VIRGINIA DEPARTMENT OF HEALTH

DIVISION OF WOMEN'S & INFANTS' HEALTH

Sterilization Guidelines

Division of Women's & Infants' Health
1500 East Main Street, Room 135
Richmond, Virginia

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FAMILY PLANNING PROGRAM

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Office of Family Health Services
Division of Women's & Infants' Health
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Fax Number #: (804) 371-6032

STERILIZATION

GENERAL OVERVIEW

The Virginia Department of Health (VDH) offers voluntary sterilization services for women and men who meet the eligibility requirement. This sterilization program is sponsored by the Family Planning services Program using general funds allocated by the General Assembly of Virginia.

Annually, the Department provides funding to support a limited number of qualified patients from within the Commonwealth who have expressed a desire for a permanent sterilization surgical procedure. **All patients must be 21 years of age and may be male or female.**

The VDH program is not in competition with a similar Commonwealth Medicaid program funded through the Department of Medical Assistance Services—**although our payment rates are exactly the same.**

A copy of the counseling guidelines from the Association for Voluntary Sterilization, located in your Family Planning Manual, will help guide you through the process of counseling for informed consent as well as for the well being of the patient

COMMONWEALTH of VIRGINIA

Department of Health

Robert B. Stroube, MD, MPH
State Health Commissioner

1500 East Main Street, Suite 135
Richmond, Virginia 23219
(804) 786-7569

FAMILY PLANING SERVICES
VOLUNTARY STERILIZATION PROGRAM OVERVIEW

PREFACE

The information provides a summary overview of the program and contractual provisions attendant to the Virginia Department of Health (VDH), Family planning Services, and Voluntary Sterilization Program. This information is not intended to be all-inclusive but rather provides a potential provider with essential information outlining the terms and conditions for participation. If further information is desired or you would like to be provided an invitation to sign a service agreement, please contact the Virginia Department of Health as provided herein.

PROGRAM

Annually, the Department provides funding to support a limited number of qualified patients from within the Commonwealth who have expressed a desire for a permanent sterilization surgical procedure. All patients must be 21 years of age and may be of either sex. They are interviewed and screened within local health department. If approved, an established process is initiated to fully inform the patient of the procedure implication, obtain consent, and to secure resources for required period of time from the Department to fund the procedure.

Once the local health department approves an application, ***Consent To Sterilization*** forms are signed, and the designated amount of funds committed, the patient is then authorized to contact their physician (surgeon) of choice. The patient is encouraged to immediately schedule the surgical procedure within 60 days after a “30-day waiting period” following the signing of ***Consent To Sterilization***. This program provides a unique public health opportunity and service for indigent patients who are not enrolled in Medicaid and who have no other source of funds to pay the associated fees.

The VDH program is not in competition with a similar Commonwealth Medicaid program funded through the Department of Medical Assistance Services – **although our payment rates are exactly the same.** One of the VDH patient qualification requirements is that they not be enrolled in Medicaid. However, in spite of our attempts to identify those enrolled, there are from time-to-time a few occasions when duplicative payments may be made by Medicaid or through

private insurance. In such cases, VDH will not agree to make any form of duplicative or supplementary payment and would recall its initial payment to providers for their services.

The services that you and your colleagues provide to our patients are most valued and your interest and support is greatly appreciated. We are currently offering providers (surgeons, pathologists, anesthetists, hospital or surgical facilities, etc.) with an agreement opportunity to participate for a period of five years. This agreement does not obligate you in any way to deliver service to our patients. If you do not wish to see any patients during the five-year agreement period then it is your right to refuse service at any time.

TERMS AND CONDITIONS

Should you become a contracted provider with VDH, there are several key terms and conditions that we require:

All providers must first have a current countersigned contractual agreement on file with the Virginia Department of Health.

All medical providers agree to accept the Commonwealth's established Medicaid rates for reimbursement cost to charge ratios for reimbursement of the VDH supported services.

All medical provider-billing statements will be presented to the **local health department** for payment reflecting CPT codes on Form HCFA-1500 (12-90) within 60 days of the procedure date. **Billings received beyond the 60 days limit will not be reimbursed.**

All hospital or surgical facility provider billings will be presented to the local health department for payment on Form UB-92 HCFA-1450 within sixty days of the procedure date. **Billings received beyond the 60 day limit period will not be reimbursed.**

Any medical provider who is the attending surgeon must sign and return a ***Physician's Statement*** verifying patient counsel and the date that the procedure was completed before payment will be released to the surgeon.

All providers agree to accept reimbursement as payment in full and shall not bill or otherwise seek payment from the patient for any balance. **The patient will not be held responsible for any charges incurred as a result of his or her sterilization procedure.**

The Virginia Department of Health hopes that this information has been informative and helpful. As well, we hope that you will favorably consider an agreement to provide our patients with your much needed professional skills and services. We welcome the opportunity to work with you.

If you are interested in our offer or desire further information, you should contact the program management at the following address:

Virginia Department of Health
Division of Women's and Infants' Health
ATTN: Ardriene D. Stuart
1500 East Main Street, Room 135
Richmond, Virginia 23219

Office Telephone: (804) 786-7569 Office Fax: (804) 371-6032

If you are requesting an agreement we ask that you please provide your full name, title, business address, telephone number, and Taxpayer Identification number (TIN). Should there be associates within your firm who would like to contract for participation in the VDH program the same information is required from all.

Please further assist our efforts in publicizing the Department's program provisions and pass a copy of this information along to any other interested parties!

SECTION 2

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Coordinator Guidelines
Contract Request Form
Consent Form A
Consent Form A (Spanish)
Consent Form B
Consent Form B (Spanish)
Information Check Sheet – Instructions
    Information Check Sheet (English & Spanish)
Patient Agreement
Letters
    Surgeon
    Hospital

Federal Regulations and Suggested Guidelines
Title X Voluntary Sterilization Program in Virginia

1. **Age Requirements**

   ∗A. Must be 21 years of age (male or female)
   NO EXCEPTIONS

   ♦B. Client preferably between the ages of 30 and 40 years

   ♦C. If above 40 years of age, must have had a recent pregnancy within the past year.

   ♦D. If below 25 years of age, should have parity of 3 or greater, and less than 2 years between pregnancies.

2. **Income Requirements**

   ∗A. Income Level "A" of the Federal Poverty Guidelines (100% of poverty)

   ♦B. Must **not** be currently enrolled in or eligible for Medicaid

   ♦C. Has **no** private insurance unless
   a. The insurance plan does not cover the sterilization procedure.
   b. The combined medical and hospital deductible exceeds $500.
   Anyone with private insurance exceptions must still meet the A income criteria

3. **∗Mentally Competent – Client must be able to give legal consent.**

4. **∗Not Court Ordered**

5. **∗Male Clients – All males must meet Federal Regulations 1A, 2A, 3, 4**

6. ♦Parity – Client male or female suggested to be parity of 2 or more

7. ♦Medical and/or Social High Risk

8. ♦Do not enroll pregnant women after January 31 if you know they will be receiving Emergency Medicaid at the time of delivery

∗Required Criteria – Federal Title X Requirements

♦**Suggested Program Guidelines –** The sterilization program guidelines are recommendations intended to assist the local sterilization program coordinators in formulating their selection of appropriate individuals for the Voluntary Sterilization Program under Title X. When local sterilization coordinators are determining eligible clients, they should consider the federal regulations, the statewide program guidelines, individual client circumstances and the reality that the statewide program service requests always exceed the available financial resources.

STERILIZATION COORDINATOR* GUIDELINES

1. **Determine eligibility using guidelines.**

2. **Provide sterilization counseling (See Family Planning Manual, Sterilization Program)**

3. **Complete required forms:**

   a. **Consent to Sterilization - Part A**

   b. **Physician's Statement - Part B**

   c. **Sterilization Check Sheet**

   d. **Patient Agreement**

4. **Determine if physician, surgical facility or other providers (anesthesiologist, pathologist, or radiologist, etc.) have a current contract on the list provided. If you do not have a care provider in your area with a contract and a provider is interested, give him/her a copy of the "Voluntary Sterilization Program Overview". Fax the Contract Request Form to Ardriene Stuart, Program Manager, in the Division of Women's & Infants Health (DWIH), at (804) 371-6032 with the name, business address, telephone number and *NAME OF A CONTACT* person if a contract is desired. A contract will be sent to the care provider (Contract Request Form included).**

   - ➔ Provider must accept current Medicaid established rates of reimbursement.

   - ➔ Must accept reimbursement as payment in full and not bill the patient for any balance.

   - ➔ **Medical providers must bill using current CPT codes on Form HCFA-1500 (12-90). Hospital or surgical facility providers must bill using form UB-92 HCFA-1450.**

   - ➔ **Surgeon must provide signed Physician's Statement" with the bill.**

   - ➔ **Bills must be submitted to local health department within 60 days of the procedure.**

   a. **Assist in process by calling the DWIH to determine if contract was sent, if care provider received contract, and encourage prompt return of the contract when received.**

a. **Patient may not schedule a surgery date with a physician unless a contract has been signed and returned to the OFHS. A Procedure Confirmation Number (PCN) will not be assigned until the provider has a signed contract on file in OFHS.**

5. **Call Ardriene Stuart in the Division of Women's and Infants' Health (DWIH) to obtain a confirmation (PCN) for funding at (804) 786-7569. Provide in - formation on the VDH Family Planning Services Voluntary Sterilization Case Management Worksheet", lines 1 – 9.**

6. **Provide both written and verbal information to the patient about her/his responsibilities. Have patient sign the patient agreement and give her/him a copy.**

7. **Give the patient 2 envelopes. Stress to the patient the importance of the envelopes being given to the surgeon and to the facility when admitted for the procedure.**

a. **Envelope # 1 – Surgeon (write surgeon's name on envelope).**

- ➔ **Consent to Sterilization - Part A**
- ➔ **Physician's Statement – Part B**
- ➔ **Letter to Physician (Use local health department letterhead)**
- ➔ **Copy of Family Planning Services Voluntary Sterilization Program Overview".**

b. **Envelope # 2 – Surgical Facility (write name of surgical facility on envelope).**

- ➔ **Letter to Admissions Officer (Use your local health department letterhead).**
- ➔ **Copy of Family Planning Services Voluntary Sterilization Program Overview".**

8. Call Ardriene Stuart in the DWIH, Phone: (804) 786-7569 and provide the following information: (MM-DD-YY). If desired, you can fax: (804) 371-6032 or mail a copy of the coordinator's worksheet to the Program Manager. All of this information is very important. FAILURE TO PROVIDE THIS INFORMATION *CAN PREVENT* ANOTHER PATIENT FROM PARTICIPATING IN THE PROGRAM.

a. **Date of appointment with surgeon (if patient fails to contact you before the 30-day waiting period has expired, attempt to contact her/him). If patient fails to contact you or you cannot contact the patient, funds allocated for that patient will be released.**

b. **Date of scheduled surgery (notify DWIH within 35 days from the date the consent was signed with the appointment date for the surgery). If DWIH is not notified by that date, the allocated funds will be released.**

c. **Date of actual surgery (notify DWIH within 95 days from the date the consent was signed with the date the sterilization procedure was done). If DWIH is not notified by that date, the allocated funds for the patient's sterilization procedure will be released.**

9. **Develop a system for tracking the various time limits (i.e., tickler cards).**

a. **date consent form signed**

b. **30 day waiting period: appointment date with surgeon**

c. **35 day waiting period: date for scheduled surgery**

d. **95-day period for the sterilization procedure: date of surgery**
e. **60-day care provider billing period: received bills from care providers**

10. **Contact care provider if bills have not been received within the 60 days from date of surgery. Review bills for accuracy when received. (See Section # 6 for coordinator billing guidelines).**

Date Contract Returned:

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

CONTRACT REQUEST FORM

TO: **Ardriene D. Stuart** **FAX #: 804-371-6032**
Telephone #: (804) 786-7569

FROM: _____ **Date of Request:** _____

PROVIDER INFORMATION

NAME: _____

_____

ADDRESS: _____

_____

NAME OF CONTACT: _____

TELEPHONE #: _____

COORDINATOR NAME: _____

TELEPHONE #: _____

NEW CONTRACT ☐ **CONTRACT RENEWAL** ☐

Type of Service To Be Provided (Specialty)

Surgeon	☐	Facility	☐
Pathologist	☐	Radiologist	☐
Anesthesiologist	☐	Urologist	☐

Date Contract Sent Out: _____

VIRGINIA DEPARTMENT OF HEALTH

Form Approved: OMB No. 0937-0166
Expiration date: 08/31/2006

CONSENT FOR STERILIZATION

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.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the 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 30 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 ____ (day), ____(month), ____ (year).

I, _____, hereby consent of my own free will to be sterilized by _____ by a method 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 and Human Services 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

Ethnicity:
G Hispanic or Latino
G Not Hispanic or Latino
Race (mark one or more):
G American Indian or Alaska Native
G Asian
G Black or African American
G Native Hawaiian or Other Pacific Islander
G White

INTERPRETER=S STATEMENT

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_____

STATE OF PERSON OBTAINING CONSENT

Before _____ (name of individual), signed the consent 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_____
11/03

CONSENTIMIENTO PARA LA ESTERILIZACION

Nota: SU DECISION EN CUALQUIER MOMENTO DE NO SER ESTERILIZADO (A) NO RESULTARIA EL DE QUITARLE O RETENER CUALQUIERA DE LOS BENEFICIOS PROVEIDOS POR LOS PROGRAMS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

CONSENTIMIENTO A LA ESTERILIZACION

Yo he preguntado y he recibido información acerca de la esterilización de _____ (doctor o clínica). Cuando primero yo pregunté por la información, me dijeron que la decisión a ser esterilizado(a) es completamente mía. Si yo decido de no ser esterilizado(a), mi decisión no afectaría mis derechos a un cuidado o tratamiento en el futuro. Yo no perdería ninguna ayuda o beneficios de los programas que reciben fondos Federales como A.F.D.C o Medicaid que ahora yo obtengo o por el cual yo soy elegible.

YO ENTIENDO QUE LA ESTERELIZACION DEBERA DE SER CONSIDERADA PERMANENTE Y NO ES REVERSIBLE. YO HE DECIDIDO QUE YO NO QUIERO EMBARASARME, PARIR HIJOS O PROHIJAR.

Me dijeron acerca de estos métodos temporeros de control de natalidad que están disponibles y me puedan ser proveídos, el cual me permitiría de parir o prohijar un hijo en el futuro. Yo he rechazado estas alternativas y he elegido de ser esterilizado(a).

Yo entiendo que yo seré esterilizado(a) por una operación conocida como _____. Las molestias, riesgos, y beneficios asociados con la operación se me han explicado. Todas mis preguntas han sido respondidas satisfactoriamente.

Yo entiendo que la operación no será hecha hasta por lo menos 30 días después que yo firme este formulario. Yo entiendo que yo puedo cambiar de mente en cualquier momento y que mi decisión de no ser esterilizado(a) no resultaría en que me nieguen ningunos de los beneficios o servicios médicos proveídos por los programas con fondos Federales.

Yo tengo por lo menos 21 años de edad y nací el _____(día), _____(mes), _____, (año) _____. Yo, _____
Por este medio consiento de mi propia voluntad a ser esterilizado(a) por_____
Un método llamado_____. Mi consentimiento vence en 180 días desde la fecha de mi firma.

También yo doy consentimiento a poder circular este formulario y otros documentos médicos acerca de la operación a los Representantes del Departamento de Salud y Servicios Humanos o Empleados de programas o proyectos con fondos por ese Departamento, pero sólo para determinar las leyes Federales que fueron observadas.

Yo he recibido una copia de este formulario.

Firma_____

Fecha:_____
(Día, mes, año)

Le pedimos que suministre la siguiente información, pero es opcional

Raza y Etnicidad

Etnicidad

- ☐ Hispano o Latino
- ☐ No-Hispano o Latino

Raza

- ☐ Indio Americano o Nativo de Alaska
- ☐ Negro o Afro-Americano
- ☐ Nativo de Hawaii o de las islas de Pacífico
- ☐ Blanco

DECLARACION DEL INTERPRETE

Si un intérprete es proveído para asistir a la persona que vá a ser esterilizada:

Yo he traducido esta formulario y le he aconsejado verbalmente a la persona que será esterilizado(a) por la persona que está obteniendo este consentimiento. También yo le he leído a él o ella el formulario de consentimiento en _____idioma y le he explicado el contenido de este a él o ella. A mi mejor conocimiento y creencia, él o ella entiende esta explicación.

Intérprete:_____

Fecha:_____
(Mes, día, año)

DECLARACION DE LA PERSONA QUE ESTA CONSIGUIENDO EL CONSENTIMIENTO

Antes _____ (nombre de la persona), firmó el formulario del consentimiento. Yo le expliqué a él o ella la naturaleza de la operación de esterilización.
_____, el hecho del cual es deseado que sea un procedimiento final e irreversible y las molestias, riesgos, y beneficios que estén asociados.

Yo aconsejé a la persona que vá a ser esterilizado(a) de los disponibles métodos alternos para el control de la natalidad que son temporeros. Yo les expliqué que la esterilización es diferente porque es permanente.

Yo le informé a la persona que vá a ser esterilizado(a) que el consentimiento de él o ella podría ser retirado en cualquier momento y que él o ella no perdería ninguno de los servicios de salud o ningunos de los beneficios proveídos con fondos Federales.

Al mejor conocimiento y creencia de la persona que vá a ser esterilizado(a) debe de tener por lo menos 21 años de edad y estar mentalmente competente. El o Ella con el conocimiento y voluntariamente, pidió de ser esterilizado(a) y aparenta entender la naturaleza y consecuencias del procedimiento.

Firma de la persona que está obteniendo el consentimiento: _____
Fecha:_____
Dirección:_____

PHYSICIAN=S STATEMENT

Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on _____ (date of sterilization), _____ (operation), I explained to him/her the nature of the sterilization operation _____ (specify type of 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 30 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):

G Premature delivery
Individual's expected date of delivery:_____

G Emergency abdominal surgery:
(describe circumstances):_____

_____
Physician=s Signature

Date_____

PAPERWORK REDUCTION ACT STATEMENT

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the

OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual=s consent, pursuant to any applicable confidentiality regulations.

11/03

DECLARACION MEDICA

En breve, antes de realizar la operación de esterilización_____(nombre de la persona que vá a ser esterilizado(a), en_____ (fecha de esterilización), _____(operación). Yo le expliqué a él o ella la naturaleza de la operación _____(especifiqué la clase de operación), el hecho que sea deseado, final y un procedimiento irreversible y las molestias, riesgos, y los beneficios asociados con la operación.

Yo le informé a la persona que vá a ser esterilizado(a) que el consentimiento de él o ella puede ser retirado en cualquier momento y que él o ella no perdería los servicios de salud o beneficios proveídos por los fondos Federales.

A mi mejor conocimiento y creencia, la persona que vá a ser esterilizado(a) deberá de tener por lo menos 21 años de edad y estar mentalmente competente. El o Ella con el conocimiento propio y voluntariamente pidió ser esterilizado(a) y comprende la naturaleza y las consecuencias del procedimiento.

(Instrucciones para el uso alterno de los párrafos finales: Use el primer párrafo de abajo, excepto en caso de un parto prematuro o una cirugía de emergencia abdominal donde la esterilización se hizo en menos de los 30 días después de la fecha en que la persona firmó el formulario de consentimiento. En estos casos, el segundo párrafo siguiente deberá de ser usado. Tache el párrafo el cual no vá a ser usado).

(1) Por lo menos han pasado 30 días entre la fecha del formulario de la persona en el formulario de consentimiento y la fecha en que la esterilización fue hecha.

(2) Esta esterilización fué hecha en menos de los 30 días, pero más de 72 horas después de la fecha en que la persona firmó el formulario de consentimiento por las siguientes circunstancias (Marque la casilla que aplique y llene la información requerida)

- ☐ Parto prematuro
- ☐ Fecha en que se espera el parto de la persona
- ☐ Cirugía abdominal de emergencia (describa las circunstancias)

_____

_____ Fecha: _____

Firma del Médico

DECLARACION DEL ACTA DE REDUCCION DE DOCUMENTOS

Una agencia federal no puede conducir o patrocinar, y una persona no es obligada a responder a la información coleccionada a menos que enseñe un número de control válido de OMB. El gravamen público de informar para la colección de información puede variar; sin embargo, nosotros estimamos un promedio de una hora por respuesta, incluyendo para la revisión de las instrucciones, colecciones y mantenimiento de los datos necesarios, y la información revelada. Envíe cualquier comentario con respecto al estimado del gravamen o cualquier otro aspecto de la información coleccionada a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building 200 Independence Avenue,SW, Washington, D.C. 20201.

Las personas respondientes deberán de ser informados que la colección de la información requerida en este formulario está autorizada bajo la ley 42 CAR part 30, subpart B relacionada con la esterilización de personas en los programas federales asistidos de salud pública. El objetivo de requerir esta información es para asegurarse que las personas que requieran la esterilización reciban la información concerniendo los riesgos, beneficios y consecuencias, y para asegurar la información voluntaria e informar el consentimiento de todas las personas que están siendo esterilizadas en programas federales asistidos de salud pública.

Toda la información con referencia a circunstancias y datos personales obtenidos mediante este formulario, son estrictamente confidencial, y no se darán a conocer sin el consentimiento de la persona, de acuerdo a cualquier reglamento en confidialidad que aplique.

INSTRUCTIONS FOR COMPLETING THE

VOLUNTARY STERILIZATION INFORMATION CHECK SHEET

1. **The person who interviews and counsels the patient while completing the consent form cannot complete the check sheet. A different interviewer must complete the check sheet after discussing the questions with the applicant. (The check sheet is to be used to assure that all items have been discussed with the applicant).**

2. **The check sheet must be signed and dated by the applicant after all questions have been asked and answered.**

3. **The check sheet must be signed and dated by the second interviewer.**

4. **Retain the completed "Sterilization Information Check Sheet" in the patient's files. Give a copy to the patient.**

STERILIZATION INFORMATION CHECK SHEET

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.

1. Was your decision to be sterilized voluntary? Yes ☐ No ☐

2. Do you understand that your decision about sterilization will not influence any benefits you are receiving? Yes ☐ No ☐

3. Do you understand that you cannot be sterilized until 30 days after you have signed the consent document? Yes ☐ No ☐

4 a. Do you understand the medical procedure? Yes ☐ No ☐

b. Do you understand the probable risks and discomforts? Yes ☐ No ☐

c. Do you understand that being sterilized will prevent pregnancy without using any other form of birth control? Yes ☐ No ☐

d. Do you understand that sterilization is permanent and cannot be undone? Yes ☐ No ☐

e. Do you understand there is a small possibility this procedure will not prevent pregnancy. Yes ☐ No ☐

f. Do you understand that there are other temporary birth control methods that will prevent pregnancy? Yes ☐ No ☐

g. Do you understand sterilization will not protect you from acquiring a sexually transmitted disease. Yes ☐ No ☐

h. Do you understand that you may change your mind about being being sterilized anytime prior to being sterilized? You may reapply should you decide to be sterilized at some later date. Yes ☐ No ☐

5. Are you 21 years of age or older? Yes ☐ No ☐

6. Do you have any questions in regard to the sterilization procedure Yes ☐ No ☐

or your decision to be sterilized?

_____ _____

(Patient Signature) (Date)

I have asked and discussed the above questions with this patient and feel that he/she is mentally competent to consent to a sterilization procedure

_____ _____

(Second Interviewer's Signature) (Date)

PLANILLA PARA VERIFICAR INFORMACIÓN DE ESTERILIZACIÓN

AVISO: LA DECISIÓN EN CUALQUIER MOMENTO DE NO SER ESTERILIZADO/A NO DARÁ COMO RESULTADO EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO SUMINISTRADO POR LOS PROGRAMAS O PROYECTOS QUE RECIBAN FONDOS DEL GOBIERNO FEDERAL.

1. ¿Fue voluntaria su decisión de ser esterilizado/a? Sí
   □ No □

2. ¿Sabe que su decisión sobre ser esterilizado/a no afectará los beneficios que recibe? Sí
   □ No □

3. ¿Sabe que no puede ser esterilizado/a hasta 30 días después de haber firmado el documento de consentimiento? Sí
   □ No □

4 a. ¿Sabe cómo va a ser el procedimiento médico? Sí
   □ No □

b. ¿Sabe que existe la probabilidad de riesgos y de malestares? Sí
   □ No □

c. ¿Sabe que al ser esterilizado/a no habrá riesgo de embarazo sin necesidad del uso de ninguna otra forma de control de la natalidad? Sí
   □ No □

d. ¿Sabe que la esterilización es permanente y no puede revertirse? Sí
   □ No □

e. ¿Es consciente que existe una posibilidad remota de que este procedimiento no impida el embarazo? Sí
   □ No □

f. ¿Sabe que hay otros métodos de control temporal de la natalidad que impiden el embarazo? Sí
   □ No □

g. ¿Sabe que la esterilización no lo/a protegerá de contraer una enfermedad venérea? Sí
   □ No □

h. ¿Sabe que puede cambiar de decisión acerca de ser esterilizado/a en cualquier momento antes de hacerlo? Puede presentar una nueva solicitud en fecha posterior. Sí
   □ No □

5. ¿Es usted mayor de 21 años? Sí
   □ No □

6. ¿Tiene alguna pregunta en relación con el procedimiento de esterilización

o con su decisión de ser esterilizado/a? Sí □ No □

_____ _____

(Firma del paciente) (Fecha)

He planteado a y considerado con este/a paciente las preguntas arriba mencionadas y considero que el/la paciente se encuentra en pleno uso de sus facultades mentales para dar su consentimiento al procedimiento de esterilización.

_____ _____

(Firma del segundo interlocutor) (Fecha)

PATIENT AGREEMENT

We need your help to make sure that you get your sterilization without any problems or delays. You can help by **AGREEING TO THE FOLLOWING**:

I understand if I do not keep my case manager informed, I will not get my sterilization paid by the Virginia Department of Health. If I should get my operation without keeping my case manager informed, as stated above, I will be responsible for the bill.

I WILL IMMEDIATELY call my health department:

- If I change my mind about having the sterilization operation.
- If I get a different doctor to do my sterilization operation.
- If I can not keep or did not keep any of my appointments.
- If I move to a new address or change my telephone number.

- Wait **30 days** after signing the consent before getting my sterilization operation.
- As soon as possible, but before the 30 day waiting period has passed, call the doctor who is going to do my operation for an appointment so my doctor and I can make arrangements for the operation.
- Call my health department within 30 days of signing the consent form as soon as I have an appointment with the doctor.
- Call my doctor if I need to reschedule or cancel my appointment or surgery.
- When I go for my appointment, I will give the doctor the envelope with his/her name on it. **It contains all the important information needed for my operation**. If I lose the envelope, I will call my health department for another envelope. I **must not** go to the doctor without the envelope. **I must not go to the surgical facility without the envelope. If they do not get this information, they may bill me.**
- Call my health department service coordinator as soon as I know the date for my sterilization operation.
- I will call my health department as soon as I have my operation.
- **I WILL SEND ANY BILLS I GET FOR MY OPERATION TO MY LOCAL HEALTH DEPARTMENT SERVICE COORDINATOR.**

PATIENT's SIGNATURE_____ **DATE**_____
Witnessed by:
COORDINATOR's SIGNATURE _____ **DATE** _____

TELEPHONE NUMBER: _____

LOCAL HEALTH DEPARTMENT LETTEREAD

Date

Dear Dr.:

_____ is approved for Virginia Department of Health funding for a voluntary sterilization. She/he may not be scheduled for the procedure before _____ and not after _____ at which date this approval is **void**. As a participant in this program you have previously signed a contract and agreed to the following terms and conditions:

- **Will have a current countersigned contract on file with the Virginia Department of Health (VDH), Office of Family Health Services, Richmond, Virginia.**
- **Will accept current Medicaid established rate for reimbursement of all VDH supported services.**
- **Will bill the local health department using current CPT codes on Form HCFA- 1500 (12-90).**
- **Will bill within 60 days of the procedure date. INVOICE RECEIVED BEYOND 60 DAYS OF PROCEDURE WILL NOT BE REIMBURSED.**
- **Will accept reimbursement as payment in full and not bill the patient for any balance.**

Should an associate accept this assignment, they must have a valid contract. If this is assigned to another physician, they must have a signed contract.

Enclosed are a signed "Consent to Sterilization" (Part A) and a "Physicians Statement" (Part B) that must be completed and returned with the invoice for payment.

Please submit all bills associated with the sterilization procedure to:

_____

_____

_____

If you have any questions or need further information, please call me at _____.

Thank you for providing this much needed service.

Sincerely,

{LOCAL HEALTH DEPARTMENT LETTERHEAD}

Date

Dear Admissions Officer,

_____ has been approved for Virginia Department of Health funding for a voluntary sterilization procedure to be performed by _____. As a participant in this program your facility has previously signed a contract with VDH and agreed to the following terms and conditions:

- **Will have a current countersigned contract on file with the Virginia Department o Health (VDH), Office of Family Health Services, Richmond, Virginia.**
- **Will accept the current Medicaid established reimbursement cost-to-charge rates or the ASC Group Code ("M" CODE) for reimbursement of all VDH supported services.**
- **Will bill the local health department using the Form UB-92 HCFA-1450.**
- **Will bill within 60 days of the procedure date. INVOICE RECEIVED BEYOND 60 DAYS OF PROCEDURE WILL NOT BE REIMBURSED.**
- **Will accept reimbursement as payment in full and not bill the patient for any remaining balance.**

Should a medical profession associate (i.e., anesthesiologist, pathologist, radiologist, etc.) contracted by your facility accept any supporting role within the performance of the procedure, they must have a separate signed contract on file with the VDH. The associates' billing procedure must follow a separately established protocol. For further information please contact the local health department.

Please submit all bills associated with the sterilization procedure directly to:

_____

_____

_____

If you have any questions or need further information, please call me at _____ .
Thank you for providing this much needed service.

Sincerely,

SECTION 3

Case Management Worksheet – Instructions
Case Management Worksheet

CASE MANAGEMENT WORKSHEET INSTRUCTIONS

Sterilization Coordinator

A. Call, fax or email your client level information to: **Ardriene Stuart** in the Division of Women's & Infants' Health, **Phone: (804)786-7569; FAX: (804) 371-6032, Email: Atownsend@vdh.state.va.us**

B. Provide the following information as displayed on the **"VDH Family Planning Services Voluntary Sterilization Case Management Worksheet - SFY 01":**

LINE No.

l - District Cost Code & Telephone Number

2 - Service Coordinator's Name

3 - Patient Clinic Site

4 - Patient **VISION** NUMBER

5 - Patient Name

6 - Patient Sex

7 - Patient Race (White, Black, Hispanic or Other)

8 - Patient Date of Birth (MM-DD-YY)

9 - Consent Signed (MM-DD-YY)

DWIH will only provide you with a **Procedure Confirmation Number (PCN)** after line 1-9 data has been provided to DWIH. Please record date and name of the person giving you the PCN for your records.

. 10 - Appointment with Surgeon (DD-MMM-YY)
Notify DWIH within 35 days from the date the consent was signed with the patient's appointment date with the surgeon. This can be done by FAX, but you must verify DWIH receipt. **If DWIH not notified by that date, the encumbered funds will be released.**

11 - Procedure Scheduled (DD-MMM-YY)

Notify DWIH as soon as possible to provide the date patient is scheduled for surgery but no later than 30 days after the initial appointment date to see surgeon.

12 - Procedure Performed (DD-MMM-YY)

Notify DWIH **within 95 days** from the date the consent was signed with the actual date the sterilization procedure was done. This should be done by phone to be sure the information is received on time, but may be sent by FAX or email. If DWIH is not notified by that date, the encumbered **funds for the patient's sterilization procedure will be released.**

13 - Approved Provider(s) Vouched Amount(s)

Approval must be given for any unapproved CPT codes.

Notify DWIH within 65 days from the date the sterilization procedure was done of **all the actual amounts approved for payment of the sterilization procedure from each provider and facility**. If DWIH is not notified by that date, the encumbered **funds for the patient's sterilization procedure will be released**.

"Code # 1"	Surgeon	($0.00)
"Code # 2"	Facility	($0.00)
"Code # 3"	Anesthesiologist	($0.00)
"Code # 4"	Pathologist	($0.00)
"Code # 5"	Other	($0.00)

* As a matter of course, one should always record the date and name of DWIH employee receiving your notification(s). This is most important to avoid losing funds committed to your patient.

NOTE: ANY STERILIZATION PROCEDURES TAKING PLACE AFTER THE FUNDS HAVE BEEN RELEASED WILL NOT BE COVERED BY THE PROGRAM.

SECTION 4

CPT Codes

- All Areas
- Northern Virginia

CPT CODE LISTING

Effective 7/02 **CPT 2002-2003**

ALL AREAS EXCEPT Alexandria, Arlington, Fairfax, Loudoun, & Prince William County

VASCULAR INJECTION PROCEDURES		
36000	Insert Needle or Intracatheter, vein	$ 18.77
INTRA-ARTERIAL		
36140	Introduce Needle-Extremity Artery	83.85
36410	Venipuncture requiring MD's skill - Diagnostic/Therapeutic	15.90
36415 G0001	Venipuncture-routine or finger stick	3.00
VAS DEFERENS		
55200	Vasectomy, cannulization with or without incision	189.78
55250	Vasectomy, unilateral or bilateral	281.02
LAPAROSCOPY/PERITONESCOPY/HYSTEROSCOPY		
56301	Laproscopic/fulguration of oviducts	309.22
56302	Laproscopic/occlusion by devise	328.31
56304	Laproscopic/lysis of adhesions	483.50
OVIDUCT		
58600	Ligation/Transection Fallopian tubes	304.36
58605	Ligation/Transection Fallopian tube(s)-pp	261.36
58611	Ligation/Transection Fallopian Tube(s), c-section or intra-abdominal	87.60
58615	Occlusion Fallopian Tube(s) Device	218.36
58670	Laparoscopy/Fulguration of Oviducts (w/or wo transection)	266.13
58671	Laparoscopy/Occlusion Oviducts by Device	273.94
58700	Salpingectomy, complete or partial unilateral or bilateral	321.85
58740	Lysis of Adhesions	300.50

INJECTION, DRAINAGE, OR ASPIRATION		
62274	Injection/therapeutic anesthetic(Epidural)	71.56
CHEST		
71010	Radiologic exam, chest; single view, frontal	$20.05
71020	Radiologic chest, two views, frontal & lateral	25.52
METABOLIC PANEL		
80049	Basic	12.48
80054	Comprehensive	14.61
URINALYSIS		
81000	By dip stick or tablet reagent	4.37
81001	By dip stick or tablet reagent	3.96
81002	By dip stick or tablet reagent	3.54
81003	By dip stick or tablet reagent	3.10
81025	Urine Pregnancy Test	8.74
MOLECULAR DIAGNOSTICS		
84702	Hcg Quantitative Pregnancy Test	12.00
84703	Hcg Quantitative Pregnancy Test	10.38
HEMATOLOGY AND COAGULATION		
85014	Blood count, other than spun hematocrit	3.27
85018	Hemoglobin	3.39
85021	Hemogram, automated (RBC,WBC,Hgb, manual CBC)	8.63
85024	Blood Count	10.78
85025	CBC, Hemogram, Platelet	10.54
85027	Hemogram & platelet count, automated	10.03
85031	Blood count, manual CBC (4 or more indices)	9.20
85060	Blood smear	17.71
CHLAMYDIA CULTURE		
86317	Immunoussay for infectious agent antibody, qualitative	11.00

SURGICAL PATHOLOTHY		
87070	Culture, Bacteria	10.00
87081	Bacterial screening only for single organisms	9.16
87490	Infectious agent detection by nucleic acid	27.05
87491	Infectious agent detection by nucleic acid - chlamydia	45.45
87590	Infectious agent detection by nucleic acid	27.05
87591	Infectious agent detection by nucleic acid – neisseria gonarrah	45.45
88150	Pap Smear	7.15
88156	Cytopathology, Smears, Cervical	8.02
88300	Surgical Pathology – Level I	12.25
88302	Surgical Pathology - -Level II	28.68
89300	Semen Analysis, presence and/or motility of sperm including Huhner test	13.83
89310	Sperm Count	13.83
89320	Semen Analysis, complete	12.60
CARDIOGRAPHY		
93000	EKG Routine	20.57
93005	EKG Tracing Only without Interp & Report	12.76
93010	EKG Report Only	8.63
MISCELLANEOUS SERVICES		
99000	Specimen, Handling	3.26
99024	Postop F/U Visit included in Global Service	incl. In Surgery Fee
99070	Supplies/Materials	27.13
OFFICE OR OTHER OUTPATIENT SERVICES		
99201	Office or Other Outpatient Visit for Evaluation & Management	28.90
99202	Office or Other Outpatient Visit for Evaluation & Management	45.05

99203	Office or Other Outpatient Visit for Evaluation & Management	63.28
99204	Office or Other Outpatient Visit for Evaluation & Management	91.40
99205	Office or Other Outpatient Visit for Evaluation & Management	114.18
99211	Office or Other Outpatient Visit for Evaluation & Management	14.32
99212	Office or Other Outpatient Visit for Evaluation & Management	24.50
99213	Office or Other Outpatient Visit for Evaluation & Management	34.41
99214	Office or Other Outpatient Visit for Evaluation & Management	53.70
99215	Office or Other Outpatient Visit for Evaluation & Management	79.77
99241	Office Consult - New & Established Patient	39.58
99242	Office Consult - New & Established Patient	65.10
99243	Office Consult - New & Established Patient	83.07
99244	Office Consult - New & Established Patient	115.10
99245	Office Consult - New or Established Patient	149.38

CPT CODE LISTING

Effective 7/02 **CPT 2002-2003**

Northern Virginia
Alexandria, Arlington, Fairfax, Loudoun, & Prince William County

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36415 G0001	Venipuncture-routine or finger stick	3.00
VAS DEFERENS		
55200	Vasectomy, cannulization with or without incision	189.78
55250	Vasectomy, unilateral or bilateral	281.02
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56301	Laproscopic/fulguration of oviducts	309.22
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58605	Ligation/Transection Fallopian tube(s)-pp	261.36
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URINALYSIS		
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81003	By dip stick or tablet reagent	3.10
81025	Urine Pregnancy Test	8.74
MOLECULAR DIAGNOSTICS		
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85021	Hemogram, automated (RBC,WBC,Hgb, manual CBC)	8.63
85024	Blood Count	10.78
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CHLAMYDIA CULTURE		
86317	Immunoussay for infectious agent antibody, qualitative	11.00

SURGICAL PATHOLOTHY		
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87490	Infectious agent detection by nucleic acid	27.05
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88150	Pap Smear	7.15
88156	Cytopathology, Smears, Cervical	8.02
88300	Surgical Pathology – Level I	12.25
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89300	Semen Analysis, presence and/or motility of sperm including Huhner test	13.83
89310	Sperm Count	13.83
89320	Semen Analysis, complete	12.60
CARDIOGRAPHY		
93000	EKG Routine	20.57
93005	EKG Tracing Only without Interp & Report	12.76
93010	EKG Report Only	8.63
MISCELLANEOUS SERVICES		
99000	Specimen, Handling	3.26
99024	Postop F/U Visit included in Global Service	incl. In Surgery Fee
99070	Supplies/Materials	27.13
OFFICE OR OTHER OUTPATIENT SERVICES		
99201	Office or Other Outpatient Visit for Evaluation & Management	28.90

99202	Office or Other Outpatient Visit for Evaluation & Management	45.05
99203	Office or Other Outpatient Visit for Evaluation & Management	63.28
99204	Office or Other Outpatient Visit for Evaluation & Management	91.40
99205	Office or Other Outpatient Visit for Evaluation & Management	114.18
99211	Office or Other Outpatient Visit for Evaluation & Management	14.32
99212	Office or Other Outpatient Visit for Evaluation & Management	24.50
99213	Office or Other Outpatient Visit for Evaluation & Management	34.41
99214	Office or Other Outpatient Visit for Evaluation & Management	53.70
99215	Office or Other Outpatient Visit for Evaluation & Management	79.77
99241	Office Consult - New & Established Patient	39.58
99242	Office Consult - New & Established Patient	65.10
99243	Office Consult - New & Established Patient	83.07
99244	Office Consult - New & Established Patient	115.10
99245	Office Consult - New or Established Patient	149.38

SECTION 5

Contract Care Provider Listings

- Anesthesiologist
- Facilities
- Pathologists
- Radiologists
- Surgeons

BUSINESS ADDRESS	CITY	ST	ZIP CODE	AREA CODE	TELE NUMBER	FEDERAL TAX ID	CONTRACT END
P. O. Box 631728	Baltimore	MD	21263-1728	410	337-9429	54-0882254	**08/31/07**
							06/30/05
P.O. Box 2689	Lynchburg	VA	24501	804	845-7392	54-1070213	**04/30/05**
2900 Lamb Circle, Suite 340	Christiansburg	VA	24073	540	731-1898	54-0948315	**02/28/06**
134 Business Park Dr.	Va. Bch	VA	23462	757	473-0044	54-1855514	**02/28/06**
Danville Anesthesiologist, 1114 Main St,	Danville	VA	24541	804	432-2058	54-0938661	**07/31/05**
P.O. Box 1584	Bluefield	WV	24701	304	327-3408	55-0577385	**07/31/05**
321 Midway Medical Park, Suite 1	Bristol	TN	37621	615	968-2363	62-1091810	**05/31/05**
1114 Main St.	Danville	VA	24541	804	799-0183	54-0938661	**07/31/05**
P. O. Box 1300	Arlington	VA	22210	800	222-1442	54-1937574	**07/31/05**
P.O. Box 877	Wytheville	VA	24382			031-34-851	**08/31/07**
Danville Anesthesiologist, 1114 Main St,	Danville	VA	24541			54-0938661	**07/31/05**
4718 Carr Drive	Fredericksburg	VA	22408			54-2051680	**11/30/06**
4718 Carr Drive	Fredericksburg	VA	22408	540	710-2943	54-1646213	**08/31/06**
Anesthesia Dept.-Twin Co. Regional Hospital 200	Galax	VA	24333	540	236-8181	258-8181	**09/30/05**
565 Radio Hill Road	Marion	VA	24354	540	782-1234	54-1691724	**02/28/06**
312 Bradley Street	Abingdon	VA	24210	540	676-3307	54-1590914	**08/31/05**
P.O. Box 1694	Leesburg	VA	20177	703	771-2829	54-1716863	**07/31/05**
P.O. Box 819	Nassawado	VA	23413	757	442-5800	54-1257452	**06/30/05**
Danville Anesthesiologist, 1114 Main St,	Danville	VA	24541	804	432-2058	54-0938661	**07/31/05**
P. O. Box 444	South Boston	VA	24592			54-1640961	**01/31/06**
Danville Anesthesiologist, 1114 Main St,	Danville	VA	24541	804	432-2058	54-093661	**07/31/05**
2000 Meade Parkway	Suffolk	VA	23432	757	934-9334		**11/30/05**
Danville Anesthesiologist, 1114 Main St,	Danville	VA	24541	804	432-2058	54-0938661	**07/31/05**
P. O. Box 1476	Abingdon	VA	24212			54-1377658	**02/28/06**
1720 Amherst Street	Winchester	VA	22601	540	662-8336	54-0897356	**06/30/05**
Danville Anesthesiologist, 1114 Main St,	Danville	VA	24541	804	432-2058	54-0938661	**07/31/05**
P.O. Box 1480	Grundy	VA	24614			54-1721195	**12/31/04**

LINE NO.	SURGICAL FACILITY	ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	PHONE NUMBER	OUTPATIENT	INPATIENT	FED TAX ID	CONTRACT E
1	Alexandria Hospital	4320 Seminary Road	Alexandria	VA	22304	703	504-3194	42.00%	56.00%	54-0505861	**06/30/05**
2	Bluefield Regional Medical Center	500 Cherry Street	Bluefield	WV	24701	304	327-2511	57.14%	46.53%	31-0956326	**08/31/04**
3	Centra Health d/b/a Virginia Baptist Hospital	3300 Rivermont Avenue	Lynchburg	VA	24503	804	947-4753	77.00%	71.33%	54-07155698	**04/30/06**
4	Columbia Montgomery Regional Hospital	3700 South Main Street	Blacksburg	VA	24060	540	951-5111	50.51%	29.39%	54-0889154	**07/31/04**
5	Columbia Pulaski Community Hospital	2400 Lee Highway	Pulaski	VA	24301	540	994-8100	54.14%	41.81%	54-0941129	**07/31/04**
6	Devine-Tidewater Urology [ASC]	400 W. Brambleton Ave., Suite 100	Norfolk	VA	23510	757		[see ASC footnote]		54-1834415	**06/30/04**
7	Halifax Regional Hospital	2204 Wilborn Avenue	South Boston	VA	24592	804	575-3100	62.15%	37.37%	54-0648699	**09/30/07**
8	Holston Valley Community Hospital	P. O. Box 1089	Bristol	TN	37621	423	246-3322	65.34%	29.37%	62-0477727	**07/31/04**
9	Johnston Memorial Hospital, Inc.	351 Court Street, N.E.	Abingdon	VA	24210	540	676-7000	47.42%	39.25%	54-0544705	**06/30/04**
10	Lonesome Pine Hospital	1990 Holton Avenue E.	Big Stone Gap	VA	24219	540	523-3111	48.19%	31.66%	54-0835835	**07/31/05**
11	Loudoun Hospital Center	44045 Riverside Parkway	Leesburg	VA	20176	703	858-8042	47.00%	58.10%	54-0525802	**05/31/06**
12	Medical College of Virginia Hospitals	401 North 12th Street	Richmond	VA	23298	804	828-4401	64.04%	63.48%	54-6001758	
13	Memorial Hospital of Martinsville & Henry Cty	320 Hospital Drive	Martinsville	VA	24112	540	666-7200	55.55%	33.13%	54-0555800	
14	Piedmont Day Surgery Center, Inc. [ASC]	1040 Main Street	Danville	VA	24541	804	792-1433	[see ASC footnote]		54-0858249	
15	R.J. Reynolds-Patrick Community MemorialHospital	18688 Jeb Stuart Road	Stuart	VA	24171	540	694-8600	64.38%	35.81%	54-0695078	**06/30/04**
16	Riverside Regional Medical Center	500 J. Clyde Morris Boulevard	Newport News	VA	23601	757	599-2020	53.23%	51.20%	52-1245746	**09/30/04**
17	Riverside Walter Reed Hospital	Route #17, Box 1130	Gloucester	VA	23061	804	693-4400	57.14%	46.53%	52-1241836	**10/31/04**
18	Rockingham Memorial Hospital	235 Contrell Avenue	Harrisonburg	VA	22601	540	433-4100	50.00%	67.36%	54-0506331	
19	Sentara Hampton General Hospital	3120 Victoria Boulevard	Hampton	VA	23669	757	727-7103	57.16%	37.28%	54-0505907	**10/31/04**
20	Sentara Norfolk General Hospital	600 Gresham Drive	Norfolk	VA	23507	757	668-3361	79.57%	53.05%	54-0506323	

21	Sentara Va. Beach General Hospital	1060 First Colonial Road	Virginia Beach	VA	23454	757	395-84488	45.89%	33.27%	544-0683504	**08/31/04**	
22	Smyth County Community Hospital	700 Park Boulevard	Marion	VA	24354	540	782-1493	49.02%	34.56%	54-0794913	**06/30/04**	
23	Tazewell Community Hospital	141 Ben Bolt Avenue	Tazewell	VA	24651	540	988-2506	50.49%	31.16%	54-6074580	**08/31/04**	
24	Twin County Regional Hospital	200 Hospital Drive	Galax	VA	24333	540	666-7200	49.12%	36.87%	54-6075662	**06/30/04**	
25	UVA - Health Services Foundation	500 Ray C Hunt Drive	Charlottesville	VA	22903	804	980-6130	99.00%	73.19%	54-1124769	**03/31/06**	
26	VA Beach Ambulatory Surgery Center [ASC]	1700 Will-O-Wisp Drive	Virginia Beach	VA	23454	757	496-6400	[see ASC footnote]		54-1448218	**10/31/07**	
27	VA Hospital Center of Arlington	1701 N. George Mason Dr.	Arlington	VA	22205	703	558-6104	67.70%	38.41%	54-0505989	**07/31/04**	
28	Virginia Ambulatory Surgical Center [ASC]	337 15th Street S.W.	Charlottesville	VA	22903	804	295-4800	[see ASC footnote]		54-1259545		
29	Wellmont Bristol Regional Medical Center	209 Memorial Drive	Bristol	TN	37621-1089	423	844-4506	52.38%	29.48%	62-0522040	**06/30/04**	
30	Wellmont Holston Valley Hospital	East Ravine Street	Bristol	TN	37622-1089	423	246-3322	65.34%	29.37%	62-0477727		
31	Women's Health Center of VA, Inc.	3698 South Main Street	Blacksburg	VA	24060	540	951-7880	50.51%	29.39%	54-0889154	**07/31/04**	
32	Wythe County Community Hospital	600 West Ridge Road	Wytheville	VA	24382	540	228-0204	44.12%	31.75%	54-6068279	**06/30/04**	

LINE NO.	PROVIDER	BUSINESS ADDRESS	CITY	ST	ZIP CODE	FEDERAL TAX ID	AREA CODE	PHONE #	CONTRACT END
1	Armbrister, Douglas K. MD	592 Radio Hill Road	Marion	VA	24354	230-48-3069			**08/31/03**
2	Bostwick, David MD	Tidewater Technical Laboratories, 408 Oakmears Crese	Va. Beach	VA	23462	888171			**08/31/04**
3	Clinch Pathology Associates								**05/31/05**
4	Dillingham, Robert MD	Shenandoah Valley Pathology lab, P.O.Box 3340	Winchecter	VA	22604	54-0931441			**07/31/05**
5	Langebeck, Miguel MD	Columbia Montgomery Regional Hospital 3700 South Ma	Blacksburg	VA	24060	54-19619997	540	953-5457	**08/31/05**
6	Medex Regional Laboratories	Blue Ridge Pathology Consultants, 102 E. Ravine St	Kingsport	TN	37660	62-1777748	423	224-4720	**03/31/05**
7	Pathology Association of Southwest VA, Inc.								**06/30/05**
8	Prince Edward Pathologists Associates, PC	800 Oak Street	Farmville	VA	23901		804	315-2616	**01/31/06**
9	Roycroft, David MD	Pathology Associates - P. O. Box 5308	Martinsville	VA	24115	54-0891562	540	632-8445	**01/31/06**
10	Settlow, Gordon	Quantum Medical Business Service, 2840 Electric	Roanoke	VA			800	207-9946	**12/31/04**
11	Shenandoah Valley Pathology	P.O. Box 3340	Winchecter	VA	22607	88-8162	540	722-8790	**07/31/04**
12	Smith, Robert L., MD, PA	P. O. Box 21156	Roanoke	VA	24018	56-1078264	800	365-0109	**11/30/06**
13	Whittle, Thomas S. MD	Pathology Associates of SW Virginia, P.O. Box 1213	Galax	VA	24333	58-1334327	540	236-9078	**06/30/05**

LINE NO.	PROVIDER	BUSINESS ADRESS	CITY	ST	ZIP CODE	TAX ID	AREA CODE	PHONE NUMBER	CONTRACT ENDS
1	Atrium, Leigh	Tidewater Physicians for Women 844 Kempsville Rd Suite 208	Norfolk	VA	23502	54-1820401C	757	461-3890	**09/30/04**
2	Abingdon OB-GYN	277 White Street	Abingdon	VA	24210	54-1430616	540	628-4335	**02/29/06**
3	Adler Center for Women's Health	2296 Opitz Blvd., Ste. 350	Woodbridge	VA	22191				**06/30/06**
4	Adult & Pediatric Urologists	4660 Kenmore Ave., Ste. 735	Alexandria	VA	22304	54-1244735			**07/31/05**
5	Agee, Robert MD	Women's Health Center 800 Buffalo Street	Farmville	VA	23901	888150	804	392-8177	**07/31/04**
6	Anderson, Abraham MD	2810 Tidewater Drive	Norfolk	VA	23509	57-95843			**06/30/05**
7	Barrett & Quioco Surgical Clinic	70 North Main Street	Rocky Mount	VA	24151	54-1094747			**07/31/06**
8	Blue Ridge Physicians for Women Division	106 Doctor's Park	Galax	VA	24333	54-1822207	540	236-2909	**02/28/06**
9	Bristol Gynecology	249 Midway Street	Bristol	TN	37620	62-0817912	423	968-3033	**03/31/06**
10	Bruder, Karen L. MD	Riverside OB/GYN & Family Care	Newport News	VA	23605	52-1245746	804	775-6140	**08/31/04**
11	Bryant, Shawne MD	Health Care for Women by Women - 5441 Virginia	Va. Beach	VA	23454	54-1436702	757	671-1112	**10/31/05**
12	Buchanan Health Care, Inc.	Route 83, Slate Creek - POB 669	Grundy	VA	24614				**07/31/06**
13	Cailion Faculty Physicians	7 Albemarle Avenue	Roanoke	VA	24014	54-0506332	540	224-6977	**06/30/06**
14	Carilion Family Practice								**08/31/07**
15	Carillion Medical Associates	199 Hospital Drive, Suite 7	Galax	VA	24333	54-1586601	276	236-6127	**08/31/07**
16	Center for Women's Health	12695 McManus Blvd., #2	Newport News	VA	23602	54-1820401			**06/30/05**
17	Chavez, Rolando MD	Post Office Box 255	Cedar Bluff	VA	24609	54-1164585	540	964-9111	**09/30/04**
18	Clary, Anthony R. MD	Mountain Empire Women's Ctr 1201 Snider Street	Marion	VA	24354	54-1822207	540	783-7748	**12/31/04**
19	Clinch Valley Phys, Inc. D/B/A The Clinic	One Clinic Drive - Claypool Hill	Richlands	VA	24641	54-1045791	540	964-6771	**01/31/06**
20	Danville Urologic Clinic	1040 Main Street	Danville	VA	24543	54-0858249	804	792-1433	**08/31/05**
21	Denbigh OB/GYN	12695 McManus Boulevard	Newport News	VA	23602	54-1820401	757	851-4810	**09/30/03**
22	Devine - Tidewater Urology	400 W. Brambleton Ave., Ste. 100	Norfolk	VA	23510	54-1834415			**06/30/04**
23	Devine Urology Clinic	Hague Medical Tower 400 Brambleton Ave., S	Norfolk	VA	23510	54-1834415	757	547-5338	**06/30/04**
24	Doonan, Joyce, MD								**08/31/07**
25	E. J. Tomeu & Associates	762 Independence Blvd., Ste. 400	Virginia Beach	VA	23455	54-1611686			**09/30/05**
26	Eastern Shore Physicians, Inc.	P.O.Box77	Nassawadox	VA	23413	54-1314852	757	442-6600	**11/30/05**
27	Eastridge, Bea	Practice of Urology-105 Doctor's Park	Galax	VA	24333		540	236-5187	**02/28/06**
28	Edwards, Robert W., MD	Bluefield Regional Medical Ctr 510 Cherry Street	Bluefield	VA	24701	55-0775746	304	327-1890	**09/30/05**

29	Eshel, Amir MD	510 Cherry Street	Bluefield	WV	24701	55-0746837	304	327-2511	**08/31/04**
30	Ferguson, Joseph J. MD	Danville Urologic Clinic 2045 Hamilton Boulevard	South Boston	VA	24592	494-56-1447	804	572-6565	**08/31/05**
31	Fitzhugh, William, MD	7603 Forest Avenue	Richmond	VA	23229	541919013	804	282-9479	**03/31/07**
32	Foster, G. Neil MD	722 East Market St. Suite 202	Leesburg	VA	22075	54-1555489	804	779-7419	**10/31/05**
33	Fuller Roberts Clinic, Inc.	2212 Wilborne Avenue	South Boston	VA	24592	54-0922785	434	572-8921	**09/30/07**
34	Gilles-Tchabo, Jean MD	1715 North George Mason Drive, Ste 302	Arlington	VA	22205	54-1124336	703	558-6591	**09/30/05**
35	Glover, Roger MD	P.O. Box 596	Abingdon	VA	24212	54-1170237	703	628-6011	**08/31/05**
36	Griffeth, James K.	506 Cliffview Road	Galax	VA	24333	25-8924685	540-236-8181		**09/30/05**
37	Gueriera, Charles J. MD	9001 Diggs Road, Suite 207	Manassas	VA	20110	54-1723334			**07/31/06**
38	Hackenburg,Virginia MD	44055 Riverside Parkway Suire 216	Leesburg	VA	21076	145523124	703	858-2811	**09/30/05**
39	Hamptons Road Urology Clinic	Middle Grounds Boulevard	Newport News	VA	23606	54-1834415	757	873-7374	**11/30/04**
40	Harman, Ann Marie								**02/28/06**
41	Harrisonburg Physician for Women	2015 A Reservoir Street	Harrisonburg	VA	22801	54-1480016			**11/30/05**
42	Health Care for Women by Women	5441 Virginia Beach Blvd., Ste. 119	Virginia Beach	VA	23462	54-1436702	757-671-1112		**10/31/05**
43	Helwig, Jane MD	Obstetrics & Gynecology Assoc.,Eastern Shore	Nassawadox	VA	23413	54-1472633	757	442-6719	**01/31/04**
44	Herbert, Frances B. MD	Practice of Urology, 105 Doctor's Park	Galax	VA	24333	54-1061267	540	236-5187	**10/31/04**
45	Hossein Faiz & Associates	P. O. Box 606	Pennington Gap	VA	24277	54-1200403	540	546-5488	**06/30/05**
46	Howard, Robert MD	OB/GYN Associates of Hampton 3116 Victoria Blvd.	Hampton	VA	23661	54-1820401			**11/30/05**
47	Humsi, Ramsi K. MD	1070 Terrace Dr.	Marion	VA	24354	54-1179927	540	783-8171	**06/30/05**
48	Isaac, Joseph MD	301 Good Way, Suite 205	Portsmouth	VA	23704	54-1723453			**07/31/05**
49	Jayanetti, Sidath MD	301 Good Way	Portsmouth	VA	23704	230-13-6579	757	398-4678	**06/30/05**
50	Johnston, John MD	211 West Main Street	Abingdon	VA	24210		540	628-7164	**01/31/06**
51	Jones, Jeffery MD	249 Midway Medical Park	Bristol	TN	37620	62-0817912	423	968-3033	**09/30/04**
52	Jusay, Feliciano MD	Wythe Medical Associates, Inc. 710 West Ridge Road	Wytheville	VA	24382	54-0912360	540	228-2191	**09/30/05**
53	Karmy, Robert MD	Shenandoah OB-GYN Grp., Inc-Doctor's Office Building-P. O. Box 447	Woodstock	VA	22664		540	459-3796	**01/31/06**
54	Khurram, Rashid MD	21515 Ridge Top Circle Suite 150	Sterling	VA	20166	52-1889021	540	338-1974	**08/31/05**
55	Kilgore, W.T. MD	590 West Ridge Road	Wytheville	VA	24382	54-1783030	540	228-3355	**08/31/07**
56	Klink, Robert MD	POB 2148	Gloucester	VA	23061	54-1138747	804	693-4410	**09/30/06**
57	Klousia, John MD	4660 Kenmore Ave. Suite 735	Alexandria	VA	22305	54-1244735	703	525-6670	**07/31/05**
58	Kramer, Ralph Jr. MD	18877 Jeb Stuart Highway	Stuart	VA	24171	058-40-2940	540	694-4466	**06/30/04**
59	Lagrimas, Fernando C. MD	Norton Community Hosp Prof. Bldg. - 716 Spring Ave SE	Norton	VA		58-6645820	540	328-2600	**11/30/04**

60	Langebeck, Miguel, MD								**08/31/05**
61	Laserna, Oscar M. MD	OB/GYN Assoc. of Fred'burg - 4103 Lafayette	Fredericksburg	VA	22401		540	899-4142	**07/31/05**
62	Lasker, Bruce MD	510 Cherry Street	Bluefield	VA	24701	55-0746837	304	327-2568	**12/31/06**
63	Magnolia OB-GYN Associates	157 Executive Drive, Ste E	Danville	VA	24541		434	791-2629	**01/31/06**
64	Manoharan, Edakandyil MD	Norwise OB/GYN Assoicates 1980 E. Holton-P.O.	Big Stone Gap	VA	24219	54-1574393	540	523-0390	**07/31/05**
65	Marks, Steven MD	Hampton Roads Urology Clinic 895 Middle Ground	Newport News	VA	23606	54-1834415	757	873-7374	**11/30/04**
66	Martinez, Marina MD	5109 Leesburg Pike Suite 914	Falls Church	VA	22041-23	54-1249999	703	845-4955	**09/30/03**
67	Mathis, David M., MD	Family Practice 213 Loudoun St., S.W.	Leesburg	VA	20175	31-1747229			**08/31/07**
68	McClintic, Eugene MD	249 Midway Medical Park	Bristol	TN	37620	888188	423	844-6750	**09/30/04**
69	Miller, Charles A. MD	316 Main Street	Newport News	VA	23601	229-62-7361	757	594-4721	**08/31/04**
70	Molera, Federico MD	P.O. Box 819	Nassawadox	VA	23413	54-1257452			**06/30/05**
71	Moore, James D.	P.O. Box 596	Abingdon	VA	24212	54-1170237	540	628-6011	**08/31/05**
72	Moskowitz, Edward J, MD	1337 North Main Street	Marion	VA	24354	54-1158085			**08/31/05**
73	Mountain Empire Women's Ctr	1201 Snider Street	Marion	VA	24354	54-1822207			**02/28/06**
74	Muhlendorf, I. Kenneth MD	Tidewater Physicians for Women 844 Kempsville	Norfolk	VA	23502	54-1820401	757	461-3890	**09/30/04**
75	Murthy, Yelameli S. MD	Virginia Med. Ctr. POB 787	Cedar Bluff	VA	24609	54-1528789	540	964-6764	**09/30/05**
76	North, A.W. MD, Inc.	P. O. Box 3906	Wise	VA	24293	22-3187755	540	328-4550	**06/30/06**
77	Norwise OB GYN Associates	102 15th Street, NW Suite 301	Norton	VA	24273		540	679-1623	**02/28/06**
78	OB&GYN Assoc. Eastern Shore	10243 Rogers Drive	Nassawadox	VA	23413	54-1472633	757	442-6719	**01/30/04**
79	OB/GYN Associates of Fredericksburg								**07/31/05**
80	OB/GYN Associates of Hampton	3116 Victory Boulevard	Hampton	VA	23661	54-1820401			**11/30/05**
81	Patel, J. MD	Tri State Clinic 124 US Route 460E	Grundy	VA	24614	54-1322575	540	935-2148	**06/30/06**
82	Perona, Barbara P. MD	Wythe County Comm. Hosp - POB 219	Wytheville	VA	24382		540	228-0287	**09/30/06**
83	Plagata, Eduardo D. MD	840 East Fincastle Road	Tazewell	VA	24651	54-1049307	540	988-5589	**10/31/05**
84	Planned Parenthood of South	910 West Mercury Blvd	Hampton	VA	23666	54-0929058			**07/31/05**
85	Practice of Urology	105 Doctor's Park	Galax	VA	24333		540	236-5187	**02/28/06**
86	Rashid, Khurram MD	21515 Ridge Top Circle, Suite 150	Sterling	VA	20166		703	404-2900	**08/31/05**
87	Raviotta, J. John MD	901 Pace Drive	South Hill	VA	23970	888167	804	955-2194	**08/31/04**
88	Riverside OB/GYN & Family Care								**08/31/04**
89	Roberts, E. Franklin MD	Commonwealth Women's Hlth Care - 2020 S. Ind	Va. Beach	VA	23456	54-1813781	757	471-6903	**07/31/04**
90	Rowe, Bruce MD	425 N. Boulevard	Richmond	VA	23220	54-1073539	804	358-5547	**06/30/04**
91	Roycroft, David, MD								**01/31/06**

92	Saul, Slater MD	400 Grasham Drive Suite 705	Norfolk	VA	23507	54-1172009	757	625-6914	**08/31/03**
93	Settlow, Gordon MD	Quantum Medical Business Svc 2840 Electric Rd. Ste 111	Roanoke	VA	24018	953-65889	800	207-9946	**12/31/04**
94	Seven Hills Urology	2542 Langhorne Road	Lynchburg	VA	24501	54-0892006			**10/31/05**
95	Shenandoah OB-GYN Group,Inc.								**1/31/2006**
96	Shenandoah Women's Care								**07/31/04**
97	Shepard, Felix E. MD	105 Doctor's Park	Galax	VA	24333	54-1061267	540	236-5187	**07/31/05**
98	Smith, Robert L. MD	2840 Electric Road, Ste. 111	Roanoke	VA	24018	52-1078264			**11/30/06**
99	Steed, Art MD	Mountain Empire Women's Center - 1201 Snider Street	Marion	VA	24354	54-1822207			**12/31/04**
100	Stiff, Leroy MD	2110 Hartford Road	Hampton	VA	23666	54-1175494			**06/30/05**
101	Tawil, George MD	4660 Kenmore Ave. Suite 735	Alexandria	VA	22305	54-1244735	703	525-6670	**07/31/05**
102	Thom, Douglas MD	12695 McManus Boulevard	Newport News	VA	23602	54-1820401			**06/30/05**
103	Tidewater Physicians for Women								**09/30/04**
104	Tomeu, Enrique MD	762 Independence Blvd. Suite 400	Va. Beach	VA	23454	54-1611686			**09/30/05**
105	Torres, Emilio B. MD	901 Hioaks Road	Richmond	VA	23225	888159	804	272-7979	**07/31/04**
106	Tri State Clinic								**06/30/05**
107	Turjman, Dordid MD	Urology Clinch Pathology Associates - P.O. Box 1647	Richlands	VA	24644	54-1900106	540	963-4006	**05/31/05**
108	Urology Associates	102 Highland Ave. SE, Ste. 105	Roanoke	VA	24013	54-1042312	540	387-5530	**03/31/06**
109	Urology Associates of New River	2900 Lamb Circle Suite 380	Christianburg	VA	24073	54-1023869	540	639-0002	**08/31/05**
110	Urology of Virginia, PC	Interstate Corp. Ctr. Bldg 11, Ste 128	Norfolk	VA	23502	54-1834415	757	466-3431	**10/31/07**
111	Urosurgical Center of Richmond	5206 Markel Rd., Ste 100	Richmond	VA	23230	54-1759643	804	287-1030	**12/31/08**
112	Williams, Annie MD	Contemporary OB-GYN Assoc., LTD - 400 Gres Norfolk	Norfolk	VA	23507	54-1547558			**07/31/05**
113	Willoughby, McLeod & Brown	116 C Edwards Ferry Road, NE	Leesburg	VA	20176	54-1569184	703	777-5111	**02/28/05**
114	Winchester Obstetrics & Gynecology								**08/30/07**
115	Woessner, William H. MD	Shenandoah Women's Care P.O. Box 508	Woodstock	VA	22664	54-1870702	540	459-3080	**07/31/04**
116	Women's Health Care Center, Inc.	511 Piney Forest Road	Danville	VA	24540	54-1647400			**02/28/06**
117	Women's Health Center	800 Buffalo Street	Farmville	VA	23901	54-0887287	804	392-8177	**07/31/04**
118	Women's Health Services	114 Nationwide Drive	Lynchburg	VA	24502	54-1679157	804	237-9229	**07/31/06**
119	Wythe Medical Associates, Inc.								**09/30/05**
120	Young, Robert MD	Women's Health Ctr of VA, Inc. 3698 S. Main Street	Blacksburg	VA	24060		540	951-7880	**07/31/04**
121	Zepeda, Fernando, MD	P. O. Box 1480	Grundy	VA	24614	54-1721195	540	935-2139	**12/31/04**

Section 6

Billing Guidelines

- **Coordinator Billing Process**
- **Anesthesiologist Billing Procedure**
- **Facility Billing Procedure**

TO THE COORDINATOR

The billing process for coding bills, have changed. You will have this responsibility and having this information grouped will make the task easier. If you have any questions, please call me before making changes. My telephone number is (804) 786-7569.

Each bill sent to your health department will have to be changed to reflect the current Medicaid rate for payment. The amount to be paid is based on the "CPT" code for the procedure (surgeon), a percentage of the total charges (facility) or based on the total time of the procedure (anesthesia). This is not a cut and dried process but it is not complicated once you have gone through it.

The process is as follows:

1. ***Review*** **medical provider invoices on *Form HCFA-1500 (12-90)*** to verify appropriate (authorized) CPT codes; **get approval** of those **not listed** for payment and **correct** all charges to reflect current Medicaid rates per CPT code for reimbursement. **See "CPT Code Listing". (A copy of the signed Physician's Statement - Part B must accompany bill from surgical care provider).**

2. ***Review*** **hospital, ambulatory center (ASC) or surgical facility invoice (Form UB -92 HCFA-1450)** to verify appropriate service charges by type and correct the "sums **charges"** to reflect the current Medicaid allowable cost-to-charge ratios (percentage or ASC Group Code) for outpatient status.

   SURGICAL FACILITY BILLS WILL REQUIRE A READJUSTMENT BASED ON A SPECIFIC PERCENTAGE TO BE APPLIED TO THE TOTAL AMOUNT BILLED.

3. **Determine the percentage of Medicaid reimbursement cost to charge allowed for the facility used. (See "Contracted Surgical Facility Listing)" and under the Medicaid Reimbursement Rate Cost to sum of charges (total amount).**

- **Multiply the outpatient percentage allowed for the facility by the amount charged to compute the amount to be paid. [Ex: 43.29% x $800.00 (.4329 x 800.00) = $346.32]. To determine the reimbursement rate for a non-hospital outpatient surgical facility, i.e., Ambulatory Surgical Center (ASC), follow the instructions provided in the footnote to the "Contracted Surgical Facility Listing".**

4. Anesthesiologist

- **Determine the number of units of time for anesthesia. (See instructions provided on "Anesthesia Payment Schedule").**

5. Pathologist/Radiologist/Laboratory

- **Determine if appropriate CPT codes from the ACPT Code Listing were used; correct the charges if not the acceptable rates.**

6. The Procedure Confirmation Number (PCN) must be placed on the bill before you submit it for payment.

IMPORTANT!!!!

Call DWIH Sterilization Program Manager at (804) 786-7569 if any unlisted CPT code is on the bill(s) before sending bills for reimbursement! Approval must be given for any UNLISTED CPT codes.

7. Need to have a "back up" person to move the bills along and review them if the coordinator is out of the office.

8. Send the original corrected bill(s) to:

Virginia Department of Health
Division of Women's & Infants' Health
1500 East Main Street, Suite 135
Richmond, VA 23219
Attn: Ardriene Stuart

9. All Sterilization invoices are to be reviewed and verified by the Sterilization Coordinator and mailed to DWIH within 3 days (72 hours) of receipt. IMPORTANT DO NOT HOLD BILLS.

10. The sterilization program manager at DWIH will be responsible to review all invoices and send the

facility/provider and local coordinator a copy of the adjusted invoice.

ANESTHESIA PAYMENT SCHEDULE

Anesthesia time "units" is determined by the **BASE UNIT** credit as follows:

BASE UNIT CREDITS

Laparoscopy = 6 units

Vasectomy = 3 units

1. **Determine** the **BASE UNIT Credits** as above.
2. **Add** the **actual Time Units as shown on the HCFA-1500 (12-90). You must give a full C**redit for each 15 minute period or ANY portion of the period. (A time of 46 minutes **Is equal to a total of 60 minutes for a total of 4 application units).**

Example:

Laparoscopy = 6 units
Application = 4 units

Total 10 units for payment

Anesthesia time "units" is determined by the **BASE UNIT** credit as follows:

BASE UNIT CREDITS

Laparoscopy = 6 units

Vasectomy = 3 units

3. **Determine** the **BASE UNIT Credits** as above.
4. **Add** the **actual Time Units as shown on the HCFA-1500 (12-90). You must give a full**

Credit for each 15 minute period or ANY portion of the period. (A time of 46 minutes

Is equal to a total of 60 minutes for a total of 4 application units).

Example: Laparoscopy = 6 units
Application = 4 units

Total 10 units for payment

Unit Designation	Number of Units	Reimbursement Rate
ANESO1	**1**	**$ 11.70**
ANESO2	**2**	**$ 23.40**
ANESO3	**3**	**$ 35.10**
ANESO4	**4**	**$ 46.80**
ANSEO5	**5**	**$ 58.80**
ANESO6	**6**	**$ 70.20**
ANESO7	**7**	**$ 81.90**
ANESO8	**8**	**$ 96.60**
ANESO9	**9**	**$105.30**
ANES10	**10**	**$117.00**
ANES11	**11**	**$128.70**
ANES12	**12**	**$140.40**

Unit **Designation**	Number of **Units**	Reimbursement **Rate**
ANES13	**13**	**$152.10**
ANES14	**14**	**$163.80**
ANES15	**15**	**$175.50**
ANES16	**16**	**$187.20**
ANES17	**17**	**$198.90**
ANES18	**18**	**$210.60**
ANES19	**19**	**$222.30**
ANES20	**20**	**$234.00**

SURGICAL FACILITY BILLS WILL REQUIRE A READJUSTMENT BASED ON A SPECIFIC PERCENTAGE TO BE APPLIED TO THE TOTAL AMOUNT BILLED.

1. **Determine the percentage of Medicaid reimbursement cost to charge allowed for the facility used. (See "Contracted Surgical Facility Listing)" and under the Medicaid Reimbursement Rate Cost to sum of charges (total amount). Always use the "Outpatient Rate' unless the patient is hospitalized overnight.**

   - **Multiply the outpatient percentage allowed for the facility x the amount charged to compute the amount to be paid. [Ex: 43.29% x $800.00 (.4329 x 800.00) = $346.32]. To determine the reimbursement rate for a non-hospital outpatient surgical facility, i.e., Ambulatory Surgical Center (ASC), follow the instructions provided in the footnote to the "Contracted Surgical Facility Listing", page 50.**

SECTION 7

Addendum Counseling

Counseling For Voluntary Surgical Contraception

Guidelines for Programs in the United States

COUNSELING FOR VOLUNTARY SURGICAL CONTRACEPTION

GUIDELINES FOR PROGRAMS IN THE UNITED STATES

Association for Voluntary Sterilization, National Division

COUNSELING OBJECTIVES

1. To ensure a voluntary, informed choice to undergo surgical contraception by producing complete, accurate, unbiased information about Voluntary Sterilization Contraception (VSC) and all alternatives in terms the client can understand. This includes explaining all written materials and reading to the client all forms that he or she must sign.

2. To identify and address any doubts or misconceptions the client may have about VSC, to avert postoperative regret, and to help the client choose an alternative course of action if it is appropriate.

3. To ensure that the client who decides to proceed with surgical contraception does so without any coercion.

4. To fulfill the legal requirements for informed consent by:

   a. documenting the discussion and the client's voluntary decision for VSC
   b. completing informed-consent form.

5. To provide information about financial arrangements and about the policies and procedures of the hospital, clinic, or private practice where the surgery will be performed; to assist in scheduling surgery or to refer the client for other services, if needed.

6. To ensure that the client or partner has interim contraceptive protection and any instructions needed to prevent pregnancy, either until the time of procedure (in cases when there is a wait between counseling and surgery) or after the procedure (in vasectomy cases).

MINIMUM RESOURCES FOR EFFECTIVE COUNSELING

1. A trained health professional responsible for counseling.

2. A Separate area of room.

3. Visual aids to illustrate anatomy and the physiological consequences of surgical contraception.

4. Request forms of informed-consent forms with copies for the client (in the client's own language).

5. Immediate access to temporary birth control methods or referrals, either for interim protection or as an alternative to "Voluntary Surgical Contraception (VSC)".

WHO CAN COUNSEL?

The client should be able to speak with a counselor of the same sex, if he or she desires. Any of the following categories of individuals, with proper training, can counsel clients:

1. Trained health educator

2. Trained nurse

3. Trained physician

4. Trained paramedic or health professional (for example, field worker, social worker)

5. Trained peer counselor (for example, a non-professional who has had VSC)

AND COMPETENCIES

KNOWLEDGE

1. Reproductive anatomy and physiology.

2. Sufficient medical background to ask the client basic medical screening questions.

3. How surgical contraction is performed, its physiological consequences, the various techniques used, and the methods of anesthesia available.

4. Asks and benefits of VSC, including the small chance of failure.

5. Risks and benefits of available family planning alternatives.

6. Medical and psychosocial contraindications to VSC.

7. Postoperative instructions, including what the client should expect to feel or experience and where he or she should go in case of complications.

8. Referral services available for alternative contraceptives or further counseling.

9. Legal or policy eligibility requirements for VSC.

10. Knowledge of applicable law.

INTERPERSONAL AND COMMUNICATION SKILLS

1. Ability to speak in a style and language that the client readily understands.

2. Ability to create a nonthreatening and nonjudgmental atmosphere that encourages the client to express reservations and ask questions.

3. Ability to listen and to identify possible psychosocial contraindications to VSC.

4. Respect for clients, including their ability to make their own decisions and their right to confidentiality.

5. Objectivity and lack of bias in presenting information.

6. Ability to deal comfortably and professionally with other people’s feelings.

7. Cordial manner and tact in asking questions and making comments.

8. Ability to recognize when problems presented by clients require skills or knowledge beyond the counselor's capability (i.e., when to refer the client for further counseling).

OF COUNSELING

Counseling is an interactive process with several components.

1. The counselor elicits information and feelings from the client.

    a. Contraceptive, social and sometimes the medical history
    b. Reasons for requesting VSC
    c. Attitudes and feelings bout VSC
    d. Anticipated response to a range of possible circumstances that may arise after the procedure (e.g., death of child, remarriage).

2. The counselor gives information

    a. Reproductive anatomy and physiology
    b. Risks and benefits of all available birth control methods, including VSC
    c. The different VSC procedures and types of anesthesia that are available; the risks, benefits, and recovery time
    d. Costs of the procedure
    e. Tests and medication.
    f. Postoperative effects
    g. Pre and postoperative instructions

3. The counselor encourages the client to ask questions and express concerns.

4. The counselor assists the client to identify and address any doubts, and to come to a firm, informed decision for either VSC or an alternative.

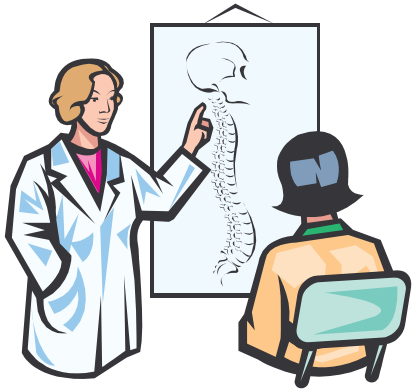
5. The counselor proves for contraindications to VSC (e.g., unrealistic expectations, coercive motivation, psychological, or martial problems) and refers the client for further counseling, if it is needed.

6. The counselor advises the client of the following:

    a. The expected permanence and usual irreversibility of VSC
    b. The small risk of failure
    c. Available contraceptive alternative and referral for services
    d. The client's right to change his or her mind anytime before surgery.

e. The probability of regret by the client (male and female) post sterilization

7. The counselor documents the discussion and the client's request for VSC and obtains the client's mark or signature as a sign of concurrence.



Counseling may be done individually or in a group. The counselor must respect the client's right to confidentiality, must inform the client that private counseling sessions are available, and provide them if they are requested.

When the client is involved in a relationship, it is important to ascertain whether or not the partner agrees with the client's the decision. It is generally desirable to involve both partners in the decision-making process. The incidence of sterilization

regret is significantly lower among couples in which the partner supported the decision for voluntary surgical sterilization.

THE TIMING OF COUNSELING

WAITING PERIOD

Although it is recognized that some people give years of thought to their decision before requesting VSC, it is generally recommended that a waiting period be required between the time the client signs the informed-consent form and the time of surgery. A waiting period allows the client and his or her partner to think about the decision and provides an opportunity for him or her to withdraw the request for permanent contraception. Programs that use federal funds for sterilization must observe a thirty-day waiting period from the time the consent form is signed until the procedure is performed.

VSC ASOCIATED WITH PREGNANCY: SPECIAL CONSIDERATIONS

When a client plans to undergo VSC immediately after delivery or abortion, particular care must be taken to ensure that the stress of the situation does not unduly influence the client's decision.

For clients who desire a sterilization at the time of delivery, counseling should be done during the prenatal period. Counseling should not be conducted nor consent obtained:

- When a woman is in labor
- When a woman is sedated
- Immediately postpartum

When possible, the client who is seeking postpartum surgical contraception should be counseled and should sign consent forms well in advance of her admission for delivery. When this is not possible and the woman seems ambivalent or under stress, it is best to postpone the procedure until her doubts can be resolved. If the client does not make a clear, voluntary decision within 48-72 hours of delivery, VSC should not be performed, and the client should be told that an interval procedure is possible, when and if she makes her choice. (an interval procedure is performed at least six weeks after delivery.) The woman should also be advised about temporary birth control methods to use in the mean time.

In case of a cesarean section, the same recommendations apply. Despite the obvious convenience, surgical contraception should not be performed in conjunction with a cesarean section unless the client has received through counseling and has given her consent before sedation or labor, if any occurs.

A physician may perform surgical contraception at the time of a vaginal delivery or a cesarean section without prior consent only if there are emergency medical indication (e.g., ruptured uterus).

Counseling for voluntary surgical contraception should not be conducted when the woman is feeling the effects of sedation. A minimum of one day should elapse between the time the medication was given and counseling.

GUIDELINES TO SAFEGUARD AGAINST COERCION

Encouraging an individual to undergo surgical contraception is coercive in the following situations:

1. When alternative contraceptive methods are not made readily available

2. When facts are misrepresented or incompletely presented

3. When the client is given a falsely limited view of the available options

4. When the counselor stresses the advantages of surgical contraception, downplays its risks, and minimizes the benefits of alternatives.

The advantages and disadvantages of all available alternatives must be presented. The counselor should make no effort to convince a client to choose surgical contraception over any suitable family planning alternative.

Clients should request surgical contraception freely, without force or inducement, fraud, deceit, constraint, or coercion. The role of the counselor is to provide information about surgical contraception, to assist the client in identifying and examining the various influences that have played a part in his or her request, and to help the client make an informed choice for either VSC or an alternative contraceptive method.

VOLUNTARY SURGICAL CONTRACEPTION

1. Gathering Information

A. Client's Personal Data

Name_____

Address_____

Age_____ Sex: M F Age of Partner_____

No. of living Children _____ Age of youngest child _____ Boys _____ Girls _____

Currently married/ Involved in stable union? Yes _____ No _____ If yes, since when? _____

Religion _____

Client's employment _____

Partner's employment _____

Any financial Difficulties? _____

B. Client's Health Status

	Yes	No		Yes	No
Heart disease	ڤ	ڤ	Psychiatric illness	ڤ	ڤ
Anemia	ڤ	ڤ	Stroke	ڤ	ڤ
Bleeding disorders	ڤ	ڤ	Liver disease	ڤ	ڤ
Blood clots	ڤ	ڤ	Kidney disease	ڤ	ڤ
Varicose veins	ڤ	ڤ	Diabetes	ڤ	ڤ
High Blood Pressure	ڤ	ڤ	Malnutrition	ڤ	ڤ
Convulsions	ڤ	ڤ	Known allergy to any		

Medication or anesthetic ☐ ☐

Inherited (genetic)

Disease or defect in Other allergies? ☐ ☐

Client or partner's family ☐ ☐ If yes, specify _____

Taking any medication? ☐ ☐ If yes, what? _____

C. Client's (Partner's) Obstetrical History

COMPLICATIONS OF PREGNANCY OR ABORTION

No. times pregnant _____ No. of cesarean sections _____

No. of live births _____ Postpartum hemorrhage _____

No. of abortions _____ Toxemia _____

No. of spontaneous _____ Malpresentation _____

No. of induced _____ Other obstetrical complication (specify)

No. of stillbirths _____

_____

Currently pregnant? _____ Abortion complication _____

Last menstrual period _____ Currently nursing? _____

Time since last delivery/or pregnancy History of menstrual problems _____

Termination _____

D. Client's Contraceptive History

Currently using birth control? ☐ Yes ☐ No Method? _____

Length of time used? _____

Any problems with

Current method? ☐ Yes ☐ No If yes, specify _____

Any problems with other Methods? ☐ Yes ☐ No If yes, specify _____

BIRTH CONTROL EVER USED

	Length of time used	Reason for discontinuing
Pills	_____	_____
IUD	_____	_____
Barrier (specify type)_____		_____
Injectable	_____	_____
Withdrawal	_____	_____
Rhythm	_____	_____
Other (specify)	_____	_____
None ever used	_____	_____

Why not? ☐ Not available ☐ Fear of side effects
☐ Not known ☐ Other (specify) _____

2. PROVIDING INFORMATION

A. Reproductive Anatomy and Physiology

Briefly explain, using visual aids.

B. The Alternatives

Explain the methods, risk, and benefits (including failure rate and possible side effects) of all available alternatives.

Method	Explained	Shown or Illustrated
Pills	☐	☐
IUD	☐	☐
Diaphragm or cap	☐	☐
Condoms	☐	☐
Foam	☐	☐

Suppository	☐	☐
Injectable	☐	☐
Other (sponge, cervical mucus, Basal body temperature, etc.)	☐	☐
VSC for partner	☐	☐
Withdrawal	☐	☐
Douching	☐	☐
Patch	☐	☐
Nuva Ring	☐	☐
No Method	☐	☐

C. Voluntary Surgical Contraception (VSC)

1. OVERVIEW OF FACTS

- **VSC will prevent pregnancy for the rest of the client's life**
- **VSC cannot be reversed, except in rare cases**
- **VSC involves an operation**
- **VSC interrupts the passageways that carry the egg/sperm**
- **VSC does not remove any organs**
- **VSC does not stop menstrual periods**
- **VSC does not alter erection or ejaculation**
- **VSC does not biologically alter sexual drive, performance, or pleasure**

2. BENEFITS

- **VSC is the most effective contraceptive method available**
- **VSC can be performed on either partner**
- **The risks are minimal if accepted medical standards are maintained. (Voluntary surgical contraception is the second safest method of birth control. The method with the lowest risk is the condom backed up by abortion.)**
- **The client is exposed to surgical risk once, compared to the ongoing risks of other contraceptive methods**
- **VSC does not require sustained motivation or the continuous inconvenience or expense of contraceptive supplies**
- **VSC does not change or interfere with sexual function**

- **Terminating fertility during or before the high-risk period of a woman's reproductive life (i.e., age 35 or older and/or more than three children) reduces the risks of maternal and infant morbidity and mortality**

3. RISKS

A. Risks related to all surgery:

1. **Complications of applicable anesthesia**
2. **Excessive bleeding**
3. **Risk of infection**

- **Risks specifically related to the VSC procedure:**
  - **Chance of damage to other organs**
  - **Chance of granuloma or hematoma (for men)**

- **Risk of regret because of a future desire for children**

- **Small risk of failure because of the natural rejoining of the tubes or because of physician error (less than 1% failure rate)**

b. AVAILABLE PROCEDURES

- **Minilaparotomy: postpartum ف interval ف**
- **Laparoscopy ف**
- **Vasectomy ف**
- **Other, if available ف** (specify) _____

c. ANESTHESIA (with fact sheets when available)

- **General**
- **Regional (spinal or epidural)**
- **Local**
- **Choice, if available**

d. POSTOPERATIVE INFORMATION AND INSTRUCTIONS

- **Discomfort and possible side effects to expect**
- **Limitation of activity and time required for recuperation**
- **Instructions about caring for the incision**

- **Who to contact and where to go in case of pain or other complications (fever, swelling, bleeding, inflammation, etc.)**
- **For male clients, the need for birth control for at least 15 ejaculations to clear the passageways of sperm (to ensure sterility, two semen specimens taken at different times should be examined to confirm the absence of sperm).**

4. Laws, Policies and Fees

- **Minimum age for client eligibility**
- **Waiting period requirements, if any**
- **Spousal consent or notification requirements, if any**
- **Explanation of the informed-consent form**
- **Costs of surgery, tests, medication, and follow-up**
- **Notification that the client can change his or her mind at any time before surgery.**

e. EXAMINING THE CLIENT'S FEELINGS AND REQUEST FOR VSC

i. <u>Client's Reasons for Requesting Surgical Contraception</u> (Check any that apply)

ف Desire to assure no more children

Why no more children? _____

_____

Why permanent contraception? _____

_____

Why now? _____

_____

ف Other methods unavailable

ف Other methods unacceptable

ف Medically contraindicated ف Experienced

ف Side effects ف Heard about

☐	Pressure from someone	If yes, from whom? _____
☐	Economic reasons	
☐	Incentive or disincentive	If yes, explain _____ _____ _____
☐	Desire to continue or complete education	
☐	Chronic or disabling disease	If yes, explain _____ _____ _____
☐	Medical risk with pregnancy	
☐	Other reason (specify)	

Why has the client, rather than the partner, chosen voluntary surgical contraception?

_____

_____

_____

B. Client's Decision Process

Did the client discuss the decision with anyone? ☐ Yes ☐ No

If yes, with whom? _____

Does the client's partner agree? ☐ Yes ☐ No ☐ No partner

Did any person or outside influence motivate the client's request? ☐ Yes ☐ No

If yes, explain _____

Does the client feel pressured by?

ف Partner ف Community
ف Other family member ف Economics
ف Other (specify) _____

Does the client have any sexual problems or problems with his or her partner? ف Yes ف No

Is the client certain he or she wants voluntary surgical contraception? ف Yes ف No

Does the client feel he or she would regret VSC?

If the client lost a living child or
A current pregnancy? ف Yes ف No

If the client lost his or her partner? ف Yes ف No

If the client lost his or her partner and wanted to have
Other children with a new partner? ف Yes ف No

Because VSC might affect the client's self-image
Or sexuality? ف Yes ف No

If his or her economic status improved? ف Yes ف No

When young children are older and child
Care responsibilities are reduced? ف yes ف No

Can the client imagine any circumstances
which he or she would regret having had VSC? ف Yes ف No

If yes, describe the circumstance _____

If yes, what would the client do? _____

CONCLUSION OF SESSION

A. Counselor's Assessment (circle applicable words)

a. Client is/is not suitable for VSC

b. Client does/does not understand the performance of VSC, as well as the contraceptive alternatives

c. Client is/is not making a voluntary, informed choice without coercion or inducement

d. Client's questions have/have not been encouraged and answered satisfactorily

e. Client does/does not require further counseling

B. Informed-Consent Form

1. Explain the form, and read it aloud for the client. (Provide other-language materials or an interpreter for non-English-speaking clients when needed)

2. Obtain the signature or mark of the client and of a witness, and sign the form attesting to the completion of thorough counseling

3. Give the client a copy of the completed form with instructions to bring it to the service facility at the time of surgery

C. REFERRAL APPOINTMENT (check any that apply)

		Facility	**Date**
☐	VSC surgery appointment	_____	_____
☐	Family planning clinic ☐ For interim protection	_____	_____

ف For alternative method _____ _____

ف Antenatal clinic _____ _____
ف Child clinic _____ _____

ف Mental health professional _____ _____

ف Other (specify) _____ _____

D. INTERIM BIRTH CONTROL (circle all applicable words)

1. Interim birth control is/is not required
2. Interim birth control has/has not been provided
3. Instructions have/have not been provided
4. Referral has/has not been provided
5. Method chosen: _____

E. HOW DID THE CLIENT HEAR ABOUT SERVICES?

		Re: VSC	**Re: Clinic**
ف	Health Staff	ف	ف
ف	Radio	ف	ف
ف	Newspaper	ف	ف
ف	Other (specify) _____		

How far did the client have to travel to the clinic? _____

How much time will pass between the client's first visit and the date of surgery (if known)?

Counselor's Name: _____

Counselor's Signature: _____

Date: _____