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TO: Directors of Nursing and Nursing Supervisors

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DATE: June 21, 2007

SUBJECT: Guidance on Billing When STD and Women's Health Services Interface

This is a re-issue and update of a memo dated May 8, 2002 on this issue.

We continue to receive questions about how to reconcile the statutes related to providing STD services with the reality of service delivery patterns at the local level and to appropriately account for and bill these services. Below is guidance based on consensus by staff from all programs. Please note that in all examples below where it is noted that a patient may be billed, the patient must be notified before the service is provided that they will be responsible for the cost (either in total or on a sliding fee scale) and must have the opportunity to decline the service.

1. If during the course of an initial or annual Family Planning or any Maternity visit the clinician needs to rule out STDs to meet standards of care, the patient cannot be charged for the STD testing and treatment services. Third party payors (Medicaid and private insurance) can be charged for these services. *NOTE that in this case and all subsequent examples, billing private insurance will result in an EOB to the home address; therefore, the patient should be informed of that and have the opportunity to say they do not want insurance to be billed.*

Example: A patient comes in to Family Planning clinic (or for family planning services in an open access clinic) for the first time. As a part of the routine screening required by the Program for such patients, the clinician must screen for gonorrhea and chlamydia. These screening tests are NOT billable to the patient but may be billed to third party payors. This visit is a FP Program type preventive medicine visit and may be billed to the patient or third party payors.

2. For follow-up and/or problem-focused visits, be consistent in using the reason for the visit to decide what may be billed to the patient. *NOTE that this should be the reason given to the clinician, since many patients may not feel comfortable sharing at a "front/check-in" desk that they have "STD-related" complaints. This "reason for the visit" will then determine the Program Type to be used for recording or billing the service and for accounting for staff time.*

Example 1: A patient comes in to the Health Department complaining of a discharge. In order to determine and treat the cause, the clinician must go through an STD "work-up" to at least rule out an STD as the cause. This is an STD Program type visit and no part of this visit is billable to the patient, but services may be billed to third party payors (see *NOTE* in number 1 above).



Example 2: A patient on oral contraceptives comes in to Family Planning Clinic with a complaint of “bleeding between menstrual periods.” The clinician would start by investigating method-related problems. If during that process the clinician decided to do a screening for an STD (e.g., chlamydia), that specific test would not be billable to the patient; however, this is a FP Program type and the remainder of the visit may be billed to the patient. That test (see *NOTE* in number 1 above) and the visit may be billed to third party payors.

Example 3: A patient comes in to the Health Department saying she may have been or has been exposed to an STD; therefore, an STD “work-up” is required. However, during the visit the clinician discovers that the woman has not had a pap smear in the last 36 months. The clinician should perform that pap smear. While **neither** the visit **nor** the STD tests are billable to the patient, the pap smear may be billed to the patient. This is a STD Program type so all services may be billed to third party payors (see *NOTE* in number 1 above).

3. If a patient presents with an STD complaint or request for STD services (e.g., screening or an HIV test), nothing is billable to the patient.
4. There is only one circumstance in which an STD screen may be billed to a patient. If a patient comes in to have a syphilis serology done *for purposes of employment ONLY* we have a legal ruling that says that patient may be charged (NOTE that the local health department could only charge for drawing the blood IF it sends the blood to an outside lab for testing.)