

# OREGON VASECTOMY PROJECT



- ▶ After a statewide assessment, the RH Program discovered that low-income clients have severely limited access to vasectomies. This is due to a variety of factors including low reimbursement rates and insufficient provider capacity.
- ▶ To mitigate this, the state RH Program raised reimbursement rates AND is currently seeking to contract directly with vasectomists who can travel throughout Oregon to perform vasectomies for your clients!



## BACKGROUND

- ▶ When we have contracted with a vasectomist, any agency within the vasectomist's chosen travel area will be able to use his/her services.
- ▶ Vasectomists will most likely travel with their own instruments but will need a private room in which to perform client services.
- ▶ State-contracted vasectomists may see clients with any source of pay, including, private insurance, OHP, CCare or self-pay.
- ▶ All services provided to self-pay clients must be rendered using Title X principles



# THE BASICS

▶ Starting January 2015, clinics that refer clients to either a state-contracted OR clinic-contracted vasectomist may collect

▶ Vasectomy Referral fee \$50

- ▶ Check box 11-OVP for Source of Pay in Section 9, regardless of the source of pay indicated on the CVR for the Counsel.
- ▶ Mark box 8 - Vasectomy Referral in Section 12 AND box 18 - Vasectomy Referral Fee in Section 13A.

▶ To be eligible for the fee, the full reimbursement rate for services rendered must be paid to the vasectomist (\$150 for Counsel and \$800 for Procedure).

# SHOW ME THE MONEY – NEW VASECTOMY REFERRAL FEE

<b>9. ASSIGNED SOURCE OF PAYMENT</b> (Check one)	
<input type="checkbox"/> 01 - No Charge	<input type="checkbox"/> 04 - Private Insurance
<input type="checkbox"/> 02 - Title XIX (OHP)	<input type="checkbox"/> 05 - Full Fee
<input type="checkbox"/> 08 - CCare*	<input type="checkbox"/> 06 - Partial Fee
<input type="checkbox"/> 03 - WA Take Charge	<input type="checkbox"/> 07 - Other
	<input type="checkbox"/> 10 - Non-CCare Visit/CCare Supply*
	<input type="checkbox"/> 11 - OVP
*Complete top section and 17 for CCare	
9A. DIAGNOSIS CODE (Complete if Question 9 is 8)	V25. <input type="text"/>
9B. WILL INSURANCE BE BILLED FOR THIS VISIT? (Complete if Question 9 is 8 or 10). <input type="checkbox"/> 1- No <input type="checkbox"/> 2- Yes (Complete 17A.)	
9C. SPECIAL CONFIDENTIALITY NEEDS <input type="checkbox"/> 1-Yes	
18. CLIENT INSURANCE STATUS (check one) (Principal Health Insurance covering primary care)	
<input type="checkbox"/> 1 - Public Health Insurance	<input type="checkbox"/> 3 - Uninsured
<input type="checkbox"/> 2 - Private Health Insurance	<input type="checkbox"/> 4 - Unknown
10. INCOME AND FAMILY SIZE	AMOUNT
a. What is your monthly family income?	
b. How many people are in your family, that is, the number supported by this income?	NUMBER
11. HEALTH INS. ENROLLMENT ASSISTANCE	
<input type="checkbox"/> 1 - Onsite <input type="checkbox"/> 2 - Referral	
<b>12. PURPOSE OF VISIT</b> (Check One)	
<input type="checkbox"/> 1 - First Annual Exam	<input type="checkbox"/> 5 - Pregnancy Test Visit
<input type="checkbox"/> 2 - Return Annual Exam	<input type="checkbox"/> 6 - Supply Only-Mailed (CCare Only)
<input type="checkbox"/> 3 - Other Medical	<input type="checkbox"/> 9 - Supply Only Visit (CCare Only)
<input type="checkbox"/> 4 - Counseling Only	<input type="checkbox"/> 8 - Vasectomy Referral (w/OVP SOP)
<b>13A. MEDICAL SERVICES</b> (Check all Applicable)	
<b>Exam &amp; Lab Services</b>	
<input type="checkbox"/> 02 - Blood Pressure	<input type="checkbox"/> 24 - Urine Dip Strip/Urinalysis
<input type="checkbox"/> 03 - Height/Weight	<input type="checkbox"/> 25 - Pap Test Conventional
<input type="checkbox"/> 04 - Thyroid Exam	<input type="checkbox"/> 26 - Pap Test Liquid-Based
<input type="checkbox"/> 05 - Heart/Lung Auscultation	<input type="checkbox"/> 27 - Colposcopy
<input type="checkbox"/> 06 - Breast Exam	<input type="checkbox"/> 34 - Immunization
<input type="checkbox"/> 07 - Abdominal Exam	<input type="checkbox"/> 42 - Male Genitalia Exam
<input type="checkbox"/> 08 - Extremities	<input type="checkbox"/> 49 - Colo-Rectal Cancer Screening
<input type="checkbox"/> 09 - Bimanual/Speculum Pelvic Exam	<input type="checkbox"/> 36 - Other Lab or Exam
<input type="checkbox"/> 23 - Hgb / Hct	<input type="checkbox"/> 37 - No Lab or Exam
<b>Contraceptive Related Services</b>	
<input type="checkbox"/> 17 - Diaphragm / Cap Fit	<input type="checkbox"/> 40 - Hormonal Injection
<input type="checkbox"/> 19 - IUD/IUS Insert	<input type="checkbox"/> 48 - EC-Immediate Need
<input type="checkbox"/> 20 - Sterilization Procedure	<input type="checkbox"/> 46 - EC-Future Need
<input type="checkbox"/> 38 - Hormone Implant In	<input type="checkbox"/> 22 - IUD/IUS Removal
<input type="checkbox"/> 39 - Hormone Implant Out	<input type="checkbox"/> 18 - Vasectomy Referral Fee
<b>Pregnancy Related Services</b>	
<input type="checkbox"/> 21 - Post Pregnancy Exam	<input type="checkbox"/> 33 - Positive Pregnancy Test
<input type="checkbox"/> 31 - Serum Pregnancy Test	<input type="checkbox"/> 35 - Infertility Screening
<input type="checkbox"/> 32 - Negative Pregnancy Test	
AHLERS & ASSOCIATES, WACO, TEXAS	

# Provider Referral Form

**VASECTOMY REFERRAL FORM**  
Oregon Health Authority  
Oregon Vasectomy Project

Date of Referral: \_\_\_\_\_

**RH Clinic**

Name:	
Phone:	Fax:
Contact Name:	

**Client**

Name:		DOB:	
Address:			
City:	State:	Zip:	Phone:

**Vasectomist**

Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

**Services**

<input type="checkbox"/> Referred for Counsel	<input type="checkbox"/> Referred for Vasectomy
Date of Counsel (if performed/scheduled):	
Date of Vasectomy (if scheduled):	

**Source of Pay**

<input type="checkbox"/> Private Insurance	<input type="checkbox"/> OHP	<input type="checkbox"/> CCare	<input type="checkbox"/> OVP/Self-Pay
Amount Client Owes for Counsel:		Amount Client Owes for Vasectomy:	

Date Referral Sent: \_\_\_\_\_

Referral Expiration Date (180 days after Counsel): \_\_\_\_\_

# Services Rendered Form

**SERVICES RENDERED FORM**  
Oregon Health Authority  
Oregon Vasectomy Project

*For use by Vasectomist to indicate which services were provided for a RH Clinic referred client. Please complete separate form for EACH service – one for the sterilization counsel and one for the vasectomy procedure. Information from this form will be used to bill for vasectomy services.*

Provider Name: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_\_

Date of Vasectomy Counsel (if applicable): \_\_\_\_\_

Date of Vasectomy Procedure (if applicable): \_\_\_\_\_

Check the boxes of services if performed:

COUNSELING PROVIDED <i>Only required if Sterilization Counsel performed</i>	MEDICAL SERVICES <i>Only required when Vasectomy performed</i>
<input type="checkbox"/> 01 – Contraceptive Options	<input type="checkbox"/> 02 – Blood Pressure
<input type="checkbox"/> 03 – Sterilization [Required]	<input type="checkbox"/> 20 – Sterilization Procedure
	<input type="checkbox"/> 42 – Male Genitalia Exam
	<input type="checkbox"/> 36 – Other Lab or Exam

Payment Amount Received (i.e. client fee, private insurance, Medicaid): \_\_\_\_\_

**PROVIDER, BY SUBMITTAL OF THIS SERVICES RENDERED FORM, HEREBY DECLARES THE STATED SERVICES WERE PERFORMED.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NEW VASECTOMY FORMS (for use with state-contracted vasectomy providers)

- ▶ Some vasectomists will prefer to conduct the sterilization counsel themselves, and some will prefer to only perform the actual sterilization procedure.
- ▶ We have developed instructions for both scenarios.
- ▶ The meat of the instructions must be followed, but the “flow” may be adjusted to how your clinic operates.



## STERILIZATION COUNSELS

- ▶ Client requests vasectomy.
- ▶ Following clinic-specific workflow processes, RH Clinic performs intake, screening Client for eligibility determining appropriate funding source.
- ▶ RH Clinic conducts Counsel.
- ▶ RH Clinic gives written Vasectomist-specific Pre/Post-Operative Instructions to Client.
- ▶ Client & RH Clinic complete and sign forms



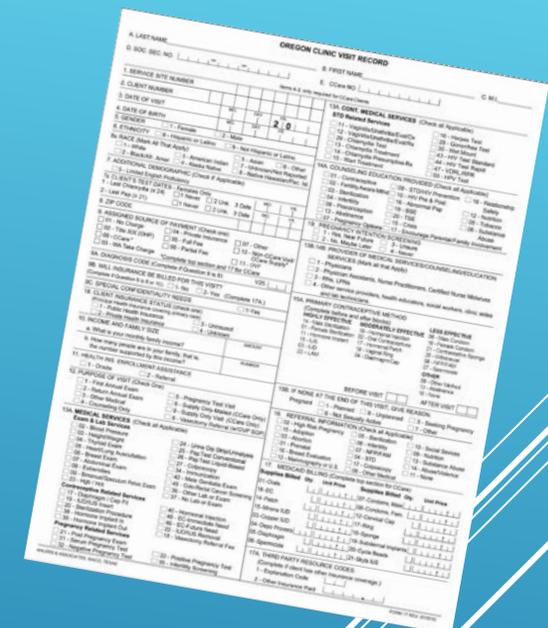
FORM	CLIENT	RH CLINIC
Release of Information	X	
Consent for Sterilization	X	X
Vasectomy Referral Form		X

- ▶ RH Clinic sends information to the Vasectomist.
- ▶ Client pays fee for Counsel, if any.



## SCENARIO: RH CLINIC DOES COUNSEL

- ▶ RH Clinic bills Private Insurance or OHP for Counsel, if applicable.
- ▶ RH Clinic completes *two* CVRs within 90 days of the date of the Counsel.
  - ▶ CVR for the Counsel
  - ▶ CVR for Vasectomy Referral listing **different date of service** than on Counsel CVR (e.g. one day after date of Counsel)
- ▶ RH Program sends payment for CVRs submitted, less payment already collected, to RH Clinic.
- ▶ The Procedure is scheduled 30-180 days from the Client's signature date on the Consent for Sterilization Form.



# SCENARIO: RH CLINIC DOES COUNSEL (CONT.)

- ▶ Client requests vasectomy.
- ▶ Following clinic-specific workflow processes, RH Clinic screens Client for eligibility determining appropriate funding source.
- ▶ Client & RH Clinic complete and sign forms



FORM	CLIENT	RH CLINIC
Release of Information	x	
Vasectomy Referral		x

- ▶ RH Clinic sends information to the Vasectomist.
- ▶ Counsel appointment is scheduled.
- ▶ RH Clinic completes CVR for Vasectomy Referral and submits to RH Program for payment.
- ▶ RH Program sends payment for Vasectomy Referral to RH Clinic.



## SCENARIO: VASECTOMIST DOES COUNSEL

- ▶ Client presents to Vasectomist for Counsel.
- ▶ Vasectomist conducts Counsel.
- ▶ Client pays fee for Counsel, if any.
- ▶ Within 90 days of the date of the Counsel,
  - ▶ Vasectomist sends Services Rendered Form and medical records to the RH Clinic.
  - ▶ RH Clinic completes **paper** CVR using information from the Services Rendered Form.
- ▶ RH Program sends payment for Counsel, less amount already collected, to Vasectomist.



The form is titled 'OREGON CLINIC VISIT RECORD' and contains the following sections:

- A. LAST NAME**, **B. SOC. SEC. NO.**, **C. CLINIC NO.**, **D. FIRST NAME**
- 1. SERVICE SITE NUMBER**, **2. CLIENT NUMBER**, **3. DATE OF VISIT**
- 4. DATE OF BIRTH**, **5. GENDER**, **6. ETHNICITY**
- 7. RACE (Check all that Apply)**: 1. White, 2. Black, 3. American Indian, 4. Asian, 5. Other
- 8. ZIP CODE**
- 9. ASSIGNED SOURCE OF PAYMENT (Check one)**: 1. No Charge, 2. Full Fee, 3. Other
- 10. DIAGNOSIS CODE**
- 11. WILL INSURANCE BE BILLED FOR THIS VISIT?**
- 12. SPECIAL CONFIDENTIALITY NEEDS**
- 13. CLIENT INSURANCE STATUS (Check one)**
- 14. INCOME AND PAY STATUS**
- 15. HEALTH INS. ENROLLMENT ASSISTANCE**
- 16. PURPOSE OF VISIT (Check one)**
- 17. MEDICAL SERVICES (Check all that Apply)**: Includes sections for 17A. CONTRACEPTIVE SERVICES, 17B. MEDICAL SERVICES, 17C. LABORATORY SERVICES, 17D. X-RAY SERVICES, 17E. OTHER SERVICES
- 18. GENERAL INFORMATION (Check all that Apply)**
- 19. MEDICAL BILLING (Check one)**
- 20. THIRD PARTY SOURCES (Check one)**

# SCENARIO: VASECTOMIST DOES COUNSEL (CONT.)

- ▶ Client presents for Procedure.
- ▶ Vasectomist conducts Procedure.
- ▶ Client pays fee for Procedure, if any.
- ▶ Within 90 days of the date of the Procedure,
  - ▶ Vasectomist sends Services Rendered Form and medical records to the RH Clinic.
  - ▶ RH Clinic completes **paper** CVR using information from the Services Rendered Form.
- ▶ RH Program sends payment for Procedure, less amount already collected, to Vasectomist.



## PROCEDURE

- ▶ If a client is determined to be covered under OHP or a private insurance that does not reimburse up to \$800 for the vasectomy, the RH Clinic & Vasectomist may bill OVP for the balance.
- ▶ The Vasectomist will indicate the amount received from OHP or private insurance on the Services Rendered Form.
- ▶ On the **paper** CVR, the RH Clinic will:
  - ▶ Indicate the amount received from OHP or private insurance in section 17A, box 2-Other Insurance Paid
  - ▶ Check box 11-OVP for Source of Pay in Section 9.



# BALANCE BILLING

**SERVICES RENDERED FORM**  
Oregon Health Authority  
Oregon Vasectomy Project

For use by Vasectomist to indicate which services were provided for a RH Clinic referred client. Please complete separate form for EAOH service – one for the sterilization counsel and one for the vasectomy procedure. Information from this form will be used to bill for vasectomy services.

Provider Name: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_\_

Date of Vasectomy Counsel (if applicable): \_\_\_\_\_

Date of Vasectomy Procedure (if applicable): \_\_\_\_\_

Check the boxes of services if performed:

COUNSELING PROVIDED <small>Only required if Sterilization Counsel performed</small>	MEDICAL SERVICES <small>Only required when Vasectomy performed</small>
<input type="checkbox"/> 01 – Contraceptive Options <input type="checkbox"/> 03 – Sterilization [Required]	<input type="checkbox"/> 02 – Blood Pressure <input type="checkbox"/> 20 – Sterilization Procedure <input type="checkbox"/> 42 – Male Genitalia Exam <input type="checkbox"/> 36 – Other Lab or Exam

Payment Amount Received (i.e. client fee, private insurance, Medicaid): \_\_\_\_\_

PROVIDER, BY SUBMITTAL OF THIS SERVICES RENDERED FORM, HEREBY DECLARES THE STATED SERVICES WERE PERFORMED.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- ▶ If RH Clinic conducts Counsel, CVR for Referral Fee must have different date of service than CVR for Counsel
- ▶ To receive Referral Fee, full reimbursement rates must be passed on to Vasectomist
- ▶ CVRs with OVP as Source of Pay must be submitted within 90 days of Date of Service
- ▶ ALL agencies may balance bill OVP for Procedures provided to clients with OHP or Private Insurance

## HIGHLIGHTS

# QUESTIONS?

