

**Nebraska Infertility Prevention Project
Lab Slip Instructions
May 1, 2003**

Nebraska Infertility Prevention Programs:

Douglas County Health Department – 402/444-7750

Eastern Metro-Nebraska Health & Human Services System – 402/444-7750

Lincoln-Lancaster County Health Department – 402/441-8056

Central Area-Kearney Office, Nebraska Health & Human Services System – 308/865-5609

Western Area-North Platte, Nebraska Health & Human Services Systems – 308/535-8134

Northeast Area-Nebraska Health & Human Services System = 402/668-7491

Quality Control Office – Nebraska Health & Human Services System – 308/632-1334

**Lincoln-Nebraska Health & Human Services System – Central Office
301 Centennial Mall South
P. O. Box 95007
Lincoln, NE 68509-5007**

**A cooperative effort between Nebraska STD Control Program, Nebraska Public Laboratory,
Nebraska Reproductive Health Program, Region VII, and U. S. Department of Health & Human
Services/Centers for Disease Control and Prevention**

INSTRUCTIONS

PATIENT NAME

Last Name	First Name	Middle Initial
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Enter the patient's name.

Multiple Race: (Check all that apply.)

- 1__ White
- 2__ African American
- 3__ American Indian/Alaska Native
- 4__ Asian
- 5__ Native Hawaiian/Pacific Islander
- 6__ Other
- 7__ Primary Race: #__

Ethnicity:

- 1__ Hispanic
- 2__ Non-Hispanic
- 3__ Unknown

Fill out both categories. These are separate categories which conform to the U.S. Census format. If not already included in the client's medical record, ask the client what she/he identifies as.

Race: In the Race category, please choose one.

- 1. White includes persons of European descent.
- 2. African American includes persons of African descent.
- 3. American Indian/Alaskan Native: American Indian includes persons having origins in any of the native people in North America. Alaska Indian, Eskimos, and Aleut are included as Alaskan Native. This box suggests person from either group.
- 4. Asian includes persons having origins in the Far East, Southeast Asia, or India.
- 5. Native Hawaiian/Pacific Islander indicates persons having origins in the Pacific Islands.
- 6. Other is for people who identify as a member of none of the above groups.
- 7. Primary Race: The Race that the client most identifies by.

Ethnicity: In the Ethnicity category, only one choice is possible.

(Please note: Hispanic is not a race)

- 1. Hispanic origin or descent includes Mexican-American, Puerto Rican, Cuban, Central or South American, and other Spanish-speaking origins.
- 2. Non-Hispanic includes all other persons.
- 3. Unknown- self explanatory.

These items are used to determine the location of the client's residence. Enter the three digits of the County F.I.P.S code (see Appendix A) and two digits of the State F.I.P.S code (see Appendix B), and five digits of the zip code. If client is out of state, put 999 in the County Code space.

DATE SPECIMEN COLLECTED/SPECIMEN COLLECTION TIME

DATE
SPECIMEN COLLECTED

TIME
SPECIMEN COLLECTED

MO DAY YR

AM / PM

Enter the date the client was tested for Chlamydia. Enter month, day and year, using two digits for each number. Enter the time the specimen was collected and circle AM or PM.

CHART NO. _____
Chart No.

Enter the patient's clinic chart number.

ICD-9 CODE:

The Nebraska Public Health Laboratory in conjunction with the Nebraska Infertility Program is now able to **bill Medicaid for charges incurred by clients who are covered under the Medicaid program.**

The lab form has been updated to provide a section that needs to be completed in order for the Nebraska Public Health Laboratory to bill Medicaid. If you have a patient who is covered by Medicaid, **YOU MUST COMPLETE THIS SECTION OF THE LAB FORM.**

If you have any questions, please call the UNMC Nebraska Public Health Laboratory billing office at (402)-559-8291.

Accession Number: For lab use only

Physician/Clinician License Number: Only needed when billing Medicare.

Please share this information with all your clinic staff and file this information with your Infertility laboratory instruction manual.

ENTERING MEDICAID BILLING INFORMATION

1. Infertility Prevention Program **requirements** (also required for Medicaid:
 - **Patient Name:** Enter the patient's name
 - **Race:** Enter the patient's race
 - **Ethnicity:** Enter the patient's ethnicity
 - **Physician/Clinician Name:** Enter clinician's name
 - **Date of Birth:** Enter patient's date of birth
 - **Sex:** Circle m = male or f = female
 - **Address:** Enter the patient's address

2. **Patient's Medicaid Number:**
 - Prior to providing services, verify the patient is currently a Medicaid client.
 - Check the patient's Medicaid card (is it current) or by calling the Nebraska Medicaid Eligibility System (NMES) **(800-642-6092)**
 - Enter the patient's 11 digit ID Medicaid number or the patient's 9 digit social security number.

3. **Medicaid ICD-9 Codes:**
 - The clinician or practitioner must enter the ICD-9 diagnosis code(s) that corresponds with the patient's visit for that day.
 - **Enclosed is a list of ICD-9 diagnosis codes.**
 - The V codes are usually adequate documentation in order for the laboratory to bill Medicaid.

COMMON DIAGNOSIS ICD-9 CODES

VO1.6	EXPOSURE TO:	GONORRHEA SYPHILIS
VO1.7	EXPOSURE TO:	AIDS VIRUS HIV VIRAL DISEASES
VO1.9	EXPOSURE TO:	CHLAMYDIA
V69.2	HIGH RISK SEXUAL BEHAVIOR	
	a. age (15-24 years)	
	b. new partner (last 90 days)	
	c. multiple partners (last 90 days)	
	d. no contraception used	

Questions? Please call UNMC billing for assistance at 402-559-8291.

Syphilis RPR ____

For the test listed above: It is not a part of the Infertility screening program. The facilities that are authorized to have these test processed without cost are aware of this fact. Do not send test samples for the above test unless you are authorized to do so.

Neisseria Gonorrhea Screen ____

Identifies alternative sites that require the use of different tests (i.e., gonorrhea/chlamydia culture for throat and rectum).

Other Testing ____

The chlamydia/gonorrhea DNA screen is approved for eye specimens. Please indicate specimen source (i.e., eye).

Amplified Chlamydia/gonorrhea DNA Screen ____

The Nebraska Public Health Laboratory utilizes the Amplified Chlamydia/gonorrhea DNA Screen assay for screening and detection of chlamydia and gonorrhea.

RISK HISTORY (CHECK ALL THAT APPLY)

- 1__ Multiple Partners In Last 90 Days
- 2__ New Partner In Last 90 Days
- 3__ Contact To A Std
- 4__ None Of The Above

Multiple Partners In Last 90 Days. Client reports she/he has more than one partner.

New Partner In Last 90 Days. Last screen. Self explanatory

Contact to a STD – Client reports she has been exposed to a STD, especially Chlamydia or Gonorrhea.

None of the above – Self explanatory

CLINICIAN OBSERVATIONS (CHECK ALL THAT APPLY)

- 1__ Cervical Friability
- 3__ PID
- 4__ Cervicitis/MPC
- 5__ Urethritis
- 8__ Not Examined/Self Collected
- 9__ None of the Above

Cervical Friability refers to easily induced bleeding when the swab touches the cervix.

PID refers to suspicion of Pelvic Inflammatory Disease, an upper genital tract infection that frequently involves the endometrium *endometritis), fallopian tubes (salpingitis), and pelvic peritoneum (Peritonitis). **Symptoms suggestive of PID include abdominal pain, pain with intercourse, vaginal discharge, excessive uterine bleeding, dysuria, onset of pain in association with menses, fever and sometimes nausea and vomiting.**

Cervicitis/MPC refers to inflammation of the cervix. It can be thought of as the female’s counterpart to male urethritis. Cervicitis is most often caused by HSV, HPV, CT or GC, yet it may be present with benign metaplasia, mechanical/chemical irritation, post-traumatic repair, neoplasia, or other unknown factors. It is defined as any of the following:

- A. Edema, erythema or follicle-like lesions in an area of ectopy (the extension of columnar epithelium onto the ectocervix). **OR**
- B. The presence of cervical mucus with ten or more polymorphonuclear leukocytes per x1000 microscopic field.

Mucopus (MPC) refers to yellow or green mucopurulent discharge from the cervix, with infection.

