

### **Scenario One:**

FP client requires a 6-month follow up Pap test based on her previous test performed at her annual/initial visit. How do you code this visit and bill in FP? Medicaid/non-Medicaid?

### **Recommendations:**

- This service is not method related. Therefore, code the appropriate E&M office visit code (99211-99215) with V76.2. If services are provided within FP clinic, client must be billed on a Sliding Fee Scale (the sliding fee scale is activated by putting in a service in the family planning program). No FP Modifier or V25.xx code would be applicable. Medicaid reimburses for Pap re-test; FP Waiver does not.

### **Scenario Two:**

A positive CT and/or GC was found at the FP annual/initial exam and was treated. Per the 2010 CDC STD Guidelines, Family Planning AA, and the Communicable Disease Branch AA, the client is required to return to the clinic at 3 months for a follow up CT/GC test. How do you code and bill this visit since the General Statutes require free testing and treatment of STDs?

**Recommendations:**

- Agencies can either see this client in the Family Planning clinic or the STD Clinic, but must document that follow-up has occurred. Either way you will bill as you have in the past. STD visits can be billed to appropriate third party payer source (i.e., Medicaid, private insurance). In addition, if you bill private insurance for the visit you should inform the client, as an Explanation of Benefits (EOB) will be generated.
- You must remember that due to General Statutes, you cannot charge clients for STD testing and treatment and HIS is programmed to bill all family planning services on the sliding fee scale, so you need to make sure that these charges are not being billed to the client.

**Scenario Three:**

An established family planning client calls the health department complaining of vaginal discharge/burning/itching, etc and she is on a contraceptive method. The agency wants to see the client in FP clinic to triage her symptoms and determine any problem with the method. If the provider finds the client to have a STD, how do you code, bill, document this encounter in HIS?

**Recommendations:**

- First enter the appropriate E&M office visit code with FP modifier, and the ICD-9 V25.xx code that reflects the current method of birth control
- Second, code your diagnosis for the finding (i.e., bacterial vaginosis, trich, etc). As with all types of STD screening, you cannot bill the wet prep to the client but can bill third party payers.
- Treat the client with appropriate medication per Communicable Disease Branch treatment guidelines and do not charge the client. You can use agency STD medications in FP as you would in STD clinic.
- STD Enhanced Role Nurses cannot bill a T code for this encounter in the Family Planning Clinic, instead bill as a 99211
- It is billable to Medicaid or private insurance (no EOB with Medicaid but there is with the private insurance carrier).

**Scenario Four:**

A FP clinic has in their protocols that they will refer clients to their Adult Health/Primary Care Clinic for any lab tests not related to contraceptive methods (i.e., cholesterol, A1C, lipid panels, thyroid screening through TSH levels, etc). Is it acceptable for them to do a separate encounter form for these tests as long as they notify the client that she will be responsible for the cost of the test? How would this be billed and coded?

**Recommendations:**

- Agencies can choose to use a separate encounter form
- Bill appropriately as an Adult Health/Primary care visit.

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