Surveillance Codes for Effective Contraceptive Use

The Effective Contraceptive Use measure looks at women age 15-50 to determine if they have evidence of an effective contraceptive type during the measurement year. **This measure is based on claims during the calendar year; codes must be submitted on a billable visit to exclude women or count her as having met the measure.** Below are exclusion and numerator diagnosis codes for Effective Contraceptive Use.

Exclusions: women can be excluded from the denominator if they have evidence of the following diagnoses.

Denominator Exclusion Codes	
Hysterectomy	N99.3, Z90.710, Z90.711
Other reproductive system removal	Z90.722
Natural Menopause	N92.4, N95.0, N95.1, N95.2, N95.8, N95.9, Z78.0
Premature Menopause due to survey, radiation or other factors	E28.310, E28.319, E28.39, E28.8, E28.9, E89.40, E28.9, E89.40, E89.41, N98.1
Congenital Anomalies of female genital organs	Q50.02, Q51.0
Female Infertility	N97.0, N97.1, N97.2, N97.8, N97.9

NOTE: Clinics do not need to document exclusions every measurement year if there is existing Medicaid claims history with evidence of exclusion.

Numerator: women in the denominator with evidence of one of the following methods of contraception during the measurement period: sterilization, IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm using the below numerator code table.

Numerator	DX Code
Female Sterilization	Z30.2, Z98.51
Intrauterine Device (IUD)	Z30.014, Z30.430, Z30.431, Z30.433, Z97.5
Hormonal Implant	Z30.016, Z30.017
Injectable	Z30.013
Oral Contraceptive Pills	Z30.011
Patch	Z79.3
Vaginal Ring	Z30.015
Surveillance of a contraceptive method	Z30.41, Z30.42, Z30.44, Z30.45, Z30.46, Z30.49
Unspecified Contraception	Z30.018, Z30.019, Z30.40, Z30.8, Z30.9

Strategies to Improve Rates

The OHA ECU Guidance Document provides a few strategies to improve rates, summarized below:

1. **Screen women for their pregnancy intention on a routine basis**
    a. Several pregnancy intention screening tools are available for use in clinical and non-clinical settings, with Oregon served as a national leader in this area with the One Key Question® initiative, developed by the Oregon Foundation for Reproductive Health. Click here for more information
2. **Improve Availability and Uptake of long acting reversible contraception (LARCs)**
    a. For clinics that can provide IUDs and implants, it is important to get the care team on board. Effective contraceptive use is not solely the responsibility of the clinician.

Administrative and other support staff, health educators, and clinicians all have roles to play in supporting LARC adoption.

i. Recommended strategies include:
    1. Create a dedicated family planning team or lead staff within the clinic to affect change.
    2. Integrate family planning into staff development initiatives, including new hire orientation.

3. **Create QI process for contraceptive care**
    a. Quality improvement processes for contraceptive care can be developed at the clinic level. Helping women plan healthy pregnancies (and avoiding mistimed) is a core component of primary care.
        i. Clinics can use administrative (claims and encounter) and/or electronic health record (EHR) data to track pregnancy intentions and contraceptive use as a core preventive service in primary care settings, similar to cancer screenings.
        ii. Clinics can ensure providers and clinic staff receive standardized training and develop skills in contraceptive counseling and the provision of contraception services.
4. **Use Telephone Visit to drop surveillance code**
    a. For organizations who do not implement ECU for the entire calendar or measurement year, a telephone visit is a way to capture information for patients and ensure they have a contraceptive method that works for them.

Telephone Visit Billing

Click here for telephone visit toolkit

Telephone and Telemedicine visits are aimed to increase access & efficiency by utilizing another means for management of chronic diseases. These visits expand the physical reach a care team has with members and reduce or eliminate barriers such as transportation, work time and child care. Below are codes that are reimbursed.

Below are codes that are eligible for payment as telephone calls.

Service by Qualified Healthcare Professional (Link)		Service by Qualified Non-Physician (Link)	
99441	Telephone assessment and mgmt 5-10 min	98966	Telephone assessment and mgmt 5-10 min
99442	Telephone assessment and mgmt 11-20 min	98967	Telephone assessment and mgmt 11-20 min
99443	Telephone assessment and mgmt 21-30 min	98968	Telephone assessment and mgmt 21-30 min
99444	On-line assessment and mgmt	98969	On-line assessment and mgmt

Click the link above for telephone visit toolkit or reach out to Primary Care Innovations Specialist (PCIS), Paula Smith (smithp@careoreon.org) for additional information.

Things to remember when billing:

- Codes are time based and the exact amount of time spent with patient should be documented.
- Phone visit should not originate from a previous visit within the previous 7 days nor should it lead to assessment in the next 24 hours.
- Phone call must be patient initiated or pre-scheduled.
- Visit should involve some medical decision making or care coordination.

What about Private Pay and billing?

Senate Bill 144 requires that health insurance companies cover and pay for a service if a doctor or nurse practitioner offers their care remotely through a secure video conference technology