

Benefits: Family Planning

This section identifies Family PACT (Planning, Access, Care and Treatment) Program services available to clients for family planning services. Additionally, services are reimbursable only for the specific contraceptive methods that are identified. Services are tailored to the management of each contraceptive method designated by ICD-9-CM codes noted in this section. Services to manage complications of covered contraceptive methods and specified reproductive health screening tests are also included in this section.

Family Planning Services

Family planning services are categorized according to contraceptive methods:

<u>ICD-9-CM Code</u>	<u>Description</u>
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures (barriers and spermicide)
<u>V25.03</u>	<u>Encounter for emergency contraceptive counseling and prescription</u>
V25.04	Counseling and instruction in natural family planning to avoid pregnancy
V25.09	Contraceptive management, general counseling and advice; other
V25.11	Encounter for insertion of intrauterine contraceptive device
V25.12	Encounter for removal of intrauterine contraceptive device
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device
V25.2	Sterilization
V25.40	Surveillance of previously prescribed contraceptive methods; unspecified (patch, vaginal ring and injection)
V25.41	contraceptive pill
V25.42	intrauterine contraceptive device
V25.43	implantable subdermal contraceptive
V25.49	other contraceptive method (barriers and spermicide)

<u>ICD-9-CM Code</u>	<u>Description</u>
<u>V25.5</u>	<u>Insertion of implantable subdermal contraceptive</u>
<u>V25.9</u>	<u>Unspecified contraceptive management (initiate patch, vaginal ring or injection)</u>
<u>V26.41</u>	<u>Procreative counseling and advice using natural family planning</u>
<u>V26.51</u>	<u>Tubal ligation status</u>
<u>V26.52</u>	<u>Vasectomy status</u>

Drugs and Contraceptive Supplies

For a list of reimbursable drugs and dispensing guidelines, including Code 1 restrictions and *Treatment Authorization Request* (TAR) requirements, refer to the *Pharmacy and Clinic Formulary* section and the “Treatment and Dispensing Guidelines for Clinicians” chart in the *Benefits Grid* section in this manual.

Modifiers

Family PACT defers to Medi-Cal policy and billing procedures for use of modifiers, unless otherwise stated in this manual. For further information, refer to the following sections of the Part 2 Medi-Cal provider manual:

- *Modifiers*
- *Modifiers: Approved List*
- *Modifiers Used With Procedure Codes*
- *Non-Physician Medical Practitioners (NMP)*
- *Pathology: Billing and Modifiers*
- *Pathology: Cytopathology*
- *Surgery: Billing With Modifiers*

FAMILY PLANNING SERVICES

The following services are reimbursable with the family planning ICD-9-CM codes listed on a preceding page, except for V25.03, V25.09 and V26.41, as noted in following pages.

Office Visits or Other Outpatient Evaluation and Management (E&M) Visits Use the following codes for Evaluation and Management (E&M) visits.

<u>CPT-4 Code</u>	<u>Description</u>
99201	New patient, females/males
99202	New patient, females/males
99203	New patient, females/males
99204	New patient, females; males for complications only
99211	Established patient, females/males
99212	Established patient, females/males
99213	Established patient, females/males
99214	Established patient, females; males for complications only

For information and billing guidelines for E&M visits, refer to the *Office Visits: Evaluation and Management and Education and Counseling Services* section in this manual.

ben fam
4

Education and Counseling
(E&C) Visits – New/
Established Clients

Use the following codes for Education and Counseling (E&C) visits.

<u>HCPCS/ CPT-4 Code</u>	<u>Description</u>
S9445	Individual orientation to Family PACT
S9446	Group family planning education (including orientation to Family PACT)
99401U6	Preventive medicine counseling service for family planning counseling (up to 15 minutes)
99402U6	Preventive medicine counseling service for family planning counseling (16 – 30 minutes)
99403U6	Preventive medicine counseling services for family planning counseling (31 – 45 minutes)

Note: HCPCS codes 99401, 99402 and 99403 are billed with modifier U6 to indicate individual family planning E&C visits.

For information and billing guidelines for E&C visits, refer to the *Office Visits: Evaluation and Management and Education and Counseling Services* section in this manual.

Facility Use

A Family PACT provider must have the appropriate provider type on file with Medi-Cal Provider Enrollment Division to bill for facility use.

<u>HCPCS Code</u>	<u>Description</u>
<u>Z7500</u>	<u>Use of hospital examining or treatment room</u>

Laboratory

<u>CPT-4 Code</u>	<u>Description</u>
81025	Urine pregnancy test, by visual color comparison methods

Note: Urine pregnancy test should only be done as clinically indicated. CPT-4 code 81025 has a frequency limit of one test, per recipient, per month. For more information regarding the Laboratory Services Reservation System (LSRS), refer to the *Laboratory Services* section in this manual.

Procedures	CPT-4	
	<u>Code</u>	<u>Description</u>
	99000	Handling and/or conveyance of specimen for transfer from the physician's office to an unaffiliated laboratory. For Family PACT, this pertains to blood specimens only.

Note: Blood tests should be ordered only as clinically indicated for safe use of contraceptive method.

Barrier Supplies and Emergency Contraception	HCPCS	
	<u>Code/Modifier</u>	<u>Description</u>
	A4267	Condom, male
	A4268	Condom, female
	A4269	Contraceptive supply, spermicide
	A4269U1	Gel/jelly/foam/cream
	A4269U2	Suppository
	A4269U3	Vaginal film
	A4269U4	Contraceptive sponge
		Note: HCPCS code A4269 is billed with modifier U1, U2, U3 or U4 to indicate the type of spermicide.
	S5199	Lubricant
	J3490U5	Ulipristal acetate 30 mg one (1) pack (one [1] tablet) limited to female clients
	J3490U6	Levonorgestrel 0.75 mg pack (two [2] tablets) and 1.5 mg pack (one [1] tablet) limited to female clients

Note: HCPCS code J3490 is billed with modifier U5 and U6 to indicate emergency contraceptive pills.

Over-the-counter barrier supplies and emergency contraception may also be dispensed by prescription at Medi-Cal participating pharmacies. For a complete list of drugs and contraceptive supplies reimbursed by the Family PACT Program, refer to the *Pharmacy and Clinic Formulary* section in this manual

COMPLICATION SERVICES

Complications that arise from the use of a covered contraceptive method that can be reasonably managed on an outpatient basis have been pre-selected for the Family PACT Program and are included in this section under each contraceptive method. A *Treatment Authorization Request* (TAR) is required for complication services, unless stated otherwise in this manual. For additional information, refer to the *Benefits: Clinical Services Overview* and *Treatment Authorization Request (TAR)* sections in this manual.

When a procedure, laboratory test or drug is for the management of a complication resulting from the use of a particular contraceptive method, an ICD-9-CM code for the complication is required on the claim. This code must be billed with the diagnosis code that identifies the contraceptive method for which the client is being seen.

Outpatient Services

The following services are available to manage all complications on an outpatient basis. Additional services to manage complications of covered contraceptive methods are included under each method in this section.

Procedures

CPT-4

Code Description

99000 Handling and/or conveyance of specimen for transfer from the physician's office to **an unaffiliated** laboratory. (For Family PACT, this pertains to blood specimens only.)

Office Visit

CPT-4

Code Description

99201 – 99204 New patient

99211 – 99214 Established patient

Consultation	<p>CPT-4 <u>Code</u> <u>Description</u> 99241 – 99244 Office Consultation, new or established patient</p>
Facility Use	<p>A Family PACT provider must have the appropriate provider type on file with Medi-Cal Provider Enrollment Division to bill for facility use.</p> <p>HCPCS <u>Code</u> <u>Description</u> Z7500 Use of hospital examining or treatment room</p>
Laboratory Tests	<p>Laboratory tests to manage a pre-selected complication of a contraceptive method are reimbursable and are noted under each method in this section and listed in the <i>Laboratory Services</i> section. A TAR may be required for some laboratory tests.</p>
Drugs and Supplies	<p>Drugs and supplies to manage a pre-selected complication of a Family PACT benefit, found in the <i>Pharmacy and Clinic Formulary</i> section in this manual, require an approved TAR when determined to be medically necessary during the course of treatment.</p>
Preoperative Evaluation of a Medical Condition	<p>Additional tests and procedures for preoperative evaluation of a medical condition to identify surgical contraindications for permanent female and male contraception require authorization as noted. These are reimbursable with ICD-9-CM codes V72.83 or V72.63, as appropriate, and must be billed with code V25.09. For details of these benefits, see “Female Sterilization – 21 Years of Age and Older” and “Male Sterilization – 21 Years of Age and Older” in this section.</p>

Inpatient Services

All services to manage complications requiring inpatient services require an approved TAR.

Additional Facility Use

Providers must have the appropriate provider type on file with Medi-Cal Provider Enrollment Division to bill for facility use.

HCPCS

<u>Code</u>	<u>Description</u>
Z7506	Use of operating room, first hour
Z7508	Use of operating room, first subsequent half-hour
Z7510	Use of operating room, second subsequent half-hour
Z7512	Use of recovery room
Z7514	Room and board, general nursing care for less than 24 hours, including ordinary medications

Anesthesia

Anesthesia services are reimbursable when medically necessary for a procedure that is authorized for treatment of a complication. These services require an approved TAR. These complications have been preselected and are included in this section under each contraceptive method. This code must be billed with the diagnosis code that identifies the contraceptive method for which the client is being seen.

CONTRACEPTIVE COUNSELING

Contraceptive Counseling Encounters

The following ICD-9-CM codes indicate encounters for contraceptive counseling when client is using no contraceptive method.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.03	Encounter for emergency contraception counseling and prescription

Note: Encounters under diagnosis code V25.03 are for emergency contraceptives only, and no contraceptive method is initiated or currently used by the client. If the encounter includes services for contraceptive management or initiation of a contraceptive method, the family planning ICD-9-CM diagnosis code for which the client is being seen, or for the method selected by the client, is to be used.

Services reimbursable under ICD-9-CM diagnosis code V25.03 are limited to the following, for females only:

Office Visits

<u>CPT-4 Code</u>	<u>Description</u>
99201, 99202	New patient
99211, 99212	Established patient

For additional office visits reimbursed with V25.03, refer to “Education and Counseling (E&C) Visits – New and Established Clients” on a preceding page in this section.

Emergency Contraceptives

<u>HCPCS Code</u>	<u>Description</u>
J3490U5	Ulipristal acetate 30mg one pack (one tablet) limited to female clients
J3490U6	Levonorgestrel 0.75 mg pack (two tablets) and 1.5 mg pack (one tablet) limited to female clients

Note: HCPCS code J3490 is billed with modifier U5 or U6 to indicate emergency contraceptive pills.

Laboratory Tests

<u>CPT-4 Code</u>	<u>Description</u>
81025	Urine pregnancy test

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.09	Contraceptive management; general counseling and advice

Note: Encounters under V25.09 are for sterilization counseling and advice, including consent and pre-operative evaluation, if indicated (refer to the “Permanent Contraception” on a following page in this section).

V25.09 is also used for counseling on contraceptive methods but no contraceptive method is initiated during the visit or currently used by the client. If a contraceptive method is initiated, or the client is already on a method, use the family planning ICD-9-CM code for the method selected by the client.

Services reimbursable under ICD-9-CM diagnosis code V25.09 for general counseling and advice on contraceptive methods, other than sterilization, are limited to the following for males and females:

Office Visits

<u>CPT-4 Code</u>	<u>Description</u>
99201– 99203	New patient
99211 – 99213	Established patient

For additional office visits reimbursed with V25.09, refer to “Education and Counseling (E&C) Visits – New and Established Clients” on a preceding page in this section.

Laboratory Tests

<u>CPT-4 Code</u>	<u>Description</u>
81025	Urine pregnancy test, by visual color comparison methods

Note: Pregnancy test is covered only when clinically indicated to rule out pregnancy prior to initiation of contraceptive method, but no contraceptive method is initiated during the visit or currently used by the client. Providers must include the justification in the *Remarks* field (Box 80) on the *UB-04* claim and *Additional Claim Information* field (Box 19) on the *CMS-1500* claim. Pregnancy confirmation for women not seeking family planning services is not reimbursable under V25.09.

CONTRACEPTIVE METHODS

Reversible Contraception

Family PACT reversible contraceptive methods include procedures, prescription drugs, devices, selected over-the-counter products and contraceptive supplies that are provided by clinicians during an office visit, or dispensed by a pharmacy, along with education and counseling on all contraceptive methods.

**Oral Contraceptives,
Transdermal Patch and
Vaginal Ring**

Oral contraception, transdermal patch and vaginal ring services are billed with ICD-9-CM codes V25.01, V25.40, V25.41 or V25.9 as appropriate.

ICD-9-CM	
<u>Code</u>	<u>Description</u>
V25.01	Prescription of oral contraceptives
V25.9	Unspecified contraceptive management (initiation of patch and vaginal ring)
V25.40	Surveillance of previously- prescribed contraceptive, unspecified (maintain adherence and surveillance for a current user of patch and vaginal ring)
V25.41	Surveillance of previously prescribed contraceptive method; contraceptive pill (maintain adherence and surveillance for a current user of the oral contraceptive)

Laboratory Tests for Oral Contraceptives, Transdermal Patch and Vaginal Ring, as Clinically Indicated	<u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	80061	Lipid panel	One per six months per client, any provider. Only if elevated screening cholesterol or significant risk factors for cardiovascular disease.
	80076	Hepatic function panel	One per six months per client, any provider
	82465	Cholesterol, serum or whole blood, total	N/A
	82947	Glucose; quantitative, blood (except reagent strip)	One per year per client, any provider
	82951	tolerance test (GTT), three specimens (includes glucose)	One per client per year, any provider. Only if a history of abnormal fasting blood sugar screen.

Management of Complications

The following ICD-9-CM codes are used to bill for complication services related to oral contraceptives, contraceptive patch and vaginal ring. An approved TAR is required unless stated otherwise. An additional ICD-9-CM code that identifies the contraceptive method in which the complication arose is required.

ICD-9-CM

<u>Code</u>	<u>Description</u>
415.19	Pulmonary embolism and infarction
453.40	Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity

The following additional services are reimbursable with ICD-9-CM codes 415.19 and 453.40.

Procedures	CPT-4 Code	Description
	36000	Introduction of needle/intracatheter, vein
	36425	Venipuncture, cutdown
Radiology	75741	Angiography pulmonary, unilateral, selective, radiological supervision and interpretation
	75820	Venography, extremity, unilateral, radiological supervision and interpretation
	75822	Venography, extremity, bilateral, radiological supervision and interpretation
	78456	Acute venous thrombosis imaging, peptide
	78457	Venous thrombosis imaging, venogram; unilateral
	78458	bilateral
Extremity Venous Studies	78596	Pulmonary quantitative differential function (ventilation/perfusion) study
	93965	Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)
	93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
	93971	unilateral or limited study

Laboratory	CPT-4	
	<u>Code</u>	<u>Description</u>
	82803	Gases, blood, pH only
	82805	with O ₂ saturation, by direct measurement, except pulse oximetry
	82810	Gases, blood, O ₂ saturation only, by direct measurement, except pulse oximetry

Pharmacy
Heparin
Warfarin sodium

For TAR requirements and dispensing guidelines, refer to the *Pharmacy and Clinic Formulary* section in this manual.

Contraceptive Injection

Contraceptive injection services are billed with ICD-9- CM codes V25.40 or V25.9, as appropriate.

ICD-9-CM	
<u>Code</u>	<u>Description</u>
V25.40	Contraceptive surveillance, unspecified (maintain adherence and surveillance for a current user of the contraceptive injection)
V25.9	Unspecified contraceptive management (initiation of contraceptive injection)

Supplies
No additional supply services are reimbursable for this method.

ben fam
16

Drugs Onsite Dispensing

HCPCS

Code Description

J3490U8 Medroxyprogesterone acetate **150** mg

Note: HCPCS code J3490 is billed with modifier U8 to indicate medroxyprogesterone acetate for contraceptive use.

S5000/ Prescription drugs, generic/brand (Estradiol)
S5001

Note: Billing of estradiol requires additional ICD-9-CM code 626.6

Drugs Administered by a
Physician or Clinic

Any drug administered by a physician or clinic must be billed by the the physician or clinic, not by the pharmacy providing the drug for such administration. Refer to the *Pharmacy Claim Form (30-1): Special Billing Instructions* section in the Part 2 Medi-Cal *Pharmacy* manual.

Pharmacy

For a complete list of drugs and contraceptive supplies reimbursed by the Family PACT Program, refer to the *Pharmacy and Clinic Formulary* section in this manual.

Laboratory Tests for Contraceptive Injection	CPT-4		
	<u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	80076	Hepatic function panel	Limited to one every six months per client.
	82947	Glucose; quantitative, blood (except reagent strip)	Limited to one per year per client.
	82951	tolerance test (GTT), three specimens (includes glucose)	Limited to one per year per client. Only if history of abnormal fasting blood sugar screen.

Management of Complications

The following ICD-9-CM codes are used to bill for complication services related to contraceptive injections. An approved TAR is required, unless stated otherwise. An additional ICD-9-CM code that identifies the contraceptive method in which the complication arose is required.

ICD-9-CM

<u>Code</u>	<u>Description</u>
626.2	Excessive or frequent menstruation

The following additional services are reimbursable with ICD-9-CM code 626.2.

Anesthesia	<u>CPT-4 Code</u>	<u>Description</u>
	00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
	00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
Procedures		
	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
	58120	Dilatation and curettage, diagnostic and/or therapeutic (nonobstetrical)
	58150	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)

Hydration	CPT-4	
	<u>Code</u>	<u>Description</u>
	96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
	96361	each additional hour (List separately in addition to code for primary procedure)
Laboratory	CPT-4	
	<u>Code</u>	<u>Description</u>
	85014	Blood count; hematocrit (Hct)
	85018	Hemoglobin (Hgb)
	85025	complete (CBC), automated (Hgb, Hct, RBX, WBC and platelet count) and automated differential WBC count
	85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
	88305	Level IV – Surgical pathology, gross and microscopic

Contraceptive Implant

Contraceptive implant services are billed with family planning ICD-9- CM code V25.43 or V25.5, as appropriate.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.43	Surveillance of previously prescribed contraceptive methods; implantable subdermal contraceptive (also used for contraceptive implant removals)
V25.5	Insertion of implantable subdermal contraceptive

Procedures

CPT-4

<u>Code</u>	<u>Description</u>
11976	Removal, implantable contraceptive capsules
11981	Insertion, non-biodegradable drug delivery implant

Note: Modifiers UA and UB are not reimbursable with code 11981 when billed in conjunction with HCPCS code J7307 (etonogestrel [contraceptive] implant system, including implant and supplies) because surgical supplies are included in code J7307.

Supplies

Modifier UA is required when billing supplies for the following procedure code.

<u>CPT-4 Code</u>	<u>Description</u>
11976	Removal, implantable contraceptive capsules

Drugs

The following code is used to bill for an implantable contraceptive capsule.

<u>HCPCS Code</u>	<u>Description</u>
J7307	Etonogestrel contraceptive implant

Onsite Dispensing

<u>HCPCS Code</u>	<u>Description</u>
S5000/ S5001	Prescription drugs, generic/brand (Estradiol)

Note: Billing of estradiol requires additional ICD-9-CM code 626.6.

Pharmacy

For a complete list of drugs and contraceptive supplies reimbursed by the Family PACT Program, refer to the *Pharmacy and Clinic Formulary* section in this manual.

Laboratory Tests for Contraceptive Implant

<u>CPT-4 Code</u>	<u>Description</u>
80076	Hepatic function panel (one per six months per client, any provider)

Management of Complications

The following ICD-9-CM codes are used to bill for complication services related to contraceptive implant. An approved TAR is required unless stated otherwise. An additional ICD-9-CM code that identifies the contraceptive method in which the complication arose is required, unless otherwise noted.

ICD-9-CM

<u>Code</u>	<u>Description</u>
996.59	Mechanical complication due to other implant and internal device not elsewhere classified.

Note: This code should be used for procedures/services associated with removal of the contraceptive implant. This code should only correspond to those surgical procedure codes applicable to the removal of the implant.

V45.52	Presence of contraceptive device: Subdermal contraceptive implant
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Note: This code should be used for services associated with confirming the presence of a contraceptive implant, and if present, localizing its position in the upper arm. This code should only correspond to those procedure/service codes applicable to implant confirmation and localization. An additional ICD-9-CM code is not required.

The following additional services are reimbursable with V45.52 and 996.59.

Procedures

<u>CPT-4 Code</u>	<u>Description</u>
11976	Removal, implantable contraceptive capsules (no TAR required for this code)

Radiology

77055	Mammography, unilateral
76882	Ultrasound, extremity, nonvascular, real time with image documentation: limited, anatomic specific

ICD-9-CM

<u>Code</u>	<u>Description</u>
996.69	Infection and inflammatory reaction due to other internal prosthetic device, implant and graft

The following additional services are reimbursable with 996.69.

Procedures

<u>CPT-4 Code</u>	<u>Description</u>
10060	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Laboratory	CPT-4 <u>Code</u>	<u>Description</u>
	85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
	85651	Sedimentation rate, erythrocyte; non-automated
	85652	automated
	87081	Culture, presumptive, pathogenic organisms, screening only
	87181	Susceptibility studies, antimicrobial agent (reflex from positive 87081)
	87184	disk method, per plate (Reflex from positive 87081)
	87186	microdilution or agar dilution (minimum inhibitory concentration [MIC] or breakpoint), each multi-antimicrobial, per plate (reflex from positive 87081)

Pharmacy

Cephalexin
Clindamycin

For TAR requirements and dispensing guidelines, refer to the *Pharmacy and Clinic Formulary* section in this manual.

ICD-9-CM <u>Code</u>	<u>Description</u>
996.70	Other complications due to unspecified device, implant, and graft (<u>hematoma at insertion site/removal site</u>)

The following additional service is reimbursable with 996.70.

Procedures	CPT-4	
	<u>Code</u>	<u>Description</u>
	10140	Incision and drainage of hematoma, seroma or fluid collection
	ICD-9-CM	
	<u>Code</u>	<u>Description</u>
	626.2	Excessive or frequent menstruation

The following services are reimbursable with 626.2.

Anesthesia	CPT-4	
	<u>Code</u>	<u>Description</u>
	00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
	00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
Procedures	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
	58120	Dilatation and curettage, diagnostic and/or therapeutic (nonobstetrical)
	58150	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)

ben fam
26

	<u>CPT-4</u> <u>Code</u>	<u>Description</u>
Hydration	96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
	96361	each additional hour
Laboratory	85014	Blood count; hematocrit (Hct)
	85018	Hemoglobin (Hgb)
	85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
	85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
	88305	Level IV – Surgical pathology, gross and microscopic examination

Intrauterine Contraceptives

Intrauterine contraceptive device (IUC/IUD) procedures are billed with ICD-9-CM codes V25.11, V25.12, V25.13 or V25.42, as appropriate.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.11	Encounter for insertion of <u>IUC/IUD</u>
V25.12	Encounter for removal of <u>IUC/IUD</u>
V25.13	Encounter for removal and reinsertion of intrauterine device (Use V25.13 when replacing an IUC/ <u>IUD</u> with another of the same type or a different type. Both insertion and removal may be billed on the same date of service.)
V25.42	Surveillance of previously prescribed contraceptive method; intrauterine contraceptive device

Procedures

CPT-4

<u>Code</u>	<u>Description</u>
58300	Insertion of <u>IUC/IUD</u>
58301	Removal of <u>IUC/IUD</u>

Supplies

Modifier UA is required for the following supplies.

<u>CPT-4 Code</u>	<u>Description</u>
58300	Insertion supplies
58301	Removal supplies

Drugs Onsite Dispensing

<u>HCPCS Code</u>	<u>Description</u>
J7300	ParaGard
<u>J7301</u>	Skyla
J7302	Mirena Intrauterine System
S5000/ S5001	Prescription drugs, generic/brand (Estradiol)

Note: Billing of estradiol requires additional ICD-9-CM code 626.6.

Radiology

The following codes require ICD-9-CM code V25.42 and additional ICD-9-CM code V45.51 (presence of intrauterine contraceptive device). These codes are restricted to use for evaluating missing IUC strings only.

<u>CPT-4 Code</u>	<u>Description</u>
74000	Radiologic examination, abdomen; single anteroposterior view
76830	Ultrasound, transvaginal
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up

Pharmacy

For a complete list of drugs and contraceptive supplies reimbursed by the Family PACT Program, refer to the *Pharmacy and Clinic Formulary* section in this manual.

Laboratory Tests for Intrauterine Contraception	CPT-4		
	<u>Code</u>	<u>Description</u>	<u>Additional Restrictions</u>
	85013	Blood count; spun microhematocrit	When medically indicated in the context of contraceptive services.
	85014	hematocrit (Hct)	When medically indicated in the context of contraceptive services.
	85018	hemoglobin (Hgb)	When medically indicated in the context of contraceptive services.

Management of Complications

The following ICD-9-CM codes are used to bill for complication services related to IUC. An approved TAR is required unless stated otherwise. An additional ICD-9-CM code that identifies the contraceptive method in which the complication arose is required, unless otherwise noted.

ICD-9-CM	
<u>Code</u>	<u>Description</u>
996.32	Mechanical complication due to intrauterine contraceptive device (perforated or translocated IUD/IUC). An additional ICD-9-CM code is not required.

The following additional services are reimbursable with ICD-9-CM 996.32.

Anesthesia	<u>CPT-4 Code</u>	<u>Description</u>
	00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
	00952	hysteroscopy and/or hysterosalpinography

Procedures	<u>CPT-4 Code</u>	<u>Description</u>
	49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s), (separate procedure)
	49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
	49402	Removal of peritoneal foreign body from peritoneal cavity
	58120	Dilatation and curettage, diagnostic and/or therapeutic (nonobstetrical)
	58301	Remove IUC/IUD (No TAR required for this code)
	58555	Hysteroscopy diagnostic, separate procedure
	58562	Hysteroscopy, remove impacted foreign body

Laboratory	<u>CPT-4 Code</u>	<u>Description</u>
	88305	Level IV – Surgical pathology, gross and microscopic examination

Pharmacy
Antibiotic regimens are the same as for treatment of uncomplicated PID, as listed in the “Treatment and Dispensing Guidelines for Clinicians” in the *Benefits Grid* section in this manual. Also refer to the *Pharmacy and Clinic Formulary* section.

Barrier Methods

Encounters regarding correct and effective use of barrier methods are billed with V25.02.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.02	Initiation of other contraceptive measures (barriers and spermicides)
V25.49	Surveillance of previously prescribed contraceptive methods; Other contraceptive methods (barriers and spermicides)

Procedure

CPT-4

<u>Code</u>	<u>Description</u>
57170	Diaphragm or cervical cap fitting with instructions

Onsite Supplies Dispensing

HCPCS

<u>Code</u>	<u>Description</u>
A4267	Condom, male
A4268	Condom, female
A4269	(Contraceptive supply, spermicide):
A4269 U1	Gel/jelly/foam/cream
A4269 U2	Suppository
A4269 U3	Vaginal film
A4269 U4	Contraceptive sponge

Note: A4269 is billed with modifier U1, U2, U3, or U4 to indicate the type of spermicide.

S5199	Lubricant
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Pharmacy

For a complete list of drugs and contraceptive supplies reimbursed by the Family PACT Program, refer to the *Pharmacy and Clinic Formulary* section in this manual.

Laboratory Tests for Barrier
Methods

There are no additional laboratory tests for this method.

Natural Family Planning

Encounters for natural family planning are billed with the following ICD-9-CM codes.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.04	Counseling and instruction in natural family planning to avoid pregnancy

ICD-9-CM

<u>Code</u>	<u>Description</u>
V26.41	Procreative counseling and advice using natural family planning

Services reimbursable under ICD-9-CM code V26.41 are limited to the following:

Office Visits

CPT-4

<u>Code</u>	<u>Description</u>
<u>99201 – 99203</u>	<u>New patient</u>
<u>99211 – 99213</u>	<u>Established patient</u>

For additional office visits reimbursed with V26.41, refer to “Education and Counseling (E&C) Visits – New and Established Clients” on a preceding page in this section.

Use of codes 99201 – 99203, 99211 – 99214 or 99401U6 – 99403U6, with inclusive diagnosis code V26.41, are limited to a maximum of two occurrences in any combination in a 12-month period per recipient, per provider.

Laboratory Test

CPT-4

<u>Code</u>	<u>Description</u>
<u>81025</u>	<u>Urine pregnancy test</u>

Supplies

Basal body thermometer

Permanent Contraception

These methods include female and male sterilization procedures, preoperative screening and postoperative management.

Informed consent for sterilization must be documented on the *Consent Form* (PM 330) at least 30 days prior to the procedure. A completed *Consent Form* is required for elective sterilization procedures and anesthesia and must be attached to all claims for sterilization services. For additional information, refer to the *Provider Responsibilities* section in this manual.

Unless stated otherwise, Family PACT defers to Medi-Cal policy and billing procedures for sterilization services. For more information, refer to the *Sterilization* section in the appropriate Part 2 Medi-Cal manual.

At the end of the 90-day postoperative period, or earlier, if the clinician determines a client is no longer at risk for pregnancy or causing pregnancy, the client is no longer eligible for the Family PACT Program. For hysteroscopic sterilization, the post-operative period is 36 weeks (252 days), or earlier, when the clinician determines by hysterosalpingography that the client is no longer at risk of pregnancy.

Once the post-operative period is complete, the client is no longer eligible for the Family PACT Program, and the HAP card must be de-activated. For more information, refer to the *Client Eligibility Certification and HAP Card Activation* section of this manual.

**Female Sterilization –
21 Years of Age and Older**

Bilateral tubal ligation (BTL) and hysteroscopic sterilization procedures are billed with ICD-9-CM code V25.2 and the following pre-selected procedure codes, as appropriate.

Additionally, V72.63 (pre-procedural laboratory examination) and V72.83 (other specified pre-operative examination) are billed for women with medical conditions that need screening for surgical contraindications. An approved TAR is required for preoperative tests unless noted otherwise. ICD-9-CM codes V72.63 and V72.83 must be billed with ICD-9-CM code V25.09.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.09	General counseling and advice; other (sterilization)
V25.2	Sterilization procedure
V26.51	Tubal ligation status (postoperative management and surveillance, whether or not the client is new to the provider)
V72.63	Pre-procedural laboratory examination
V72.83	Other specified pre-operative examination

Procedures	CPT-4 <u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	Only for use with code 74740 to confirm occlusion at 12 weeks after code 58565 is used. May be repeated one time at 24 weeks. Claim must include date 58565 was performed in <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19) of claim. Use ICD-9-CM code V26.51 (tubal ligation status).
	58555	Hysteroscopy, diagnostic (separate procedure)	Only when 58565 is attempted and bilateral placement of micro-insert fails. Restricted to 3 times in a lifetime – twice by same provider and once by different provider.
	58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	NA

Procedures (<i>continued</i>)	CPT-4 <u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	NA
	58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	NA
	58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	NA
	58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	NA
Anesthesia	CPT-4 <u>Code</u>	<u>Description</u>	
	00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction	
	00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix, or endometrium); hysteroscopy and/or hysterosalpingography	
	99144	Moderate sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time	
	99145	each additional 15 minutes intra-service time	

Supplies

Modifier UA or UB is required for the following supplies.

<u>CPT-4 Code</u>	<u>Description</u>	<u>Restrictions</u>
58555	Hysteroscopy, diagnostic	Limited to 3 in a lifetime, per client, any provider
58565	Hysteroscopic surgical supplies	Limited to 3 per client, any provider
58600	Minilap supplies	
58615	Minilap w/clip supplies	
58670	Lapscope fulguration supplies	
58671	Lapscope w/ring or clip supplies	

Modifier 50 or 52 is required for the following device.

<u>HCPCS Code</u>	<u>Description</u>	<u>Restrictions</u>
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	Restricted for use with 58565

Hydration	CPT-4	<u>Description</u>	<u>Restrictions</u>
	<u>Code</u>		
	96360	Intravenous infusion, hydration, initial; 31 minutes to 1 hour	
	96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	
Radiology	CPT-4	<u>Description</u>	<u>Restrictions</u>
	<u>Code</u>		
	71020	Radiologic examination, chest, two views, frontal and lateral	When required by the outpatient facility or medically indicated by clinical assessment in the context of provision of contraceptive services. TAR not required, <u>limited to ICD-9-CM code V72.83.</u>
	74740	Hysterosalpingography, radiological supervision and interpretation	Use ICD-9-CM code V26.51 (tubal ligation status). Claim must include date 58565 was performed in <i>Remarks</i> field (Box 80)/ <u>Additional Claim Information</u> field (Box 19) of claim. Use with code 58340.

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Cardiography	CPT-4		
	<u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Limited to evaluation of a pre-existing cardiovascular condition as medically indicated for preoperative evaluation. TAR not required, <u>limited to ICD-9-CM code V72.83.</u>
Echocardiography	CPT-4		
	<u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Limited to evaluation of a pre-existing cardiovascular condition as medically indicated for preoperative evaluation. TAR required; limited to ICD-9-CM code V72.83.
Consultation	CPT-4		
	<u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	99241 – 99245	Office, initial, new or established patient	TAR required; limited to ICD-9-CM code V72.83.
	99251 – 99255	Inpatient, initial, new or established patient	TAR required; limited to ICD-9-CM code V72.83.
Facility Use	HCPCS		
	<u>Code</u>	<u>Description</u>	
	Z7506	Use of operating room, first hour	
	Z7508	Use of operating room, first subsequent half hour	
	Z7510	Use of operating room, second subsequent half hour	
	Z7512	Use of recovery room	
	Z7514	Room and board, general nursing care for less than 24 hours, including ordinary medications	

Laboratory	CPT-4 <u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	N/A
	81001	automated with microscopy	N/A
	81002	non-automated, without microscopy	N/A
	81003	automated, without microscopy	N/A
	85002	Bleeding time	TAR required, limited to ICD-9-CM code V72.63
	85013	Blood count; spun microhematocrit	N/A
	85014	hematocrit (Hct)	N/A
	85018	hemoglobin (Hgb)	N/A

<u>CPT-4 Code</u>	<u>Description</u>	<u>Restrictions</u>
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	When required by the outpatient facility or medically indicated by clinical assessment in the context of provision of sterilization services.
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	When required by the outpatient facility or medically indicated by clinical assessment in the context of provision of sterilization services.
85610	Prothrombin time	TAR required, limited to ICD-9-CM code V72.63
85730	Thromboplastin time	TAR required, limited to ICD-9-CM code V72.63
88302	Surgical pathology, gross and microscopic examination	Two specimens only

Management of Complications

The following ICD-9-CM codes are used to bill for complication services related to tubal sterilization. An approved TAR is required unless stated otherwise. An additional ICD-9-CM code that identifies the contraceptive method in which the complication arose is required.

ICD-9-CM

<u>Code</u>	<u>Description</u>
995.22	Unspecified adverse effect of anesthesia requiring an overnight hospital stay

The following additional benefits are reimbursable with 995.22 when complications require an overnight hospital stay.

Evaluation & Management

CPT-4

<u>Code</u>	<u>Description</u>
99221 – 99223	Initial hospital care, per day
99231 – 99233	Subsequent hospital care, per day
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes

ICD-9-CM

<u>Code</u>	<u>Description</u>
868.10	Injury to other intra-abdominal organs with open wound into cavity; unspecified (within 30 days postoperative)

The following additional benefits are reimbursable with 868.10.

Anesthesia	CPT-4	<u>Description</u>
	<u>Code</u>	
	00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
Procedures	49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy
	49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
Laboratory	88305	Level IV – Surgical pathology, gross and microscopic examination
	ICD-9-CM	<u>Description</u>
	<u>Code</u>	
	998.59	Other postoperative infection (Female Sterilization – Operative site infection, within 30 days postoperative)

The following additional procedures are reimbursable with ICD-9-CM code 998.59.

Anesthesia	CPT-4	<u>Description</u>
	<u>Code</u>	
	00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified

Procedures	CPT-4 <u>Code</u>	<u>Description</u>
	10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
	10180	Incision and drainage, complex, postoperative wound infection
	49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy
	49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
Laboratory	87081	Culture, presumptive, pathogenic organisms, screening only
	87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)
	87184	disk method, per plate (12 or fewer agents)
	87186	microdilution or agar dilution (minimum inhibitory concentration (MIC or breakpoint), each multi-antimicrobial, per plate
	88305	Level IV – Surgical pathology, gross and microscopic examination
Pharmacy	Cephalexin Clindamycin	
		For TAR requirements and dispensing guidelines, refer to the <i>Pharmacy and Clinic Formulary</i> section in this manual.

Male Sterilization – 21 Years of Age and Older

Vasectomy procedures for male sterilization are billed with ICD-9-CM codes V25.2 and the following pre-selected procedure codes, as appropriate.

Additionally, V72.63 (pre-procedural laboratory examination) is billed for men with medical conditions that need screening for surgical contraindications. ICD-9-CM code V72.63 must be billed with ICD-9-CM code V25.09.

ICD-9-CM

<u>Code</u>	<u>Description</u>
V25.09	General counseling and advice; other (sterilization)
V25.2	Sterilization procedure
V26.52	Vasectomy Status (routine postoperative management and surveillance, and postoperative semen analysis up to 90 days)
<u>V72.63</u>	<u>Pre-procedural laboratory examination</u>

Procedures

<u>CPT-4 Code</u>	<u>Description</u>
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

Anesthesia	CPT-4	
	<u>Code</u>	<u>Description</u>
	00921	Anesthesia, vasectomy, unilateral or bilateral
	99144	Moderate sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time
	99145	each additional 15 minutes intra-service time

Supplies

Modifier UA or UB is required for the following supply.

CPT-4	
<u>Code</u>	<u>Description</u>
55250	Vasectomy supplies

Laboratory	CPT-4 <u>Code</u>	<u>Description</u>	<u>Restrictions</u>
	81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	Preoperative testing only.
	81001	automated with microscopy	Preoperative testing only.
	81002	non-automated, without microscopy	Preoperative testing only.
	81003	automated, without microscopy	Preoperative testing only.
	85013	spun microhematocrit	Preoperative testing only.
	85014	hemotocrit (Hct)	Preoperative testing only.
	85018	hemoglobin (Hgb)	Preoperative testing only.
	85025	Blood count complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	When required by the outpatient facility or medically indicated by clinical assessment.
	85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	When required by the outpatient facility or medically indicated by clinical assessment.
	88302	Surgical pathology, gross and microscopic examination	Two specimens only

Management of Complications

The following ICD-9-CM codes are used to bill for complication services. An approved TAR is required unless stated otherwise. An additional ICD-9-CM code that identifies the contraceptive method in which the complication arose is required.

ICD-9-CM

<u>Code</u>	<u>Description</u>
998.11	Hemorrhage complicating the procedure (Vasectomy: Testicular or spermatic cord hemorrhage, 30 days postoperative)
998.12	Hematoma complicating the procedure (Vasectomy: Testicular or spermatic cord hematoma, 30 days postoperative)

The following additional services are reimbursable with 998.11 and 998.12.

Anesthesia

CPT-4

<u>Code</u>	<u>Description</u>
00920	Anesthesia for procedures on male genitalia (including open urethral procedures; NOS)

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Procedures	<u>CPT-4 Code</u>	<u>Description</u>
	54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
	54670	Suture/repair of testicular injury
	54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)
	54865	Exploration of epididymis, with or without biopsy
Laboratory	<u>CPT-4 Code</u>	<u>Description</u>
	85018	Blood count; hemoglobin (Hgb)
	85025	Blood count; complete (CBC) automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
	Note:	CPT-4 codes 85018 and 85025 do not require a TAR.

ICD-9-CM

<u>Code</u>	<u>Description</u>
998.59	Other postoperative infection (acute infection at vasectomy operative site within 30 days postoperative)

The following additional services are reimbursable with 998.59.

Anesthesia

<u>CPT-4 Code</u>	<u>Description</u>
00920	Anesthesia for procedures on male genitalia (including open urethral procedures; NOS)

Procedures

54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)
55100	Drain scrotal abscess

Laboratory

87081	Culture, presumptive, pathogenic organisms, screening only
87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)
87184	disk method, per plate (12 or fewer agents)
87186	microdilution or agar dilution (minimum inhibitory concentration (MIC or breakpoint), each multi-antimicrobial, per plate

Pharmacy

Cephalexin
Clindamycin

For TAR requirements and dispensing guidelines, refer to the *Pharmacy and Clinic Formulary* section in this manual.

The following additional services are reimbursable with 338.28.

Anesthesia	CPT-4 <u>Code</u>	<u>Description</u>
	00920	Anesthesia, for procedures on male genitalia (including open urethral procedures, NOS)
Procedures	54865	Exploration of epididymis, with or without biopsy
	55110	Scrotal exploration
	55520	Excision of lesion of spermatic cord (separate procedure)

Reproductive Health Screening Tests

These services may be provided as clinically indicated. These services are not reimbursable for V25.03, V25.09 and V26.41, as noted in preceding pages in this section.

Reproductive Health Screening Tests *			
CPT-4 Code	Description	Reflex Testing (based on a positive screening test result)	Restrictions
86592	VDRL, RPR	86780 TP-confirmatory test; if positive, 86593 is required	
		86593 Syphilis test, non-treponemal antibody; quantitative	
86701	HIV-I	86689 <u>HIV confirmation test</u>	86689 Limited to HIV antibody
86702	HIV-II	<u>OR</u>	
86703	HIV-I and HIV-II, single result	<u>86701 and 86702 differentiation assay</u> <u>AND</u> <u>87535 HIV amplified probe technique (if differentiation assay results are negative or indeterminate)</u>	
87491	NAAT - Chlamydia	None	Refer to the CT and GC screening guidelines
87591	NAAT - Gonorrhea	None	

* These screening tests have a frequency limit of one test, per recipient, per month. For more information regarding the Laboratory Services Reservation System (LSRS), refer to the *Laboratory Services* section in this manual.

The Centers for Disease Control and Prevention (CDC) *Sexually Transmitted Disease Treatment Guideline, 2010* recommends chlamydia screening for all women 25 years of age and younger. The *California Sexually Transmitted Disease (STD) Screening Recommendations, 2010* recommends only targeted Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (GC) screening for women 25 years of age and older with risk factors. The risk factors and corresponding ICD-9-CM codes are noted below.

STI Risk Factors and Related ICD-9-CM Codes		
Code	Definition	Indications
V01.6	Contact with or exposure to communicable disease – venereal disease	Recent contact (exposure) to an STD, specifically chlamydia, gonorrhea, non-gonococcal urethritis, epididymitis, trichomoniasis, syphilis or HIV
V02.8	Carrier or suspected carrier of infectious disease – other venereal disease	Diagnosed with trichomoniasis (women), syphilis, or HIV, either confirmed or presumptively treated, who may be co-infected with chlamydia or gonorrhea
V69.2	High risk sexual behavior	Targeted STD screening: <ul style="list-style-type: none"> • Infection with chlamydia or gonorrhea in the past 2 years; • More than one sex partner in the previous 12 months; • A new sex partner in the previous 3 months; • Belief that a partner from the previous 12 months may have had other sex partners at the same time
V12.09	Personal history of certain other diseases – infectious and parasitic diseases, other NEC	Retesting in 3 months after treatment of CT or GC
V73.88	Chlamydia screening	High prevalence at practice site (CT > 3%)
V74.5	Screening for bacterial STDs (GC, syphilis)	High prevalence at practice site (GC > 1%)

Reproductive health screening tests for CT and GC may require an additional ICD-9-CM diagnosis code on the Family PACT claim form. For additional information refer to the Family PACT CT and GC screening guidelines in this section.

For CT and GC screening test(s) to be reimbursed, the ordering provider must indicate the medical necessity for the test with the ICD-9-CM code noted above, as appropriate, on the laboratory order. The laboratory provider must include the ICD-9-CM diagnosis code that identifies the contraceptive method for which the patient is being seen.

Family PACT Chlamydia and Gonorrhea Screening Guidelines				
Gender	Age	GC/CT test 87491 and 87591	Additional ICD-9-CM Code required	Billing restrictions
<u>Females</u>	<u>≤25Years</u>	<u>Routine annual (1x) screening, any provider</u>	<u>None</u>	<u>Covered when provided as part of the family planning visit or coincident to the visit for the management of a family planning method.</u> <u>LSRS process applies</u>
<u>Females</u>	<u>≤25 years</u>	<u>More than 1x per year/ same provider based on risk factors</u>	<u>V01.6, V02.8, V69.2, V12.09, V73.88, V74.5</u>	
<u>Females</u>	<u>>25years</u>	<u>Restricted to those with increased risk of infection</u>	<u>*See Benefits: Family Planning-Related Services for additional ICD-9-CM codes for CT and GC diagnostic testing</u>	
<u>Males</u>	<u>Any age</u>	<u>Restricted to those with increased risk of infection</u>	<u>V01.6, V02.8, V69.2, V12.09, V73.88, V74.5</u> <u>*See Benefits: Family Planning-Related Services for additional ICD-9-CM codes for CT and GC diagnostic testing</u>	