



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# NEWSLETTER

Volume 26 No. 11

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THIS NEWSLETTER ANNOUNCES NEW ICD-10 BILLING INFORMATION  
PLEASE DISREGARD NEWSLETTERS VOLUME 19, NO. 08 FOR CLAIMS WITH SERVICE DATES  
ON OR AFTER OCTOBER 1, 2015

**TO:** Family Planning Clinics, Physicians, Advanced Practice Nurses, Nurse Midwives, Independent Clinics, Laboratories, Hospitals – **For Action**  
Health Maintenance Organizations – **For Information Only**

**SUBJECT:** **ICD-10 Update: Family Planning Services and Sterilization Consent Forms**

**EFFECTIVE:** Immediately

**PURPOSE:** To notify providers regarding (1) billing procedures for requesting payment for family planning services; and (2) guidelines for completing the Sterilization Consent Form (Form-7473-M, Edition 3-81).

**BACKGROUND:** **Family planning services** prevent or delay pregnancy or otherwise control family size. Section 1905(a)(4)(C) of Title X requires states to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State Plan and who desire such services and supplies. Family planning services include medical history and physical examination (including pelvic and breast); the ordering of diagnostic and laboratory tests; the prescribing of drugs and biologicals, medical devices and supplies; and providing continued medical supervision, counseling, and continuity of care (see N.J.A.C. 10:49-5.2).

Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the NJ FamilyCare Program.

**Sterilization** is any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing (see N.J.A.C. 10:52-2.13, 10:54-5.41 or 10:66-2.15). The individual to be sterilized shall be at least 21 years of age at the time the sterilization consent form is signed by the individual to be sterilized; mentally competent; and voluntarily given informed consent in accordance with all requirements prescribed in 42 CFR 441.257 through 441.258.

## **ACTION:**

### **Family Planning Billing Procedures**

1. For paper 1500 claim forms, providers must report a Family Planning Indicator value of '2' for Family Planning Services or a value of '3' for Family Planning Services when part of EPSDT in Field 24H or Field SV112 in the HIPAA claim transaction.
2. For paper UB-04 claim forms, providers must report the Condition Code 'A4' in Field 18-28 or Field H101-2 in the HIPAA claim transaction.
3. **For claims with service dates prior to October 1, 2015**, providers must report ICD-9-CM diagnosis codes in the following series: V25 (Encounter for Contraceptive Management); or V26 (Procreative Management).
4. **For claims with service dates on or after October 1, 2015**, providers must report ICD-10-CM diagnosis codes in the following series: Z30 (Encounter for Contraceptive Management); or Z31 (Encounter for Procreative Management).

### **Sterilization Consent Forms**

The Consent Form 7473-M ED 3-81 (see Fiscal Agent Billing Supplement) is a replica for the form mandated by federal regulations and the completed form is required when requesting State payments for sterilization procedures. All providers associated with a sterilization procedure (i.e. hospital, operating physician, anesthesiologist, clinic, etc.) are required to complete the Consent Form 7473-M ED 3-81 and attach the completed form to a **paper claim form** (HIPAA claims not accepted) submitted to the State fiscal agent for payment consideration. **Without a properly completed and signed Consent Form attached to the claim, any payment request will be denied by the State of New Jersey.**

### **Post Payment Reviews**

The State shall conduct a post-payment review of paid claims for family planning services utilizing a random sample of NJ FamilyCare claims for clinic, laboratory, radiology, practitioner or hospitals services billed as family planning services. Payments for services that do not meet the definition of family planning services based on applicable federal regulations shall be recovered by the State of New Jersey.

If you have any questions concerning this Newsletter, please contact the Division of Medical Assistance and Health Services, Office of Preventive Services, at 609-588-2739.

**RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE**

**CONSENT FORM**

Notice: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

**o CONSENT TO STERILIZATION o**

I have asked for and received information about sterilization from \_\_\_\_\_ . When I first asked for the \_\_\_\_\_ (Doctor or Clinic) information. I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT. BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a \_\_\_\_\_ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_ , (Month Day Year)

I, \_\_\_\_\_ , hereby consent of my own free will to be sterilized by \_\_\_\_\_ by a method \_\_\_\_\_ (Doctor) called \_\_\_\_\_ . My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal Laws were observed.

I have received a copy of this form.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- American Indian or Alaska Native
- Asian or Pacific Islander
- Black (not Hispanic origin)
- Hispanic
- White (not of Hispanic origin)

**o INTERPRETER'S STATEMENT o**

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter \_\_\_\_\_ Date \_\_\_\_\_

**o STATEMENT OF PERSON OBTAINING CONSENT o**

Before \_\_\_\_\_ signed the consent (Name of Individual) form, I explained to him/her the nature of the sterilization operation \_\_\_\_\_ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent \_\_\_\_\_ Date \_\_\_\_\_

Facility \_\_\_\_\_

Address \_\_\_\_\_

**o PHYSICIAN'S STATEMENT o**

Shortly before I performed a sterilization operation upon \_\_\_\_\_

(Name of individual to be sterilized) on \_\_\_\_\_ , I explained to (Date of sterilization operation)

him/her the nature of the sterilization operation \_\_\_\_\_ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery;
- Individual's expected date of delivery;
- Emergency abdominal surgery;

(describe circumstances): \_\_\_\_\_

Physician \_\_\_\_\_  
Date \_\_\_\_\_