Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Providers of Family Planning Clinic Services

Subject: Implementation of Maximum Fee Schedule

Date: March 23, 1987

Code: MAPB-87-005-P

This bulletin contains the following information:

I. IMPLEMENTATION OF THE NEW FAMILY PLANNING CLINIC MAXIMUM FEE SCHEDULE

II. NEW BILLING REQUIREMENT: TYPE OF SERVICE INDICATOR

III. BILLING FOR FAMILY PLANNING LABORATORY SERVICES

IV. PHARMACY VISIT AND SUPPLY CODES

V. FREQUENTLY BILLED LABORATORY PROCEDURE CODES

I. FAMILY PLANNING MAXIMUM FEE SCHEDULE

Effective for all dates of service on and after May 1, 1987, the Wisconsin Medical Assistance Program (WMAP) will discontinue reimbursement by contracted rates for family planning clinic services based on family planning clinic cost reports. This change in reimbursement methodology conforms with current provider Terms of Reimbursement, which specify that family planning clinics will be reimbursed according to maximum allowable fees. The maximum fees are being implemented on a statewide basis and will be reviewed annually. Reimbursement changes are based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medical Assistance Program, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.

Therefore, effective for all dates of service on and after May 1, 1987, the WMAP will reimburse family planning clinics certified in the WMAP the lower of the billed amount or the maximum allowable fee in accordance with the following maximum fee schedule:

Wisconsin Department of Health and Social Services, Division of Health, Bureau of Health Care Financing, Provider/Recipient Services, P.O. Box 309, Madison, Wisconsin 53701

WMAP FAMILY PLANNING CLINIC
MAXIMUM FEE SCHEDULE

INITIAL VISIT (90020)	ANNUAL VISIT (90080)	MD FOLLOW UP VISIT (90040)	RN FOLLOW UP VISIT (90030)	PHARMACY VISIT (09995)
$37.00	$37.00	$20.00	$26.00	$6.00

Providers are reminded that they are required to bill the WMAP for services provided to WMAP recipients at their "usual and customary charge", that being the charge for the same service billed to non-WMAP patients.

Family planning clinics currently certified by the WMAP will begin being paid at the lower of the usual and customary or the above rates for claims submitted for dates of service on and after May 1, 1987. Family planning clinics certified on or after May 1, 1987, are not required to complete a WMAP cost report. They may begin submitting claims, and receiving reimbursement according to the rates indicated on the above maximum fee schedule, starting with dates of service on and after the effective date of their WMAP provider certification.

II. NEW BILLING REQUIREMENT: TYPE OF SERVICE INDICATOR

Effective with the implementation of the Family Planning Maximum Fee Schedule, family planning clinics must bill for their services using a type of service indicator. This is a new billing requirement for family planning clinics. Family planning clinics must use type of service (TOS) 9 when submitting claims for family planning services, except for laboratory services (See III below). The type of service must be placed in element 24f under the column labeled "T.O.S." on the Uniform Health Insurance claim form.

III. BILLING FOR FAMILY PLANNING LABORATORY SERVICES

Providers should note that effective with the implementation of the maximum fee schedule on May 1, 1987, family planning laboratory services provided in conjunction with a family planning Initial, Annual, MD or RN Follow-up office visit must be billed on the Uniform Health Insurance claim form using CPT-4 laboratory procedure codes. Laboratory procedures should be billed as type of service 5. This includes laboratory services billed by the family planning clinic but performed by a WMAP certified independent laboratory. Laboratory services performed by an independent laboratory but billed by a family planning clinic are reimbursable to the family planning clinic only if the independent laboratory performing the work is WMAP certified.

The family planning clinic may bill for a handling charge if the laboratory work is sent to an independent laboratory which bills the WMAP directly. The family planning clinic may bill for a handling charge, as well as the lab work, if the laboratory which did the work does not bill the WMAP for the services and the family planning clinic indicates the name and Medical Assistance provider number of the independent laboratory in element 21 of the claim form.

If the laboratory work is performed by the family planning clinic laboratory, indicate in element 24b of the claim form place of service (POS) 1. Laboratory work sent to a WMAP certified independent laboratory, but billed by the family planning clinic, must be billed by indicating POS 6 in element 24b on the Uniform Health Insurance claim form.

The only exceptions to the CPT-4 procedure code requirement when billing for laboratory services are the following three procedures which are included in the rate of each medical visit (i.e., Initial, Annual, MD or RN Follow-up) and which will not be reimbursed if separately billed by a family planning clinic:

1. Papanicolaou Smear (88150)

2. Hematocrit (85014)

3. Urinalysis (81000)

IV. PHARMACY VISIT AND SUPPLY CODES

Laboratory services are not separately reimbursable if billed with a Family Planning Pharmacy Visit, procedure code 09995. A Family Planning Pharmacy Visit should only be billed when the sole purpose of the visit is to obtain supplies or oral contraceptives. If any medical treatment or counseling services are performed, a medical visit (i.e., Initial, Annual, MD or RN Follow-up) must be billed.

When the sole purpose of a family planning visit is to dispense a supply item, the Family Planning Pharmacy Visit and the supply item are both reimbursable. If a recipient comes into the clinic for the sole purpose of obtaining a supply of oral contraceptives, only the Family Planning Pharmacy Visit is reimbursable. There is no separate reimbursement for oral contraceptives. Each office visit rate includes reimbursement for oral contraceptives as part of the visit fee.

Following is a list of family planning supply codes and narrative descriptions. Note that the narrative for procedure code 09919 includes contraceptive sponges.

CONTRACEPTIVE SUPPLY CODES

CODE	DESCRIPTION
09917	Intrauterine Device
09918	Diaphragms

CODE	DESCRIPTION
09919	Jellies, Creams, Foams, Suppositories (per unit), Contraceptive Sponges
09920	Condoms (per 12)
09921	Natural Family Planning Supplies

V. FREQUENTLY BILLED FAMILY PLANNING LABORATORY PROCEDURES

The following list of frequently billed family planning laboratory procedures is presented to facilitate provider billing. Refer to Appendix 2 in the WMAP provider handbook, Part E, issued in September, 1981, for a more comprehensive listing of commonly billed family planning procedure codes.

CODE	DESCRIPTION
81015	Urinalysis - routine, microscopic
82465	Cholesterol level
82947	Post-prandial blood glucose
83052	Sickle, turbidimetric
84478	Triglycerides, blood
85018	Hemoglobin
85022	CBC
85660	Sickle cell screening
86280	Rubella test
86592	Syphilis, precipitation of flocculation tests, qualitative VDRL, RPR, DRT
86593	Syphilis, precipitation of flocculation tests, quantitative