Family Planning, Access, Care & Treatment (FPACT) Billing

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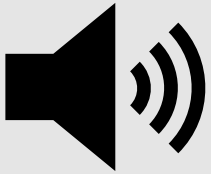

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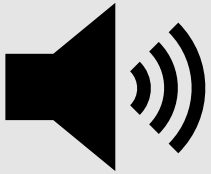

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Family Planning, Access, Care & Treatment (FPACT) Billing

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

4/9/2024

Purpose

The purpose of this module is to provide participants with an overview of the Family Planning, Access, Care and Treatment (Family PACT) Program. Family PACT is California's innovative approach to providing comprehensive family planning to low-income women and men.

Objectives

- Identify Family PACT categories of service
- Review Family PACT approved contraceptive methods
- Provide list of family planning and family planning-related ICD-10-CM diagnosis codes
- Detail the requirements for Family PACT complication services and *Treatment Authorization Requests (TARs)*
- Clarify Family PACT excluded services

Objectives

- Discuss evaluation and management/education and counseling services
- Review sterilization policy and the *Sterilization Consent Form* (PM 330)
- Detail claim documentation requirements for dispensing drugs and supplies
- Feature a case study and claim example

Acronyms

Family PACT Overview

Family PACT Overview

The Family PACT program is designed to assist individuals who are of childbearing age and have a medical necessity for family planning services.

The overall goal of the Family PACT program is to ensure that low-income women and men have access to health information, counseling and family planning services to reduce the likelihood of unintended pregnancy.

Family PACT Overview

The Office of Family Planning (OFP) administers the Family PACT program. Family PACT is a comprehensive program because it includes family planning and family planning-related services together with client-centered health education and counseling. Family PACT serves approximately 1 million eligible women and men through both public and private providers.

Family PACT Program Standards

The Family PACT Standards are designed as minimum quality improvement requirements for providers and provider organizations, serving as the basic framework of the program. The seven standards address:

- Informed consent
- Confidentiality
- Cultural and linguistic competency
- Access to care
- Availability of covered services
- Clinical and preventive services
- Education and counseling services

Federal Regulation and Program Services

Section 2303 (a)(3) of the Patient Protection and Affordable Care Act (ACA), specifies that benefits of the federally supported state family planning programs are limited to “family planning services and supplies” as well as family planning-related services such as “medical diagnosis and treatment services that are provided pursuant to family planning service in a family planning setting.”

Family Planning Services

Family planning services are those **relevant** to the use of contraceptive methods and include specified reproductive health screening tests.

These include the U.S. Food and Drug Administration (FDA) approved:

- Contraceptive methods
- Emergency contraceptives
- Office visits
- Interventions for the management of complications from the use of covered contraceptive methods

Family Planning Related-Services

Family planning-related services include diagnosis and treatment of specified sexually transmitted infections (STIs) when provided pursuant or coincident to a family planning service.

The Family FACT Program covers testing, diagnosis and treatment of specified STIs during the initial family planning visit as long as family planning services are provided. STI services are also available at subsequent visits, regardless of the initial purpose of the visit.

Family PACT covers urinary tract infections (UTIs) and screening for cervical cancer and pre-invasive cervical lesions for women when the care is provided **coincident to a visit** for the management of a family planning method.

Family PACT Overview

Telehealth Policy

For dates of service on or after July 1, 2019, telehealth services policy was established pursuant to Assembly Bill 415 known as the Advancement Act of 2011.

Services may be provided via a telehealth modality, if all the following are satisfied:

- The treating health care provider at the distant site believes the benefits or services provided are clinically appropriate being delivered via telehealth.
- Services delivered via telehealth meet the procedural definition of the CPT/HCPCS code(s) covered under Family PACT.
- Services provided via telehealth meet all laws regarding confidentiality of health care information and patient's right to his or her medical information.

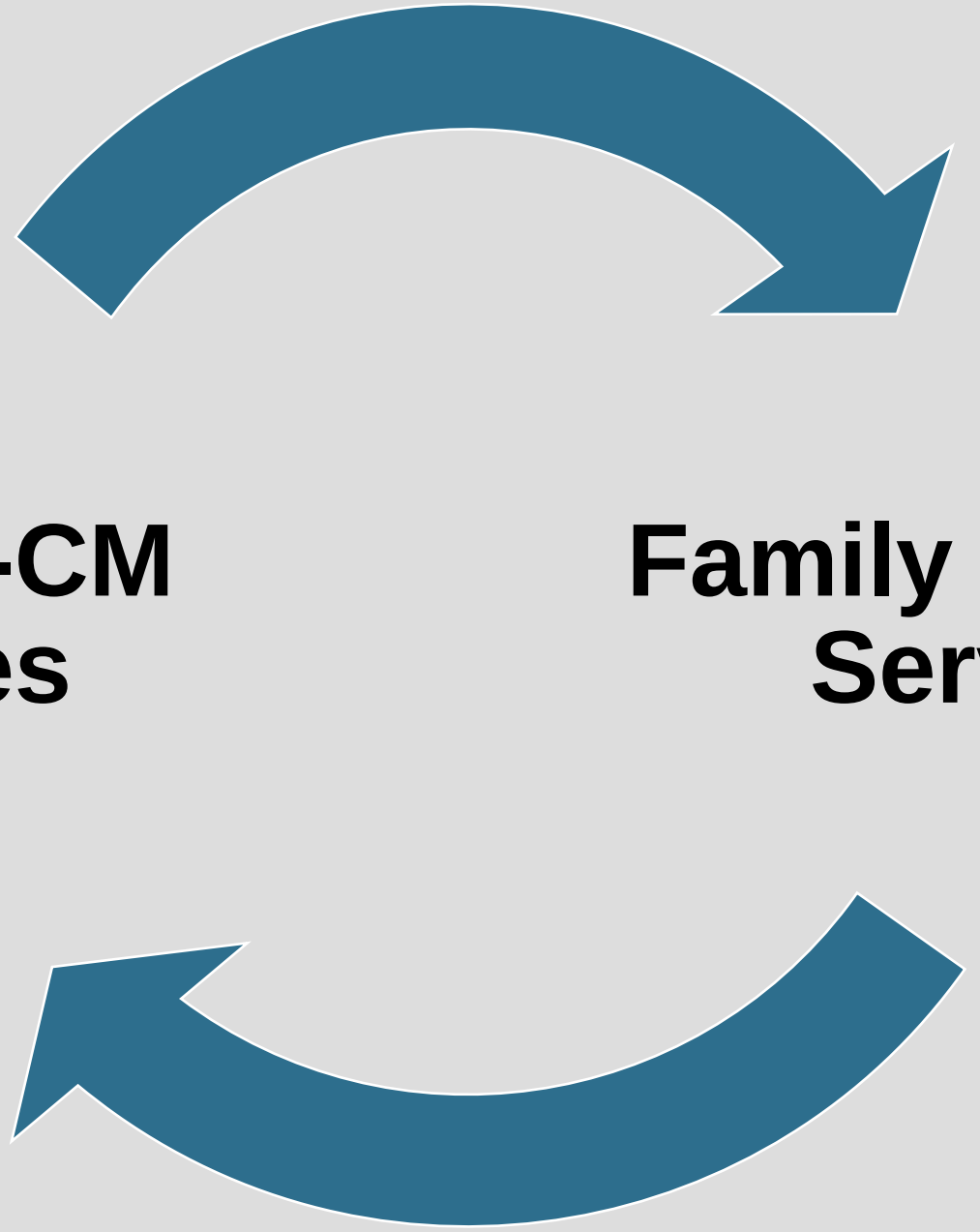
Availability of Covered Services

Contraceptive Methods Availability

All Family PACT covered FDA-approved contraceptive methods, fertility awareness methods, sterilization procedures and limited fertility services shall be made available to clients as follows:

Availability	Contraceptive Methods
Onsite or by Prescription	Contraceptive Injection, Contraceptive Vaginal Ring, Contraceptive Implant, Spermicides, Intrauterine Contraceptives, Cervical Barrier Methods, Oral Contraceptives, Male and Internal Condoms, Oral Emergency Contraceptives, Lactation Amenorrhea Method (LAM), Contraceptive Transdermal Patch
Onsite or by Referral	Fertility Awareness Methods (FAM), Female/Male Sterilization

Note: If the practitioner lacks the skills to provide specialized contraceptive procedures or sterilization, or there is insufficient volume to ensure and maintain a high skill level, clients shall be referred to another qualified practitioner for these methods/procedures. The Family PACT provider shall have an established referral arrangement with other provider(s) when making referrals for these procedures.


ICD-10-CM Codes
Family Planning Services

ICD-10-CM Codes for Family Planning

ICD-10-CM Code	Description
Z30.011	Encounter for initial prescription of contraceptive pills
Z30.012	Encounter for prescription of emergency contraception
Z30.013	Encounter for initial prescription of injectable contraceptive
Z30.015	Encounter for initial prescription of vaginal ring hormonal contraceptive
Z30.016	Encounter for initial prescription of transdermal patch hormonal contraceptive device
Z30.017	Encounter for initial prescription of implantable subdermal contraceptive
Z30.018	Encounter for initial prescription of other contraceptives Encounter for initial prescription of barrier contraception Encounter for initial prescription of diaphragm

For more information, please refer to *Family PACT - Benefits: Family Planning* ben fam 1

ICD-10-CM Codes for Family Planning

ICD-10-CM Code	Description
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
Z30.09	Encounter for other general counseling and advice on contraception
Z30.2	Encounter for sterilization
Z30.41	Encounter for surveillance of contraceptive pills
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.432	Encounter for removal of intrauterine contraceptive device
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z30.44	Encounter for surveillance of vaginal ring hormonal contraceptive device
Z30.45	Encounter for surveillance of transdermal patch hormonal contraceptive device
Z30.46	Encounter for surveillance of implantable subdermal contraceptive Encounter for checking, reinsertion or removal of implantable subdermal contraceptive
Z30.49	Encounter for surveillance of other contraceptives Encounter for surveillance of barrier contraception Encounter for surveillance of diaphragm
Z31.61	Procreative counseling and advice using natural family planning
Z98.51	Tubal ligation status
Z98.52	Vasectomy status

Availability of Covered Services

Reproductive Health Screening Tests

Reproductive Health Screening Tests may be provided as clinically indicated . Services are **not** reimbursable for ICD-10-CM diagnosis codes Z30.012, Z30.09 and Z31.61. Reflex testing is available for positive results for most of the screening tests for male and female clients.

Reproductive Health Screening Tests

CPT Code	Description	Reflex Testing (based on a positive screening test result)	Restrictions
86592	VDRL, RPR	86780 – TP-confirmatory test; if positive, 86593 is required 86593 – Syphilis test, non-treponemal antibody; quantitative	Not applicable
86701	HIV-1 antibody	86689 – HIV confirmatory test (e.g., Western Blot) **or;** 86701 and 86702 differentiation assay and; 87535 HIV – NAAT (if differentiation assay results are negative or indeterminate)	86689 limited to HIV antibody
86702	HIV-2 antibody	86689 – HIV confirmatory test (e.g., Western Blot) **or;** 86701 and 86702 differentiation assay and; 87535 HIV – NAAT (if differentiation assay results are negative or indeterminate)	86689 limited to HIV antibody
86703	HIV-1 and HIV-2 antibodies, single result	86689 – HIV confirmatory test (e.g., Western Blot) **or;** 86701 and 86702 differentiation assay and; 87535 HIV – NAAT (if differentiation assay results are negative or indeterminate)	86689 limited to HIV antibody

Reproductive Health Screening Tests

CPT Code	Description	Reflex Testing (based on a positive screening test result)	Restrictions
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	86689 – HIV confirmatory test (e.g., Western Blot) **or;** 86701 and 86702 differentiation assay and; 87535 HIV – NAAT (if differentiation assay results are negative or indeterminate)	86689 limited to HIV antibody
87806	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	86689 – HIV confirmatory test (e.g., Western Blot) **or;** 86701 and 86702 differentiation assay and; 87535 HIV – NAAT (if differentiation assay results are negative or indeterminate)	86689 limited to HIV antibody
87491	NAAT – Chlamydia	None	Refer to the CT GC screening guidelines
87591	NAAT – Gonorrhea	None	Refer to the CT GC screening guidelines

STI Risk Factors and Related ICD-10-CM Codes

The Centers for Disease Control and Prevention (CDC) *Sexually Transmitted Infections Treatment Guidelines*, 2021 recommends annual Chlamydia Trachomatis (CT) and Neisseria Gonorrhea (GC) screening for all sexually active women **under** 25 years of age and targeted CT and GC screening only for women 25 years of age and **older <u>with</u>** risk factors.

STI Risk Factors and Related ICD-10-CM Codes

ICD-10-CM Code	Definition	Indications
Z11.8	Encounter for screening for other infectious and parasitic diseases	High prevalence at practice site (CT greater than 3%)
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission	High prevalence at practice site (GC greater than 1%)
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	Recent contact (exposure) to an STD, specifically chlamydia, gonorrhea, non-gonococcal urethritis, epididymitis, trichomoniasis, syphilis or HIV
Z22.4	Carrier of infections with a predominantly sexual mode of transmission	Diagnosed with trichomoniasis (women), syphilis, or HIV, either confirmed or presumptively treated, who may be co-infected with chlamydia or gonorrhea
Z72.51	High risk heterosexual behavior	Targeted STD screening: • Infection with chlamydia or gonorrhea in the past 2 years; • More than one sex partner in the previous 12 months; • A new sex partner in the previous 3 months; • Belief that a partner from the previous 12 months may have had other sex partners at the same time

STI Risk Factors and Related ICD-10-CM Codes

Table of STI Risk Factors and Related ICD-10-CM Codes (continued)

Code	Definition	Indications
Z72.52	High risk homosexual behavior	Targeted STD screening: • Infection with chlamydia or gonorrhea in the past 2 years; • More than one sex partner in the previous 12 months; • A new sex partner in the previous 3 months; • Belief that a partner from the previous 12 months may have had other sex partners at the same time
Z72.53	High risk bisexual behavior	Targeted STD screening: • Infection with chlamydia or gonorrhea in the past 2 years; • More than one sex partner in the previous 12 months; • A new sex partner in the previous 3 months; • Belief that a partner from the previous 12 months may have had other sex partners at the same time
Z86.19	Personal history of certain other infectious and parasitic diseases	Retesting in 3 months after treatment of CT or GC

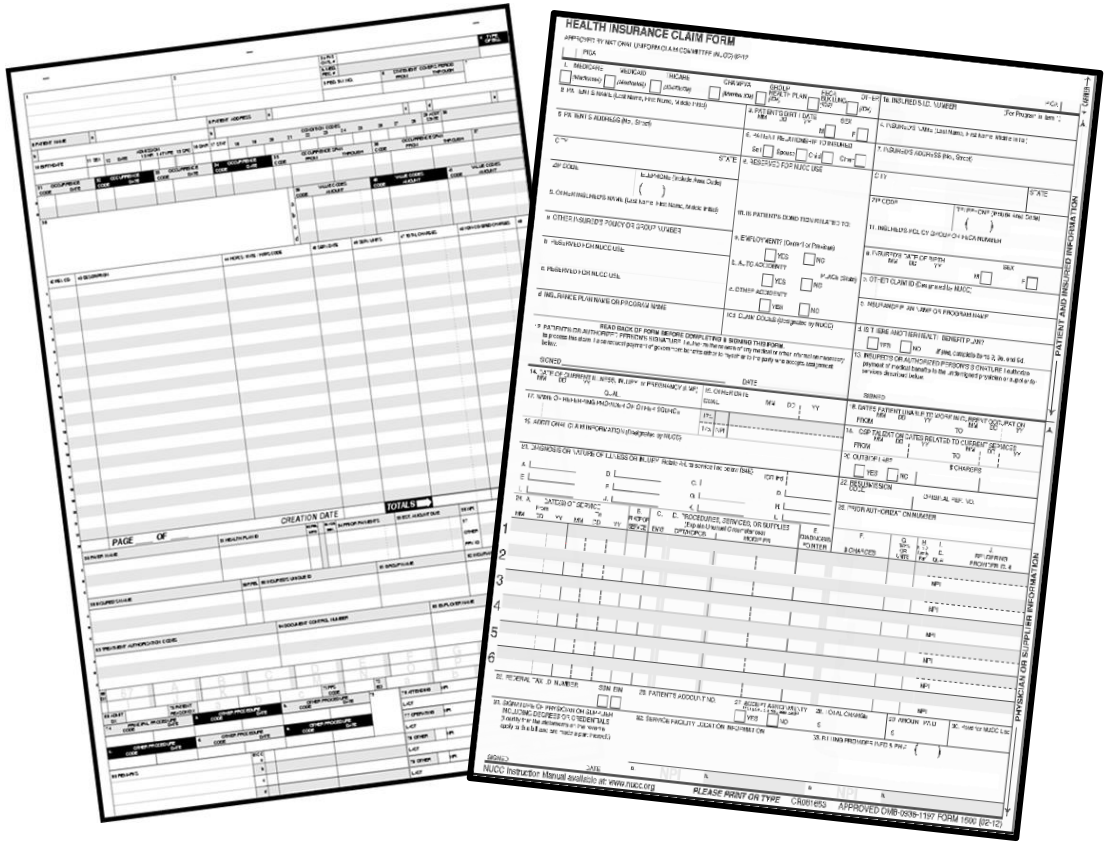
Family Planning-Related Services

Family Planning-Related Services

Family planning-related services include the diagnosis and treatment of specified STIs. In addition, the program covers urinary tract infections (UTIs), and screening for cervical cancer and treatment of pre-invasive cervical lesions for women when the care is provided coincident to a family planning visit for the management of a family planning method.

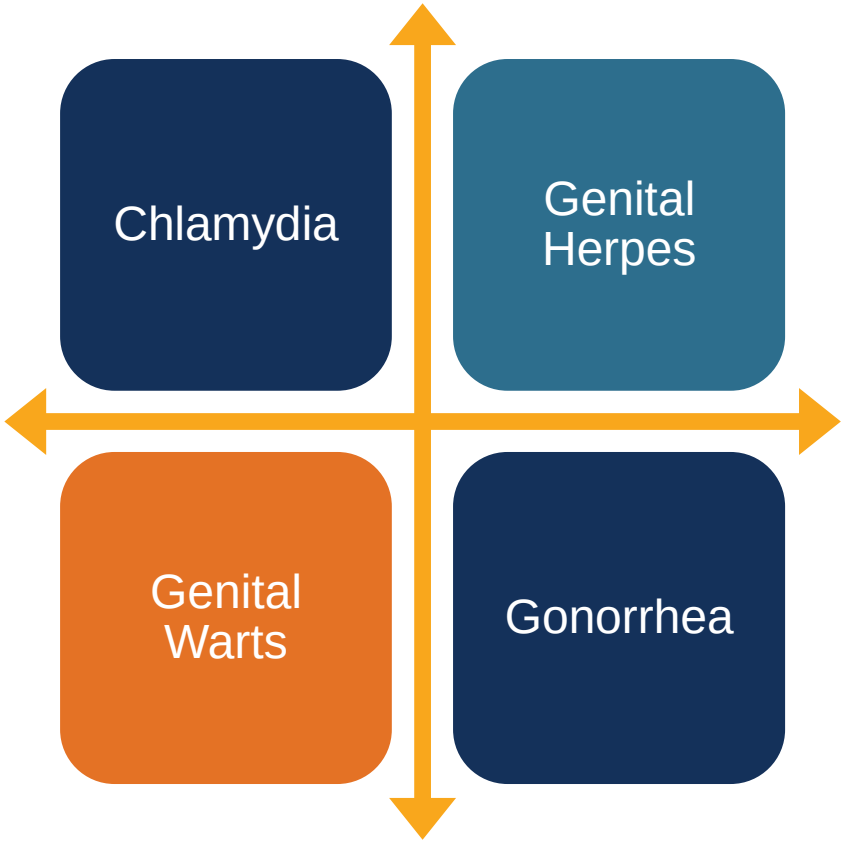
Claim Form Billing Requirements

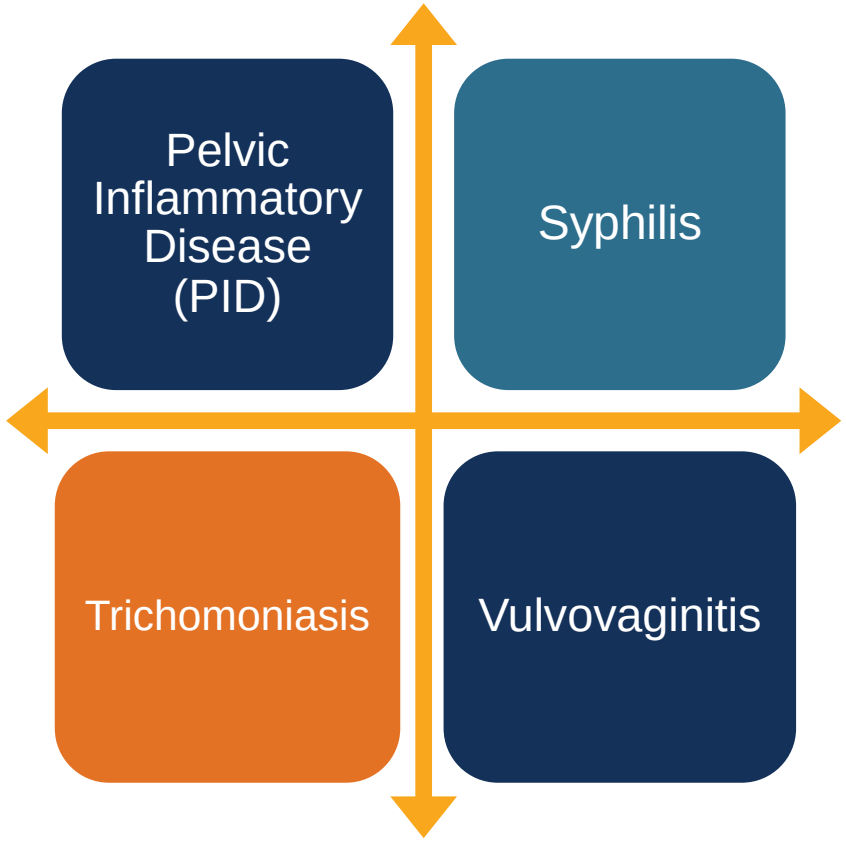
Services for the diagnosis and treatment of specified STI's, management of UTI's and pre-invasive cervical lesions, must be billed with the diagnosis code for these conditions, together with the ICD-10-CM diagnosis code that identifies the method for which the client is being seen on the ***CMS-1500*** or ***UB-04*** claim form.



Sexually Transmitted Infections (STIs)

The Treatment regimens reimbursable by Family PACT can be found in the **“Treatment and Dispensing Guidelines for Clinicians” in the *Benefits Grid*** section in the PPBI manual.





Sexually Transmitted Infections (STIs)

Chlamydia

Diagnosis Codes

ICD-10-CM	Description
A56.01	Chlamydial cystitis and urethritis (M and F)
A56.09	Other chlamydial infection of lower genitourinary tract (F)
A56.3	Chlamydial infection of anus and rectum (M and F)
A56.4	Chlamydial infection of pharynx (M and F)
N34.2	Other urethritis

Sexually Transmitted Infections (STIs)

Chlamydia

Presumptive Diagnosis Codes

ICD-10-CM	Description
N45.3	Epididymo-orchitis (M)
N72	Inflammatory disease of cervix uteri (F)
N89.8	Other specified noninflammatory disorders of vagina Indication: Leukorrhea NOS (F)
N94.10	Unspecified dyspareunia (F)
N94.11	Superficial (introital) dyspareunia (F)
N94.12	Deep dyspareunia (F)
N94.19	Other specified dyspareunia (F)
N94.89	Other specified conditions associated with female genital organs and menstrual cycle (F)
R30.0	Dysuria (M and F)
R30.9	Painful micturition, unspecified
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission (M and F) Indication: Use for an asymptomatic partner exposed to chlamydia

Sexually Transmitted Infections (STIs)

Epididymitis

Diagnosis Codes

ICD-10-CM Code	Description
N45.1	Epididymitis (M)
N45.3	Epididymo-orchitis (M)

Presumptive Diagnosis Codes

ICD-10-CM Code	Description
N50.811	Right testicular pain (M)
N50.812	Left testicular pain (M)
N50.819	Testicular pain unspecified (M)

Sexually Transmitted Infections (STIs)

Genital Herpes

Diagnosis Codes

ICD-10-CM Code	Description
A60.01	Herpesviral infection of penis
A60.04	Herpesviral vulvovaginitis

Presumptive Diagnosis Codes

ICD-10-CM	Description
N48.5	Ulcer of penis
N76.6	Ulceration of vulva

Sexually Transmitted Infections (STIs)

Pelvic Inflammatory Disease (PID)

Limited to outpatient services only; intravenous therapies are not covered.

ICD-10-CM Code	Description
N70.03	Acute salpingitis and oophoritis (F)
N70.93	Salpingitis and oophoritis, unspecified (F)
N94.10	Unspecified dyspareunia (F)
N94.11	Superficial (introital) dyspareunia (F)
N94.12	Deep dyspareunia (F)
N04.19	Other specified dyspareunia (F)
N94.89	Other specified conditions associated with female genital organs and menstrual cycle (F)

Sexually Transmitted Infections (STIs)

Syphilis

Diagnosis Codes

ICD-10-CM Code	Description
A51.0	Primary genital syphilis (M and F)
A51.31	Condyloma latum
A51.39	Other secondary syphilis of skin (M and F)
A51.5	Early syphilis, latent unspecified (M and F)
A52.8	Late syphilis, latent (M and F)
A53.0	Latent syphilis, unspecified as early or late (M and F)

Presumptive Diagnosis Codes

ICD-10-CM	Description
N48.5	Ulcer of penis
N76.6	Ulceration of vulva
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission (M and F) Indications: Use for an asymptomatic partner exposed to syphilis

Sexually Transmitted Infections (STIs)

Trichomoniasis

Diagnosis Codes

ICD-10-CM Code	Description
A59.01	Trichomonal vulvovaginitis (F)
A59.03	Trichomonal cystitis and urethritis (M and F)
N76.0	Acute vaginitis (F)

Presumptive Diagnosis Codes

ICD-10-CM	Description
N34.2	Other urethritis (M)
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission (M and F) Indications: Use for an asymptomatic partner exposed to trichomoniasis

Sexually Transmitted Infections (STIs)

Vulvovaginitis

Condition	ICD-10-CM Code	Description
Vaginal Candidiasis	B73.3	Candidiasis of vulva and vagina
Bacterial Vaginosis	N76.0	Acute vaginitis

Genital Warts

ICD-10-CM Code	Description
A63.0	Anogenital (venereal) warts (M and F)
B07.9	Viral warts, unspecified (M and F)
B08.1	Molluscom contagiosum (M and F)

Sexually Transmitted Infections (STIs)

Gonorrhea

Diagnosis Codes

ICD-10-CM Code	Description
A54.01	Gonococcal cystitis and urethritis, unspecified (M and F)
A54.03	Gonococcal cervicitis, unspecified (F)
A54.22	Gonococcal prostatitis (M)
A54.5	Gonococcal pharyngitis (M and F)
A54.6	Gonococcal infection of anus and rectum (M and F)

Sexually Transmitted Infections (STIs)

Gonorrhea

Presumptive Diagnosis Codes

ICD-10-CM Code	Description
N45.3	Epididymo-orchitis (M)
N34.2	Other urethritis (M)
N72	Inflammatory disease of cervix uteri (F)
N89.8	Other specified noninflammatory disorders of vagina Indication: Leukorrhea NOS (F)
N94.10	Unspecified dyspareunia (F)
N94.11	Superficial (introital) dyspareunia (F)
N94.12	Deep dyspareunia (F)
N94.19	Other specified dyspareunia (F)
N94.89	Other specified conditions associated with female genital organs and menstrual cycle (F)
R30.0	Dysuria (M and F)
R30.9	Painful micturition, unspecified
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission (M and F) Indication: Use for an asymptomatic partner exposed to chlamydia

Sexually Transmitted Infections (STIs)

Nongonococcal Urethritis (NGU)

ICD-10-CM Code	Description
N34.1	Nonspecific urethritis

Recurrent or Persistent Nongonococcal Urethritis or Cervicitis

For recurrent or persistent nongonococcal urethritis or cervicitis: either test for Mycoplasma genitalium or presumptively treat with oral doxycycline followed by oral moxifloxacin. Moxifloxacin is for pharmacy dispensing only and requires a TAR.

Recurrent or Persistent Nongonococcal Urethritis or Cervicitis

Mycoplasma Genitalium

CPT code **87563** (infectious agent detection by nucleic acid [DNA or RNA]; Mycoplasma genitalium, amplified probe technique) must be billed with one of the following ICD-10-CM diagnosis codes: **N34.1, N34.2, N34.3, N70.03, N70.93, and N72.**

CPT code **87563** is not split-billable and cannot be billed with modifier 26, TC or 99. This test is intended for use as a diagnostic test for recurrent urethritis, cervicitis, and in some cases of pelvic inflammatory disease (PID). This benefit is not covered when used and billed as a screening test in asymptomatic individuals.

Expedited Partner Therapy

Expedited Partner Therapy (EPT) for the prevention of STI reinfections is the clinical practice of treating sex partners of patients diagnosed with a treatable STI without the health care provider first examining the partner.

Since repeat infections are often due to untreated partners, ensuring that all recent partners have been treated is a core aspect of clinical management of partners diagnosed with:

- Chlamydia
- Gonorrhea and/or
- Trichomoniasis

Expedited Partner Therapy

If the Family PACT provider has diagnosed a Family PACT client with gonorrhea, chlamydia and/or trichomoniasis and determines that offering the client EPT is necessary to prevent reinfection of the client, the provider may either:

- Dispense medication directly to the client to provide to his/her partner **or;**
- Provide the client with a prescription written in the name of the client, for medications with a quantity and duration of therapy sufficient to treat the acute infection in the client and prevent reinfection in the client by treating the client's partner(s).

Urinary Tract Infection (UTI)

Services are restricted to **female clients only** who present with symptoms of infection.

ICD-10-CM Code	Description
N30.00	Acute cystitis without hematuria
N30.01	Acute cystitis with hematuria
R10.30	Lower abdominal pain, unspecified
R30.0	Dysuria
R30.9	Painful micturition, unspecified
R31.0	Gross hematuria
R35.0	Frequency of micturition

The treatment regimens reimbursed by Family PACT for STIs and UTIs can be found under the “Treatment and Dispensing Guidelines for Clinicians” heading in the ***Benefits Grid*** (ben grid) section in the PPBI manual.

Cervical Cancer Screening

Cervical Cancer Screening

Cervical cancer screenings are covered when provided as part of, or as a follow-up to, a family planning visit. Cervical cancer screening is not a stand-alone service. These tests are billed with the appropriate family planning ICD-10-CM code and do not require an additional diagnosis code.

Follow-up visits and services related to abnormal results from screening can be found under the: “Management of Cervical Abnormalities and Pre-invasive Cervical Lesions” heading in the ***Benefits: Family Planning-Related Services*** section (ben fam rel) of the PPBI manual.

Cervical Cancer Screening

The CPT codes for cervical cancer screening listed are restricted to women **21 to 65** years of age, regardless of sexual history. Services may be provided to women younger than 21 years or over the age of 65 who have, or do not have, a cervix.

However, the ordering provider must document on the laboratory order, and the ordering provider must document in the ***Remarks*** field (Box 80) ***Additional Claim Information*** **field** (Box 19) of the claim (or attached to the claim) that the woman meets one or more conditions, as listed in the *Benefits: Family Planning-Related Services* section of the PPBI manual.

Cervical Cancer Screening CPT Codes

CPT Codes	Description
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review under physician supervision

Screening Intervals

The U.S. Preventative Services Task Force (USPSTF) recommends screening for cervical cancer every three years with cervical cytology alone in women **21 to 29** years of age.

For women **30 to 65** years of age, USPSTF recommends screening every three years with cervical cytology alone, every five years with high-risk human papillomavirus (hrHPV) testing alone or every five years with hrHPV testing in combination with cytology (co-testing).

Primary Cervical Cancer Screening with High-Risk HPV Testing

CPT code **87624** (infectious agent detection by nucleic acid [DNA or RNA]; Human Papillomavirus [HPV], high-risk types [e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68]) is reimbursable for female clients aged 21 years and older with modifier 33. Use of modifier 33 indicates the service was provided in accordance with a U.S. Preventive Services Task Force (USPSTF) A or B recommendation.

- The service must be billed with an ICD-10-CM diagnosis code that identifies the contraceptive method client is being seen

Primary Cervical Cancer Screening with High-Risk HPV Testing

CPT code **87625** (infectious agent detection by nucleic acid [DNA or RNA]; Human Papillomavirus [HPV], types16 and 18 only, includes type 45, if performed is reimbursable for female clients 30 to 65 years of age with modifier 33. Use of modifier indicates the service was provided in accordance with a U.S. Preventive Services Task Force (USPSTF) A or B recommendation.

- The service must be billed with an ICD-10-CM diagnosis code that identifies the contraceptive method client is being seen
- Additional ICD-10-CM diagnosis code **R87.810** is required

Management of Cervical Abnormalities and Pre-invasive Cervical Lesions

Services and supplies are reimbursable when performed on an outpatient basis for the diagnosis and treatment of cervical abnormalities found on cervical cancer screening physical exam, and management of preinvasive cervical lesions.

- An ICD-10-CM code for the cervical abnormalities being treated is required on the claim form
- This code must be billed with the ICD-10-CM code that identifies the contraceptive method for which the client is being seen
- Additional age and frequency restrictions apply to some procedures

For claim documentation requirements and additional information, refer to the *Benefits: Family Planning-Related Services* (ben fam rel) section in the PPBI manual.

Cervical Abnormalities Codes

ICD-10-CM Code	Description
D06.0	Carcinoma in situ of endocervix (CIN 3)
D06.1	Carcinoma in situ of exocervix (CIN 3)
D06.9	Carcinoma in situ of cervix, unspecified (CIN 3)
N87.0	Mild cervical dysplasia (CIN 1)
N87.1	Moderate cervical dysplasia (CIN 2)
R87.610	Atypical squamous cells of undetermined significance on cytologic smear of cervix [ASC-US]
R87.611	Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear [ASC-H]
R87.612	Low grade squamous intraepithelial lesion on cytologic smear of cervix [LGSIL]
R87.613	High grade squamous intraepithelial lesion on cytologic smear of cervix [HGSIL]
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.615	Unsatisfactory cytologic smear of cervix
R87.616	Satisfactory cervical smear but lacking transformation zone
R87.618	Other abnormal cytological findings on specimens from cervix uteri **Note:** This includes benign endometrial cells
R87.619	Unspecified abnormal cytological findings in specimen from cervix uteri **Note:** This includes atypical glandular cells (AGC), atypical endocervical cells, or atypical endometrial cells on cytology.
R87.810	Cervical high-risk HPV DNA test positive

Cervical Abnormalities Codes

Other Conditions

Cervical Abnormalities Other Conditions Codes Table

ICD-10-CM Code	Description
Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear
Z87.410	Personal history of cervical dysplasia

Presumptive Diagnosis

The following code is used for a presumptive diagnosis made prior to the result of a screening Pap test.

Cervical Abnormalities Presumptive Diagnosis Codes Table

ICD-10-CM Code	Description
N88.0	Leukoplakia of cervix uteri

Cervical Cancer Screening

Complication Services

Services for management of complications that arise from the use of a contraceptive method, or treatment of a family planning-related condition that can be reasonably managed on an outpatient basis, are reimbursable for each condition.

An ICD-10-CM diagnosis code for the complication must be billed with the diagnosis code that identifies the contraceptive method for which the client is being seen. A *Treatment Authorization Request* (TAR) is required for complication services, unless stated otherwise in the PPBI manual.

Services for management of complications from the treatment of family planning-related services are pre-selected and identified in the PPBI manual.

Management of Complications

ICD-10-CM	National Code Description	Code Must be Billed with:
I26.99	Other pulmonary embolism without acute cor pulmonale	Contraceptive method in which the complication arose. For additional information, refer to the *Benefits: Family Planning* (ben fam) section of the PPBI manual.
N92.0	Excessive and frequent menstruation with regular cycle	Contraceptive method in which the complication arose. For additional information, refer to the *Benefits: Family Planning* (ben fam) section of the PPBI manual.
T83.39XA	Initial encounter, other mechanical complication of IUC	Contraceptive method in which the complication arose. For additional information, refer to the *Benefits: Family Planning* (ben fam) section of the PPBI manual.

For additional information, refer to the ***Benefits: Family Planning*** **(ben fam)** section of the Polices, Procedures, Billing Instructions (PPBI) manual

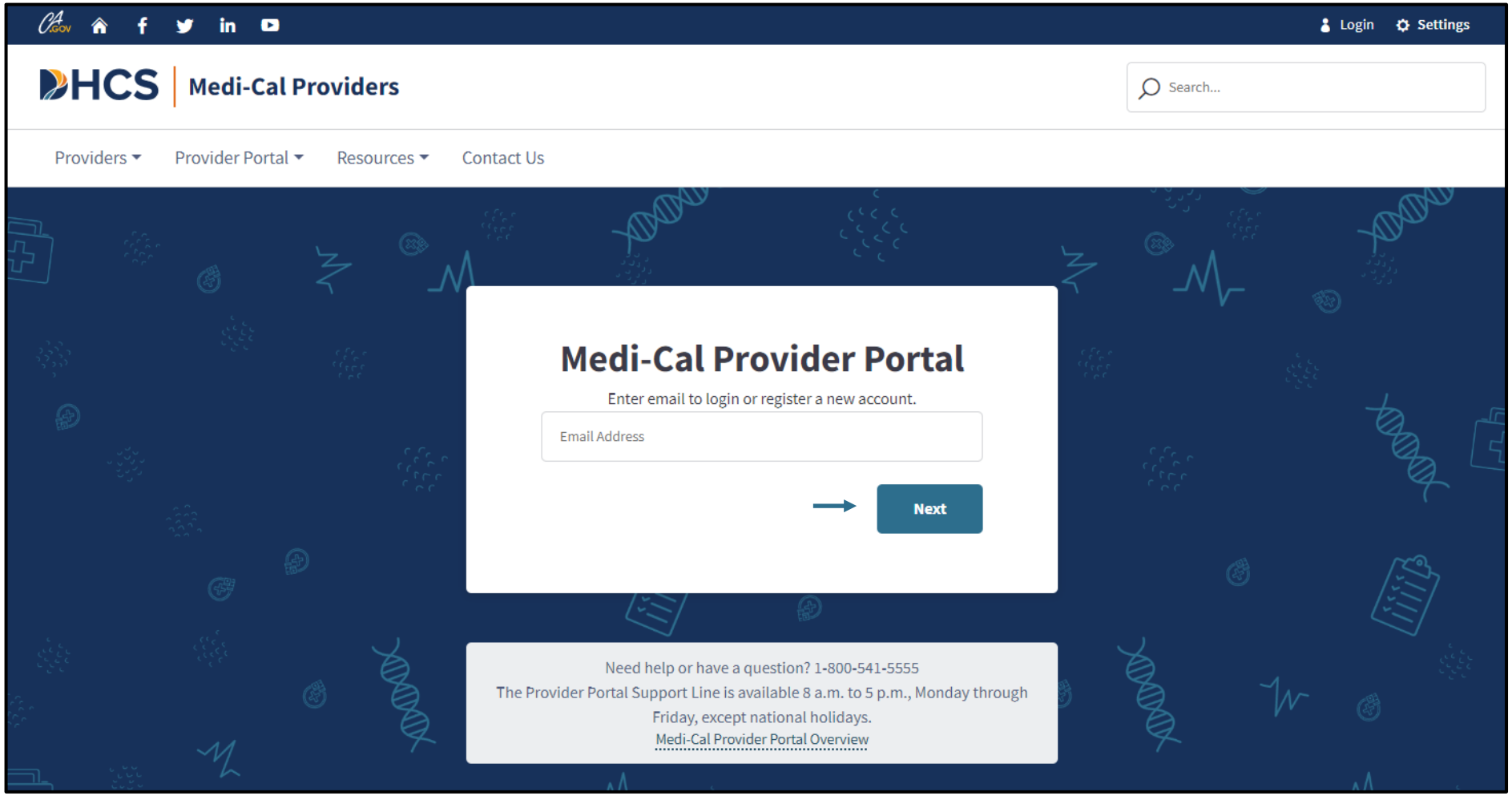
Treatment Authorization Request (TAR)

Treatment Authorization Request (TAR)

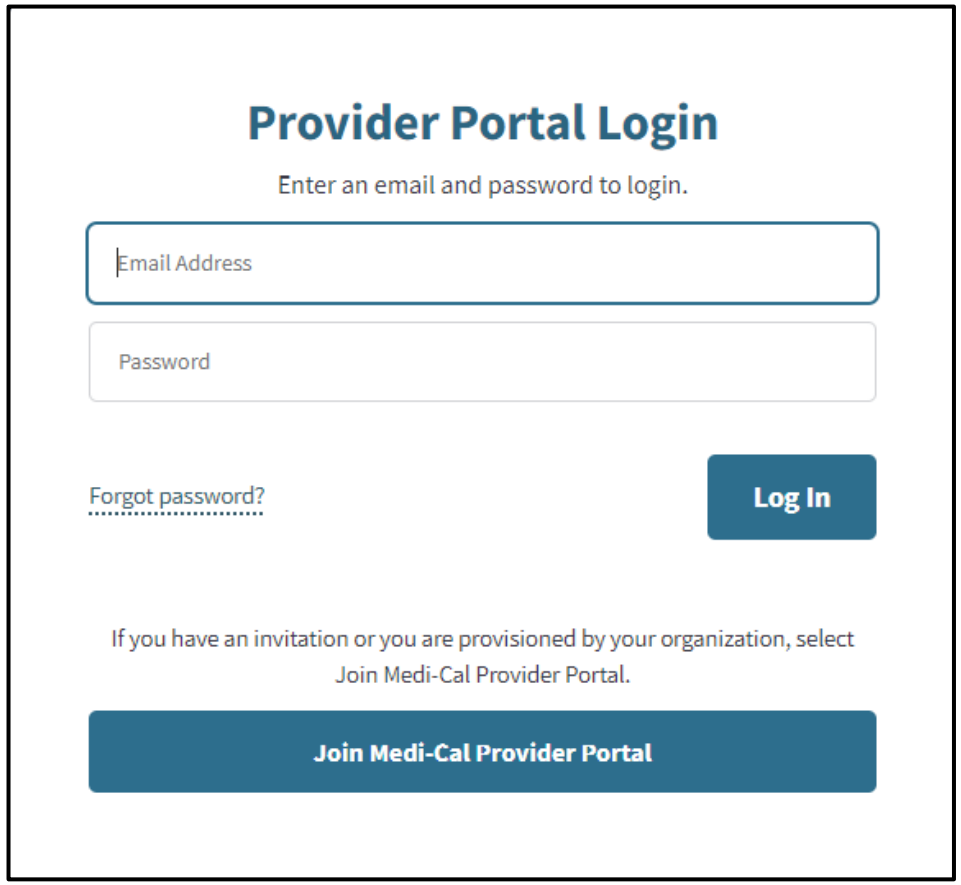
A TAR is required for services needed to evaluate and manage a complication, including office visits, procedures, facility use, laboratory, pharmacy and radiology services, unless stated otherwise in the PPBI manual.

Treatment authorization must be obtained by enrolled Family PACT providers and all Medi-Cal providers who render Family PACT services by referral, including clinicians, radiologist, laboratories, pharmacies, facilities and hospitals. Providers generally should request authorization **before** rendering a service.

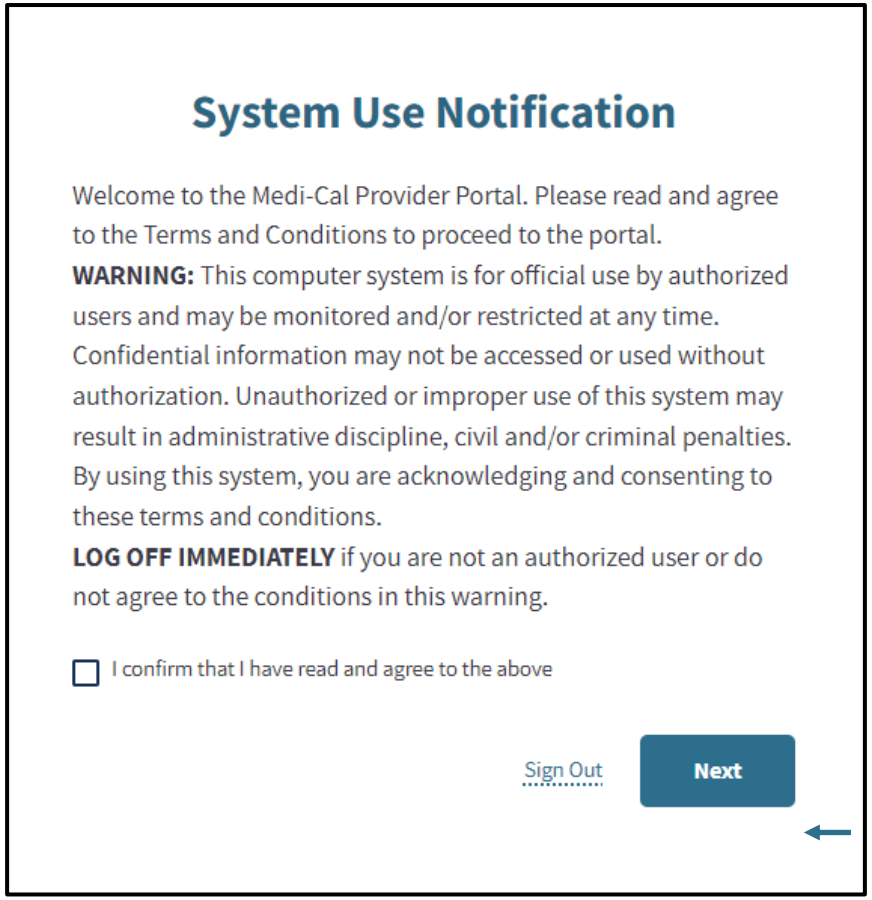
Medi-Cal Provider Portal



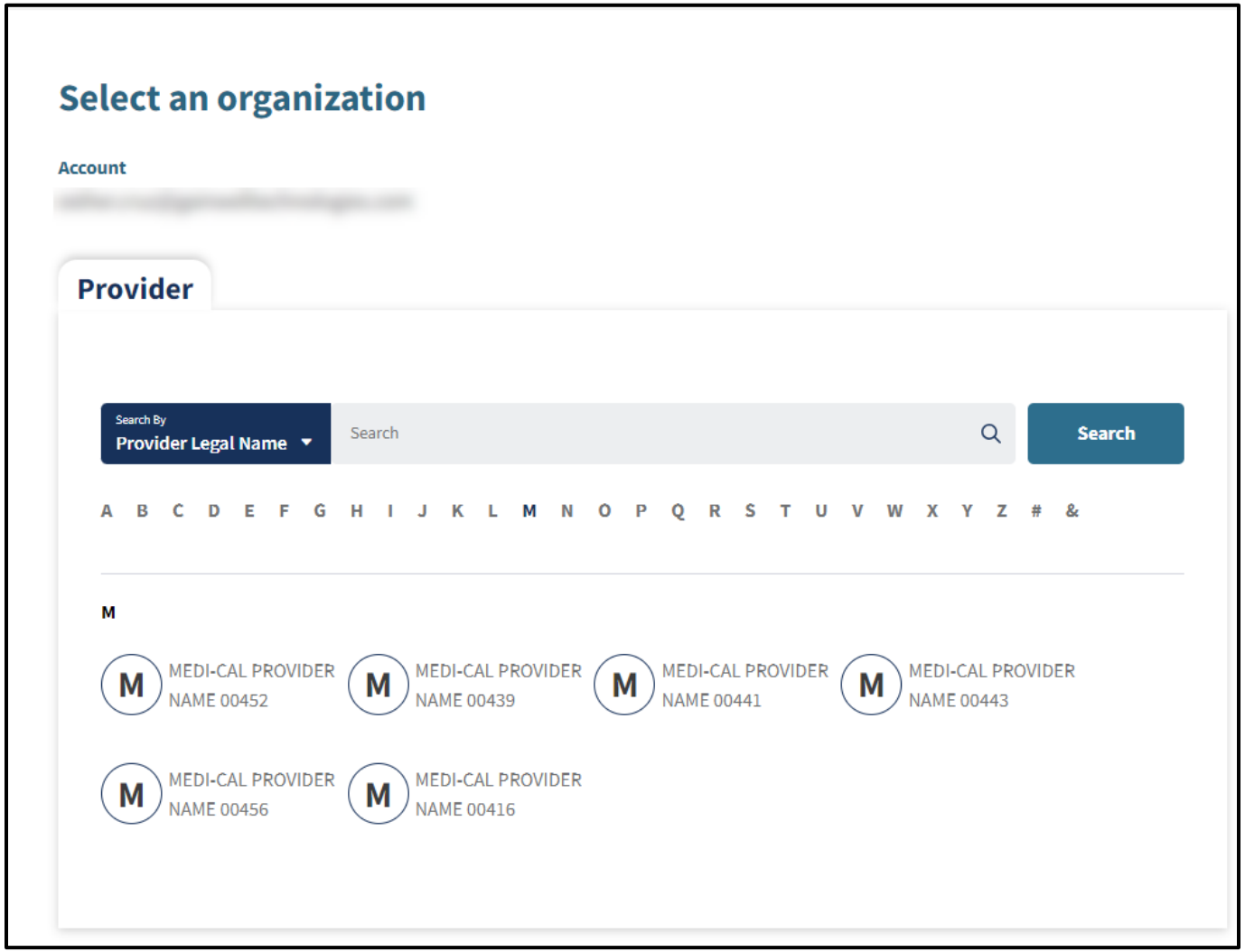
Provider Portal Login



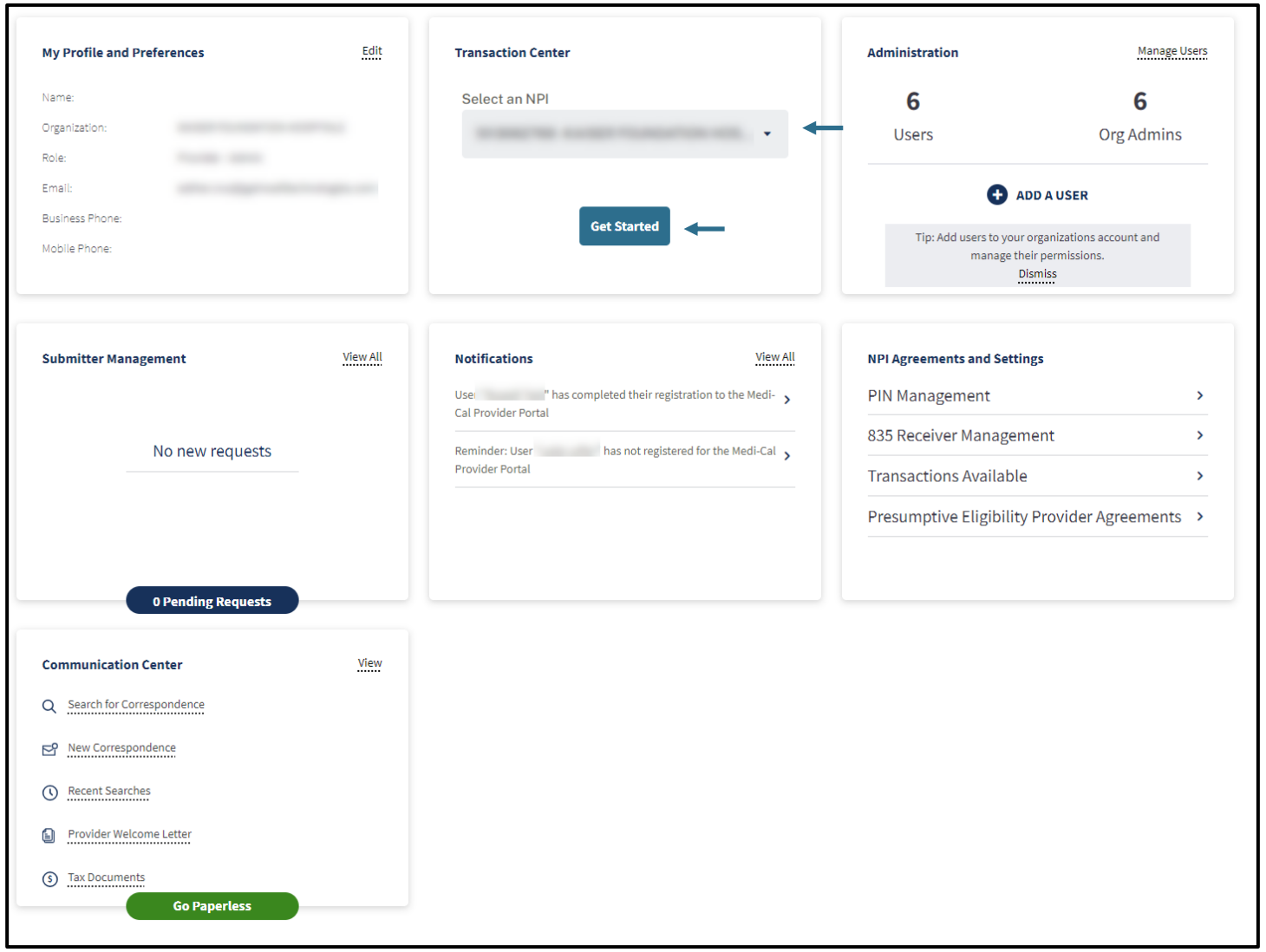
System Use Notification



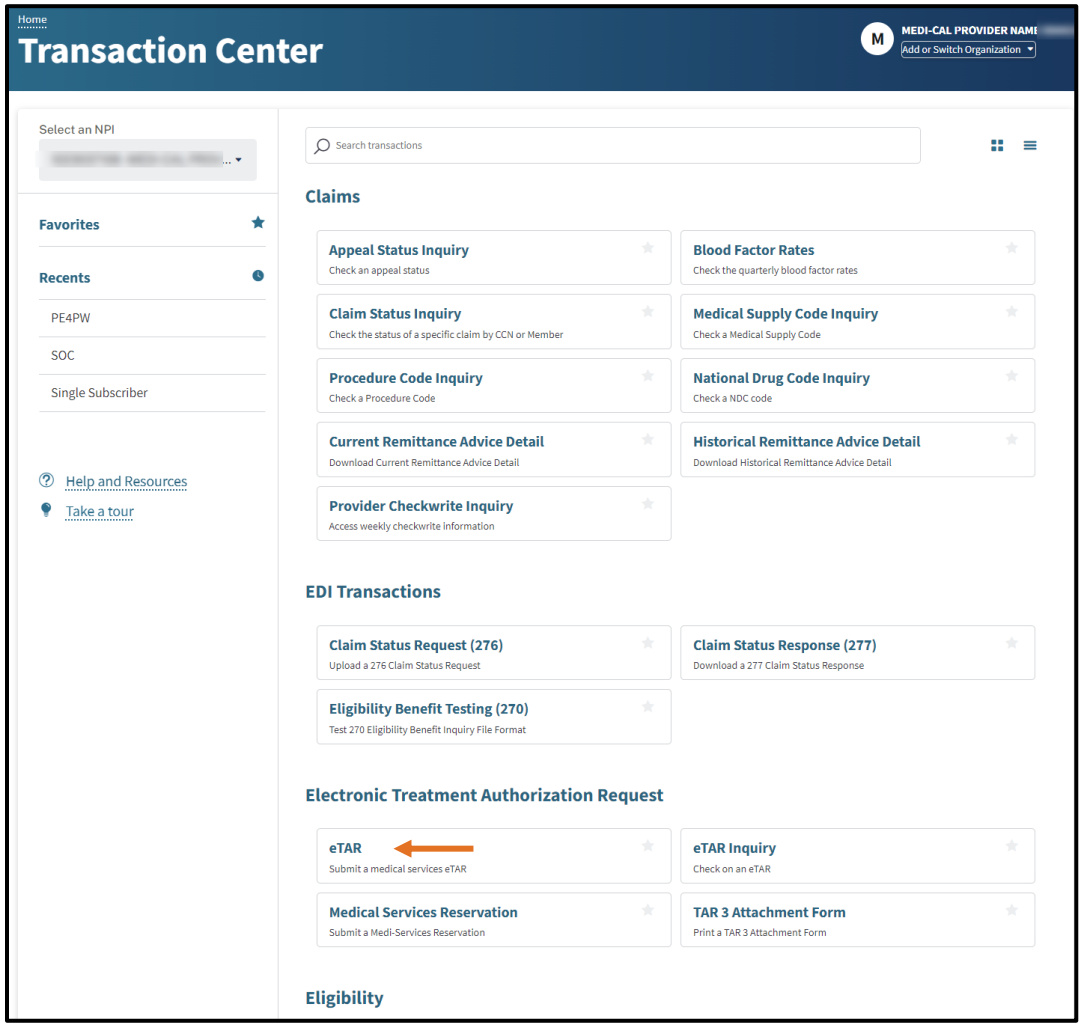
Select an Organization



Transaction Center



Electronic Treatment Authorization Request (eTAR)



TAR Requirements

A TAR is required for **Outpatient Complication Services** when:

- Complications suspected or diagnosed that exceed the scope of the family planning and/or family planning-related services
- A Family PACT provider refers a client to a non-Family PACT provider specialist/consultant for evaluation and management of complications
- Laboratory services needed for the evaluation and management of pre-selected complications

TAR Requirements

A TAR is required for **Outpatient Complication Services** when:

- Radiology services needed for the evaluation and management of pre-selected complications
- Drugs and supplies listed in the Family PACT Pharmacy Formulary on the Medi-Cal RX website and Clinic Formulary section are needed for treatment of pre-selected complications arising from a family planning or family planning-related visit

Additional TAR Reminders

- Procedure code(s) and modifier(s) on the claim must match the code(s) and modifier(s) authorized on the TAR. Failure to do so may result in denial of the claim
- An ICD-10-CM code is required on all Family PACT TARs. A second ICD 10-CM code may also be required
- For Dates of Service (DOS) on or after 5/1/23, a TAR can be submitted for drugs and services beyond published limits or restrictions.

For additional information about coding for services to manage complication services, refer to the ***Benefits: Family Planning*** **(ben fam) and** ***Benefits: Family Planning-Related Services*** **(ben fam rel)** sections in the PPBI.

TAR Requirements

A TAR is required for **Inpatient Complication Services** for the following:

- Emergency and inpatient care for hospital days and medical services
- Services for complications of contraceptive methods and/or complications of secondary-related reproductive health conditions, as defined by the Family PACT Program

For more information about referring clients to Medi-Cal providers for services, refer to the ***Provider Responsibilities* (prov res)** section in the PPBI manual.

TAR Requirements

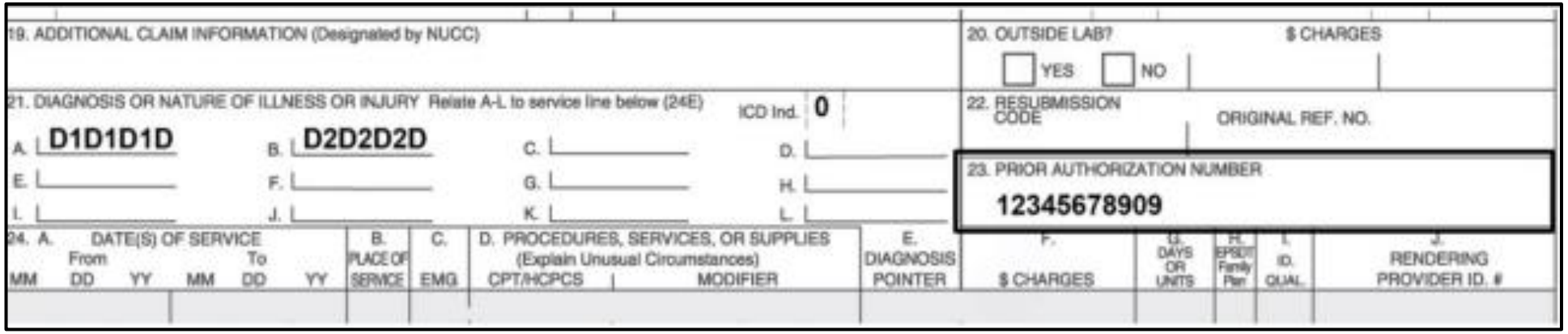
For more information on TAR requirements for Family PACT services, refer to the following sections in the PPBI manual.

- *Treatment Authorization Request* (tar)
- *Benefits: Family Planning* (ben fam)
- *Benefits: Family Planning-Related Services* (ben fam rel)

Note: The specialist/consultant must be a Medi-Cal provider. Claims and TARs by a non-Family PACT provider must include the referring provider's National Provider Identifier (NPI) to confirm the referring provider is enrolled in Family PACT.

CMS-1500
UB-04 TAR
Documentation

CMS-1500 Claim Form TAR Documentation


19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D.

E. F. G. H.

I. J. K. L.

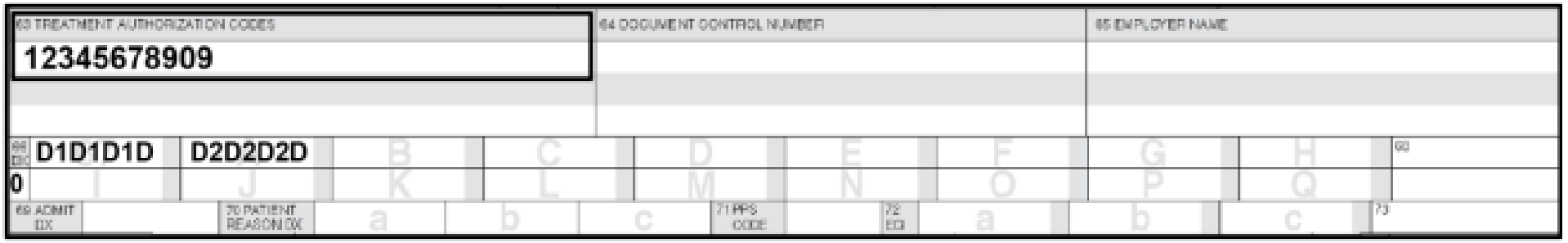
22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
12345678909

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #

Partial Sample: *CMS-1500* Claim Form 11-digit TAR number
(Box 23) **PRIOR AUTHORIZATION NUMBER** field

UB-04 Claim Form TAR Documentation



Partial Sample: *UB-04* Claim Form 11-digit TAR number **(**Box 63) **TREATMENT AUTHORIZATION CODES** field

Transgender and Gender Diverse Services

In all sections of the Medi-Cal and specialty programs provider manuals, regardless of the gender stated, the transgender diverse benefits and policy in Part 2 – *Transgender and Gender Diverse Services* section apply to recipients of all gender identities as long as the procedure/benefit is medically necessary and meets all other requirements.

Gender Override

When the gender on the claim conflicts with the billed procedure code due to a variation of sexual development or gender dysphoria, the gender difference is overridden by either:

- Attaching an approved Treatment Authorization Request (TAR) or Service Authorization Request (SAR)
- Adding modifier KX (requirements specified in the medical policy have been met) to the billed procedure code

Gender Override

The patient's medical record must support the medical necessity for the procedure, due to a medical condition that led to the gender difference

The claim does not require documentation. Use of modifier KX does not override other policy requirements for an approved TAR or SAR. For additional information, refer to the *Transgender Services* section in the appropriate Part 2 Medi-Cal manual.

Family PACT Excluded Services

Family PACT has a limited scope of benefits and is not a primary care program. If a non-covered service is recommended for a Family PACT client, the client must be informed of the medical necessity of the service and that it is not reimbursed by the program.

If a non-covered service is recommended for the client, the client must be informed of the medical necessity of the service and it may be an out-of-pocket expense.

Family PACT Excluded Services

- Prenatal, perinatal care, or any services for pregnant clients other than the diagnosis of pregnancy and required counseling about options
- Infertility diagnosis and treatment, except fertility awareness
- HIV or hepatitis treatment
- Hepatitis B immunization and Hepatitis B laboratory testing
- Screening mammograms
- Services beyond the scope of Family PACT

Evaluation and Management (E&M)

Office Visits

Evaluation and Management (E&M) office visits are rendered in an enrolled Family PACT provider's office, clinic or other ambulatory facility, and in offices of non-Family PACT Medi-Cal providers who deliver services upon referral from a Family PACT provider.

E&M services must be performed by a clinician. Consistent with American Medical Association (AMA), CPT 2021, selection of the appropriate E&M CPT code level is determined either by Medical Decision Making (MDA) or Time.

Office Visits

Medical Decision Making (MDM)

This includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements:

- The number and complexity of problem(s) that are addressed during the encounter
- The amount and/or complexity of data to be reviewed and analyzed
- The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s), or time

Office Visits

Time

- Time for services is the total time on the date of encounter. It includes both face-to-face and non-face-to-face time personally spent by physician and/or other qualified health care professional
- The total time must be documented in the medical record.

For more information, refer to ***Office Visits: Evaluation and Management and Education Counseling Services*** section in the PPBI manual.

Billing Office Visits

Medical record and chart documentation must reflect the clinical rationale for providing, ordering or deferring services for clients, including, but not limited to, client assessment, diagnosis, treatment and follow-up.

New Patients

CPT Code	New Patients
99202	Females/Males
99203	Females/Males
99204	Females/Males for complications only

Billing Established Patient Office Visits

Medical record and chart documentation must reflect the clinical rationale for providing, ordering or deferring services for clients, including, but not limited to, client assessment, diagnosis, treatment and follow-up.

Established Patients

CPT Code	Established Patients
99211	Females/Males
99212	Females/Males
99213	Females/Males
99214	Females/Males for complications only

Updated Policy E&M and E&C Office Visits Same Date of Service

On January 1, 2021, Family PACT updated its policy to allow E&M and E&C office visits to be billed on the same DOS in limited circumstances. Post-Implementation, Department of Health Care Services (DHCS) was made aware that the policy conflicted with the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits.

Effective for dates of service on or after March 28, 2022, DHCS will allow a PTP edit to bypass the NCCI audit if an appropriate modifier is appended to the E&M code and will not require medical record documentation for Family PACT claims.

Updated Policy E&M and E&C Office Visits Same Date of Service

The Family PACT Program is updating its policy to reflect the following:

- Family PACT providers are required to add modifier 25 (significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E&M code when billed with an E&C visit on the same DOS
- Medical record documentation is not required to be submitted with the claim

E&M and CPT Codes Same Date of Service

CPT codes for surgical procedures include performance of history and physical examination, performance of the procedure and postoperative care, including preoperative and postoperative counseling applicable to the procedure.

The following CPT procedure codes will accommodate an E&M code with modifier 25 when a significant, separately identifiable E&M service is provided by the same clinician on the same date of the procedure.

Note: Billing E&M codes with modifiers 24, 25 and 57 overrides the requirement of documenting the medical justification when billed in conjunction with the following surgical procedures.

Allowable CPT Codes with E&M Same Date of Service

CPT Code	Description
11976	Removal, implantable contraceptive capsules
11981	Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)
54050	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54056	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
54100	Biopsy of penis; (separate procedure)
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	Biopsy of vulva or perineum (separate procedure); one lesion
57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
57452	Colposcopy of the cervix including upper/adjacent vagina;
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
57455	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57456	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57511	Cautery of cervix; cryocautery, initial or repeat
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure.)
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)

Note: These CPT codes will require an appropriate modifier. Please refer to the *Modifiers: Approved List* (modif app) section in the appropriate Part 2 Medi-Cal provider manual.

Registered Nurses Billing CPT with E&M Codes

Registered nurses (RNs) can administer or dispense hormonal contraceptives (OCs, contraceptive patch, vaginal ring, injectable contraceptive and emergency contraceptive pills) pursuant to the California Business and Professions code, Chapter 6, Section 2725.2.

If services are performed by an RN, who has completed the required training, E&M CPT codes 99202, 99211 or 99212 (office or other outpatient visit for the E&M of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making) **must** be billed with modifier TD.

Education and Counseling

Office Visits

HCPCS and CPT codes are used to bill for health Education and Counseling (E&C) office visits.

Health education and counseling may be provided by either clinicians or non-clinician counselors. To be reimbursed by the program, E&C services must be conducted at the site of the clinical service delivery.

Medical record documentation must reflect the scope of education and counseling services provided to clients per Family PACT standards, including, but not limited to, individual client assessment, topics discussed and name and title of counselor.

Documentation must support services billed for reimbursement. The **total time** must be documented in the client's medical record.

Billing E&C Office Visits

Clients may be oriented to the Family PACT program by a clinician or by a non-clinician counselor either in a **group session** of two or more clients or in an i**ndividual session**. Providers may select only one of the codes:

HCPCS Code	HCPCS Description
S9445	Individual orientation to Family PACT, only once by the same provider for the same client.
S9446	Family planning group education (including orientation to Family PACT), only once by the same provider for the same client.

E&C HCPCS code S9445 or S9446 may be billed alone, or with E&M CPT code (99202 thru 99204, 99211 thru 99214), or with a higher-level E&C service code (99401U6, 99402U6, or 99403U6), one time per client by the same provider on the same date of service.

Billing E&C Office Visits

The following E&C visits use CPT E&M counseling codes (up to two per provider, per 30 days, per client). The provider shall take into consideration the cumulative time spent counseling the client by all staff when selecting a preventive medicine service counseling code for billing.

CPT Codes	Description
99401U6	Preventative medicine counseling and/or risk factor reduction intervention, individual, approximately 15 minutes
99402U6	Preventative medicine counseling and/or risk factor reduction intervention, individual, approximately 30 minutes
99403U6	Preventative medicine counseling and/or risk factor reduction intervention, individual, approximately 45 minutes

E&C visits billed with CPT code(s) **99401,99402, or 99403** must be billed with a **U6 modifier** to indicate individual family planning counseling provided during the office visit.

Summary of Difference Between E&M and E&C Services

Office Visit	Provided By	Level Computed By
E&M	Clinician	Based on MDM or clinician time
E&C	Non-Clinician	Counselor time

Non-Clinician Counselors

Providers must ensure that: non-clinician counselors have been trained in all family planning methods; are knowledgeable about the Family PACT Standards and program benefits; and have the essential core competence to deliver education and counseling services, including individual client history and assessment of health education and counseling needs.

Providers must maintain documentation of education and counseling training and performance. Non-clinician counselors shall work under the direction of the enrolled Family PACT provider.

Non-Clinician Counselors

Services provided by non-clinician counselors must be accompanied by onsite direct supervision. Acceptable supervisors of non-clinician counselors include:

- Physicians;
- Non physician medical practitioners (NMPs);
- Register nurses (RNs);
- Public health nurses;
- Counseling professionals, including the categories of Marriage, Family and Child Counselor (MFCC) or Marriage and Family Therapist (MFT); Licensed Clinical Social Worker (LCSW); clinical psychologist; or masters-degree prepared health educator

Summary of E&C Visit Codes

The following codes may be used to bill for family planning education and counseling for males and females. The services must be delivered in a manner consistent with the *Family PACT* Standards.

For more information, refer to Family PACT- Office Visits: ***Evaluation and Management and Education Counseling Services*** office 7-10 section in the PPBI manual.

Family PACT Education and Counseling Services	HCPCS and CPT Codes	Restrictions
Individual orientation to Family PACT: • Scope of Family PACT services • Information about family planning methods and select related conditions • Provided by a clinician and/or counselor • Up to 10 minutes	S9445: May be billed with E&M codes 99202 thru 99204, 99211 thru 99214, or with E&C codes 99401U6, 99402 U6 or 99403U6.	This code may be reported only once per client, per provider. Each client may receive either individual orientation or group orientation (S9446), but not both.
Group family planning education (including orientation to Family PACT): • Scope of Family PACT services • Information about family planning methods and select related conditions • A group setting of two or more clients • Provided by a clinician and/or counselor	S9446: May be billed with E&M codes 99202 thru 99204, 99211 thru 99214, or with E&C codes 99401U6, 99402U6 or 99403U6.	This code may be reported only once per client, per provider. Each client may receive either group orientation or individual orientation (S9445), but not both.

E&C Codes

Family PACT Education and Counseling Services	HCPCS and CPT Codes	Restrictions
Individual family planning counseling: • Lasting up to 15 minutes • Provided by a non-clinician	99401U6: May be billed with E&M codes for services rendered by clinician, but not with 99402U6 or 99403U6.	Limited to two CPT E&C code office visits (99401U6 thru 99403U6) per client, per 30 days, per provider. Codes may be billed with Family PACT laboratory, surgical, medication and supply codes. These codes may be used to report counseling issues, including lifestyle and relationship issues, risk reduction interventions, method use and adherence, infertility, preconception counseling, pregnancy options and sexually transmitted infection (STI) prevention. Documentation Requirements: Medical record documentation must support services claimed for reimbursement.
Individual family planning counseling: • Lasting up to 16 thru 30 minutes • Provided by a non-clinician counselor	99402U6: May be billed with E&M codes for services rendered by clinician, but not with 99401U6 or 99403U6.	Limited to two CPT E&C code office visits (99401U6 thru 99403U6) per client, per 30 days, per provider. Codes may be billed with Family PACT laboratory, surgical, medication and supply codes. These codes may be used to report counseling issues, including lifestyle and relationship issues, risk reduction interventions, method use and adherence, infertility, preconception counseling, pregnancy options and sexually transmitted infection (STI) prevention. Documentation Requirements: Medical record documentation must support services claimed for reimbursement.

Family PACT Education and Counseling Services	HCPCS and CPT Codes	Restrictions
Individual family planning counseling: • Lasting up to 31 thru 45 minutes • Provided by a non-clinician counselor	**99403U6:** May be billed with E&M codes for services rendered by clinician, but not with 99401U6 or 99402U6. ‹‹Modifier 25 must be appended to the E&M code.››	Limited to two CPT E&C code office visits (99401U6 thru 99403U6) per client, per 30 days, per provider. Codes may be billed with Family PACT laboratory, surgical, medication and supply codes. These codes may be used to report counseling issues, including lifestyle and relationship issues, risk reduction interventions, method use and adherence, infertility, preconception counseling, pregnancy options and sexually transmitted infection (STI) prevention. Documentation Requirements: Medical record documentation must support services claimed for reimbursement.

Family PACT Sterilization

Consent Form (PM 330)

Sterilization Consent Form (PM 330)

Claims submitted by Family PACT providers for elective sterilizations must adhere to all Medi-Cal policies regarding the submission of the sterilization Consent Form (PM 330) indicated in the ***Sterilization*** section (ster) of the Part 2 Medi-Cal provider manual.

The following CPT and HCPCS codes listed on the table on (page 42) in the workbook, require a sterilization Consent Form (PM 330) when the procedure will render the recipient sterile and unable to conceive.

Codes Requiring Consent Forms

Table of CPT Codes Requiring Consent Forms	
CPT Code	**Description**
55250	Vasectomy, unilateral or bilateral, including postoperative semen examination(s)
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
Table of HCPCS Code Requiring Consent Forms	
HCPCS Code	**Description**
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system

Consent Policy

The informed consent process should include, but is not limited to, an assessment of the client's comprehension of the following:

- Alternative family planning methods that are available and temporary
- The permanence and irreversibility of the procedure
- The discomforts, risks and benefits associated with the procedure

Coverage Conditions

1. The individual is at least 21 years of age at the time of written consent. There are no exceptions for: marital status, number of children or for a therapeutic sterilization.

2. The individual is not mentally incompetent. A mentally incompetent individual is a person who has been declared by the federal, state or local court of competent jurisdiction for any purposes which include the ability to consent to sterilization.

3. The individual is able to understand the content and nature of the informed consent process.

4. The individual is not institutionalized.

Coverage Conditions

5. At least 30 days, but no more than 180 days have passed between the date of written and signed consent and date of sterilization, except in the following instances:

- Sterilization may be performed at time of emergency abdominal surgery if:
  - Patient consented to sterilization at least 30 days before the intended date of sterilization and
  - At least 72 hours have passed after written informed consent was given and performance of emergency surgery.

- Sterilization may be performed at time of premature delivery if:
  - Written consent was given at least 30 days before expected date of delivery and
  - At least 72 hours passed after written informed consent to be sterilized was given

Coverage Conditions

6. The age limit is an absolute requirement. There are no exceptions for marital status, number of children or for a therapeutic sterilization.

7. A completed consent form must accompany all claims for sterilization services.

PM 330 Completion Tips

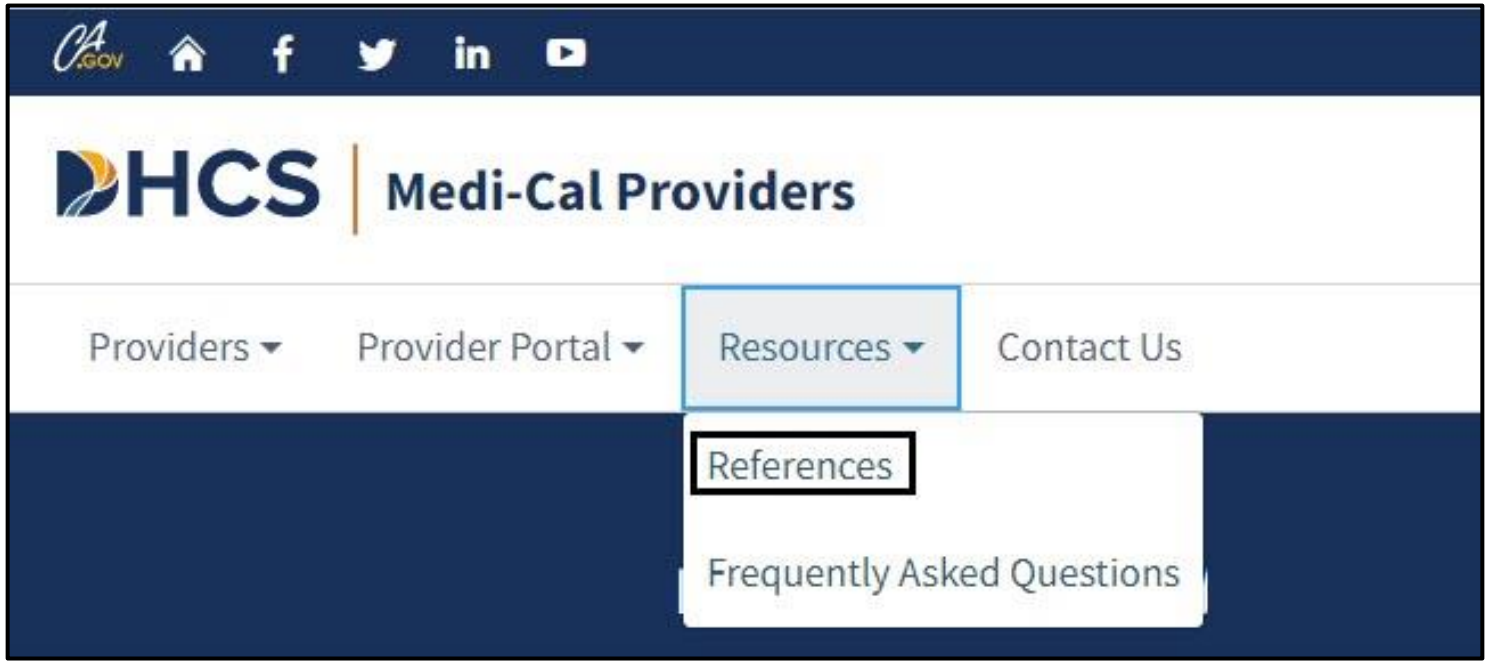
- Name of procedure must be exactly the same in all four places on the PM 330. (Fields 2,6,13 and 20)
- Abbreviations for procedures are accepted but must be consistent throughout the form and the full name of the procedure must be written out and asterisked (*) at the bottom of the consent form
- Cross out paragraph that does not apply. (Field 1 or 22)
- Client's name must appear exactly the same places in all four places on the PM 330. If a middle initial is used it must be consistent throughout the consent form. (Fields 4,7,12 and 18)
- To avoid "Physician's signature not legible" denials, type the name of the physician under the signature line and also include their professional title, such as "M.D." (Field 27)

PM 330 Completion Tips

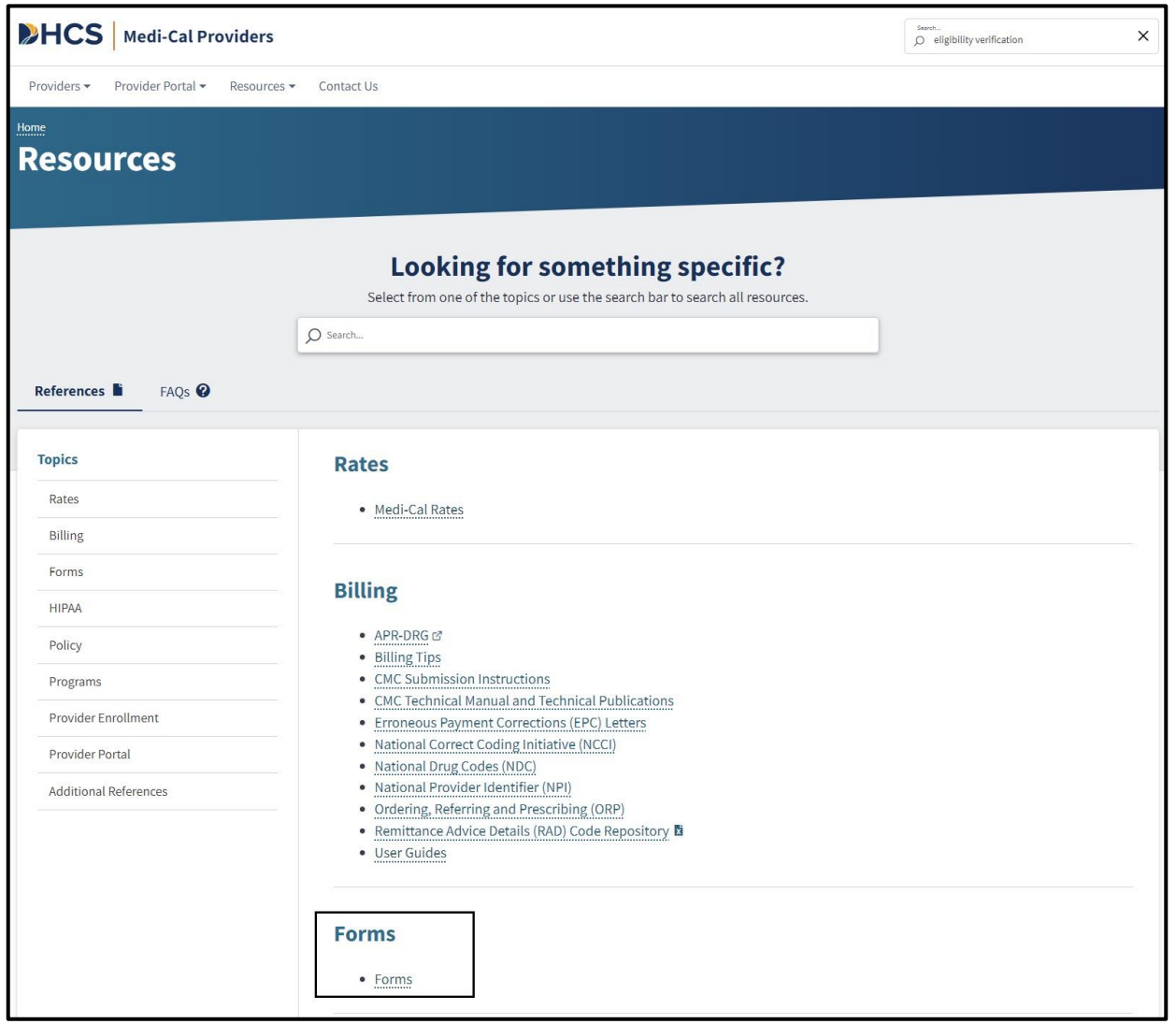
- Top right section of the consent form is the statement of person obtaining consent (Fields:12-17)
- Lower right quarter of consent form must be signed/dated on or after day of surgery, not before (Field 28)
- **Note:** If the physician whose name appears on the PM 330 is not available on the date of surgery, enter, for example, **“Dr. Joe Smith, M.D., and Associates”** when filling in the physician’s name. This allows a different doctor’s name to be accepted if the physician is not available. However, the client must be notified of the change in physician prior to the procedure.

Sterilization Consent
PM 330 Form

Accessing PM 330 Form

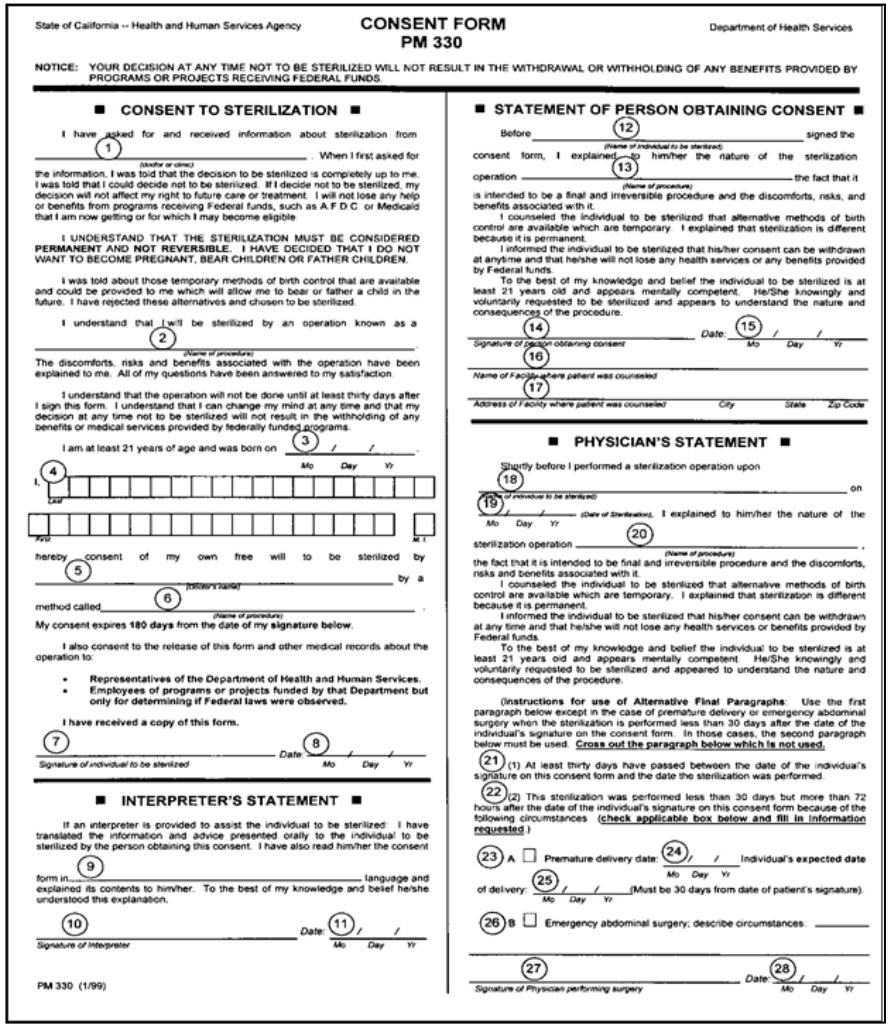


Accessing PM 330 Form



Accessing PM 330 Form

PM 330 Consent Form – English/Spanish



State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

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 (1) _____ (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 (2) _____ (Name of procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty 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 (3) ___/___/___ Mo Day Yr.

I, (4) _____ Last _____ First _____ M.I.

hereby consent of my own free will to be sterilized by (5) _____ (doctor's name) by a method called (6) _____ (Name of procedure).

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.**
- **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.

(7) _____ Date: (8) ___/___/___
Signature of individual to be sterilized — Mo Day Yr

■ 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 (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ Date: (11) ___/___/___
Signature of Interpreter — Mo Day Yr

PM 330 (1/99)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) _____ (Name of individual to be sterilized) signed the consent form, I explained to him/her the nature of the sterilization operation (13) _____ (Name of procedure) 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 anytime 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 consequences of the procedure.

(14) _____ Date: (15) ___/___/___
Signature of person obtaining consent — Mo Day Yr

(16) _____
Name of Facility where patient was counseled

(17) _____
Address of Facility where patient was counseled — City — State — Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) _____ (Name of individual to be sterilized) on (19) ___/___/___ (Date of Sterilization). I explained to him/her the nature of the sterilization operation (20) _____ (Name of procedure), the fact that it is intended to be 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 when 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 below which is not used.**

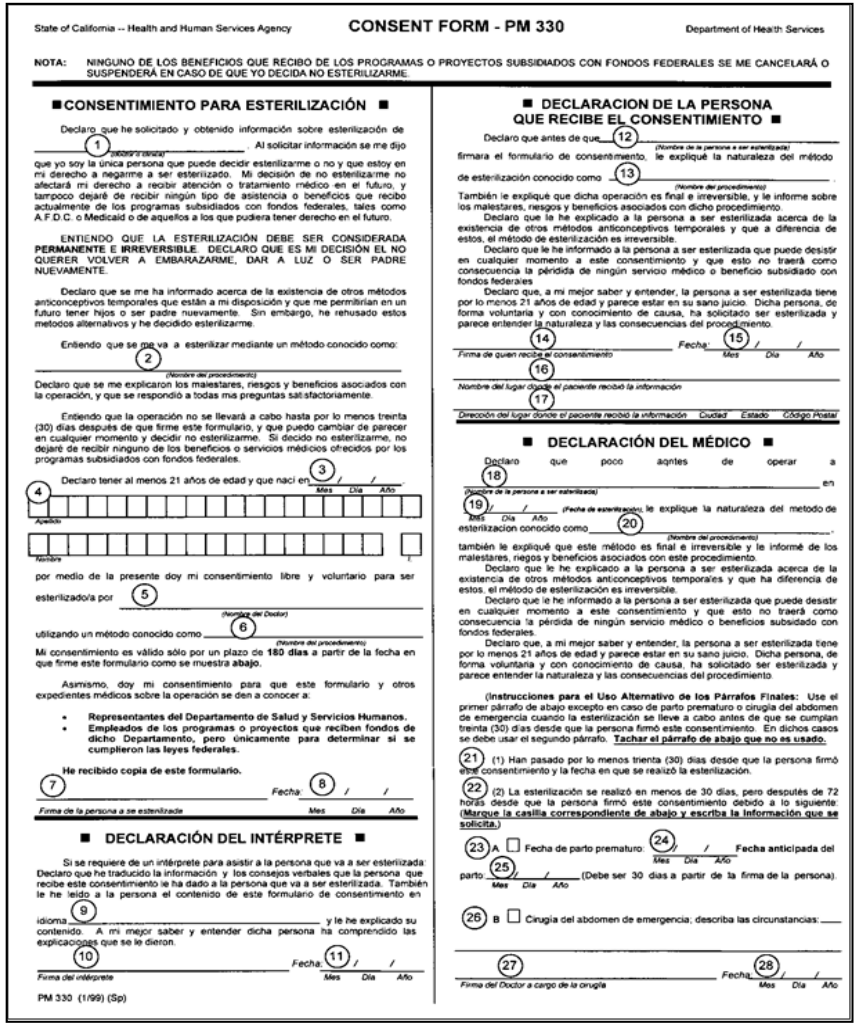
(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (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 below and fill in information requested**.)

(23) A ☐ Premature delivery date: (24) ___/___/___ Mo Day Yr Individual's **expected date** of delivery: (25) ___/___/___ Mo Day Yr (Must be 30 days from date of patient's signature).

(26) B ☐ Emergency abdominal surgery; describe circumstances: _____

(27) _____ Date: (28) ___/___/___
Signature of Physician performing surgery — Mo Day Yr



State of California -- Health and Human Services Agency

CONSENT FORM - PM 330

Department of Health Services

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de (1) _____ (doctor o clínica). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE E IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos métodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como: (2) _____ (Nombre del procedimiento).

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas ma preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicos ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en (3) ___/___/___ Mes Día Año.

(4) _____ Apellido _____ Nombre _____ I.

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por (5) _____ (Nombre del Doctor) utilizando un método conocido como (6) _____ (Nombre del procedimiento).

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

(7) _____ Fecha: (8) ___/___/___
Firma de la persona a se esterilizada — Mes Día Año

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma (9) _____ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

(10) _____ Fecha: (11) ___/___/___
Firma del intérprete — Mes Día Año

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que (12) _____ (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como (13) _____ (Nombre del procedimiento). También le explique que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que la he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de éstos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficio subsidiado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(14) _____ Fecha: (15) ___/___/___
Firma de quien recibe el consentimiento — Mes Día Año

(16) _____
Nombre del lugar donde el paciente recibió la información

(17) _____
Dirección del lugar donde el paciente recibió la información — Ciudad — Estado — Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco aqntes de operar a (18) _____ (Nombre de la persona a ser esterilizada) en (19) ___/___/___ Mes Día Año (Fecha de esterilización), le explique la naturaleza del metodo de esterilizacion conocido como (20) _____ (Nombre del procedimiento) también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Declaro que le he explicadoo a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(21) (1) Han pasado por lo menos treinta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(22) (2) La esterilización se realizó en menos de 30 días, pero después de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

(23) A ☐ Fecha de parto prematuro: (24) ___/___/___ Mes Día Año **Fecha anticipada del** parto (25) ___/___/___ Mes Día Año (Debe ser 30 días a partir de la firma de la persona).

(26) B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: _____

(27) _____ Fecha: (28) ___/___/___
Firma del Doctor a cargo de la cirugía — Mes Día Año

Sterilization Consent Form Ordering

The *Sterilization Consent Form* (PM 330) can be downloaded (in English and Spanish) from the **Forms page** of the Medi-Cal Provider website or ordered by calling the Telephone Service Center (TSC) at 1-800-541-5555.

Sterilization Consent Form Ordering

Providers must supply their NPI number when ordering the form(s). The following information also may be requested:

- Date
- Name of document (sterilization Consent form, PM 330)
- Name of provider/facility (registered provider name associated with NPI)
- Complete shipping address: Street, city, state, ZIP (P.O. Box not accepted)
- Quantity of forms requested
- Contact person and telephone number

Onsite Dispensed Contraceptives

Onsite Dispensed Contraceptives

HCPCS Code	National Code Description	Additional Information
J3490U5	Emergency Contraception: Ulipristal Acetate 30 mg	1 pack (1 tablet)
J3490U6	Emergency Contraception: Levonorgestrel 1.5 mg	1 pack (1 tablet)
J3490U8	Medroxyprogesterone Acetate 150 mg	1 injection
J7294	Segesterone acetate and ethinyl estradiol 0.15 mg, 0.12 mg per 24 hours, yearly vaginal system, each	1 ring
J7295	Ethinyl estradiol and etonogestrel 0.015 mg, 0.12 mg per 24 hours; monthly vaginal ring, each	1 ring
J7296	Levonorgestrel IUC, (kyleena), 19.5 mg	1 IUC
J7297	Levonorgestrel IUC, (liletta) 52 mg	1 IUC
J7298	Levonorgestrel IUC, (mirena) 52 mg	1 IUC
J7300	Intrauterine copper contraceptive	1 IUC
J7301	Levonorgestrel IUC (Skyla) 13.5 mg	1 IUC
J7304U1	Contraceptive patch (norelgestromin and ethinyl estradiol transdermal system)	1 patch
J7304U2	Contraceptive patch levonorgestrel and ethinyl estradiol transdermal system)	1 patch
J7307	Etonogestrel contraceptive implant (Implanon)	1 implant
S4993	Oral Contraceptives	1 cycle

For more information, refer to Family PACT- ***Drugs: Onsite Dispensing Billing Instructions drug 6-7*** section in the PPBI manual.

Onsite Dispensing Billing Instructions

The maximum reimbursement rates for many of the items dispensed onsite are set by the Medi-Cal program and are contained in the Medi-Cal rates table.

However, when a Medi-Cal maximum reimbursement rate is not specified, Family PACT sets the reimbursement rates for the drugs and contraceptive supplies in ***Drugs: Onsite Dispensing Price Guide*** section (drug onsite) section of the PPBI manual.

Onsite Dispensing Price Guide

The *Drugs: Onsite Dispensing Price Guide* section (drug onsite) section contains information for calculating the Family PACT reimbursement rates for each HCPCS codes: **A4261, A4266, A4267, A4268, A4629 (U1-U5), S5199, S5000** or **S5001** dispensed onsite.

Partial Table of Reimbursement Rates for Drugs Dispensed Onsite

Medication	Size and/or strength	Condition	Max Billing Units Per Claim	Rate Per Unit	Max Drug Cost	Clinic Disp. Fee	Upper Payment Limit	Fill Frequency (Days)
Acyclovir	400 mg tabs	Genital Herpes	30	$0.23	$6.90	$3.00	$9.90	Not Applicable
Acyclovir	400 mg tabs	Genital Herpes	60	$0.23	$13.80	$3.00	$6.80	22

Note: A clinic dispensing fee is not reimbursable for antibiotic injections.

Note: A clinic dispensing fee is **not** reimbursable antibiotic injections.

HCPCS Codes – Drugs & Supplies Dispensed Onsite

Claims for HCPCS codes A4267, A4269U1, A4269U2, A2469U3, A4269U4, A4269U5 and S5199 must document the following in the ***Remarks*** field (Box 80) or ***Additional Claim Information*** field (Box 19):

- Description of items
- Actual quantity
- “At cost” expense
- Clinic dispensing fee, If applicable

HCPCS Codes – Drugs & Supplies Dispensed Onsite

If any of the following codes: A4267, A4269U1, A4269U2, A4269U3**,** A4269U4 or S5199, or any combination of the codes is present on a claim, the total maximum allowable amount for any or all is **$14.99.**

When billing for contraceptive supplies (A4267, A4269U1, A4269U2, A4269U3, A4269U4 or S5199) dispensed for the same patient by the same provider, the minimum interval between dispensing events is **15 day**s.

Drugs & Supplies Dispensed Onsite

HCPCS Code	National Code Description	Additional Information
A4261	Cervical cap	Limited to 2 cervical caps per year
A4266	Diaphragm	Limited to 1 diaphragm per year
A4267	Condom, male, each	Up to 36 units per 27 days
A4268	Condom, internal, each	Up to 12 units per claim. No more than two claims and no more than 24 units in a 90-day period.
A4269U1	Spermicide: Gel, jelly, cream or foam	Limited to three refills in any 75-day period
A4269U2	Spermicide: Suppository	Limited to three refills in any 75-day period
A4269U3	Spermicide: Vaginal film	Limited to three refills in any 75-day period
A4269U4	Spermicide: Contraceptive sponge	Limited to three refills in any 75-day period
A4269U5	Vaginal gel	Limited to 3 dispensing per any 75-day period
S5000	Prescription drug, generic	Miscellaneous drugs
S5001	Prescription drug, brand name	Miscellaneous drugs
S5199	Personal care item, NOS each	Lubricant Limited to three refills in any 75-day period
None	Basal Body Thermometer (each)	Pharmacy dispensed only (1 per year)

For more information, refer to Family PACT- ***Drugs: Onsite Dispensing Billing Instructions drug 4*** section in the PPBI manual.

Treatment and Dispensing Guidelines for Clinicians

Treatment and Dispensing Guidelines Clinicians

The ***Benefits Grid*** **(ben grid 33-38)** section in the PPBI manual assists clinicians in determining covered medications, dosage size, regimens and clinic billing codes along with any notes or limitations for family planning-related reproductive health conditions, contraceptives and contraceptive supplies.

Condition	Medication	Dosage Size	Regimens	Fill Freq Days	Notes	Clinic Code
Bacterial Vaginosis	Metronidazole	250 mg/ 500 mg tabs	500 mg PO BID X 7 days	15	Recommended regimen	S5000/ S5001
Bacterial Vaginosis	Metronidazole	0.75% vaginal gel	5 g PV QHS X 5 days	30	Recommended regimen	S5000/ S5001
Bacterial Vaginosis	Clindamycin	2% cream	5 g PV X 7 days	30	Recommended regimen	S5000/ S5001
Bacterial Vaginosis	Clindamycin	150 mg capsules	300 mg PO BID X 7 days	15	Alternative regimen	S5000/ S5001
Bacterial Vaginosis	Clindamycin	100 mg ovules	100 mg PV QHS X 3 days	30	Alternative regimen	S5000/ S5001

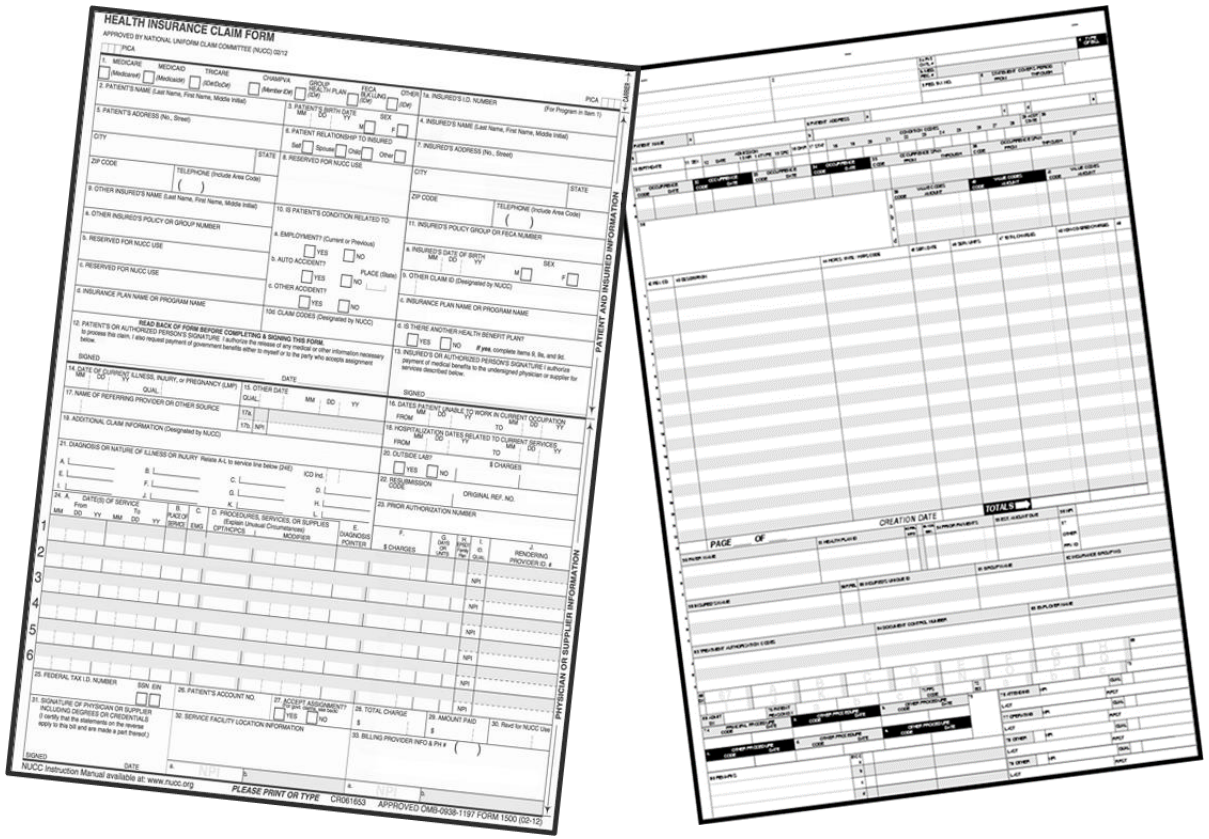
Sample: Treatment and Dispensing Guidelines for Clinicians

Policy Update for Clinic Dispensing for Certain Family-Related Drugs

Effective for dates of service on or after August 1, 2022, the dispensing frequency is updated from “one dispensing is 15 days” to “two dispensing's in rolling 30 days” for the following drugs reimbursable under HCPCS codes S5000 and S50001.

- Cefixime
- Cephalexin
- Ciprofloxacin
- Metronidazole
- Sulfamethoxale and Trimethoprim (SMX/TMP)
- Tinidazola

Claim Form Documentation



Claim Form Documentation

Claim form documentation for contraceptive supplies and miscellaneous drugs dispensed onsite must be entered in the ***Additional Claim Information*** field (Box 19) on the *CMS-1500* claim form or the ***REMARKS*** field (Box 80) on the *UB-04* claim form, or an attachment.

Refer to the ***Drugs: Onsite Dispensing Billing Instructions*** (drug) section of the PPBI manual for examples.

Claim Form Documentation

An example of claim form documentation required on a claim or attachment for condoms and foam dispensed onsite for contraceptive supplies for condoms (20 male) at $0.28 each and Foam (40 gm) at $0.20.

- Name of drug/supply (male condoms)
- Size and/or strength, if applicable
- Number of units (e.g., 20 condoms)
- Clinic dispensing fee 10% for each contraceptive item, if applicable
- Total cost (e.g., include for each claim line

19. ADDITIONAL CLAIM INFORMATION (Designated by NCC)

L1:.20 Male Condoms @ $0.28 = $5.60 + CDF 10% .56 = $6.16

L2: Foam 40 gm @ $0.20 = $8.00 + CDF 10% .80 = $8.80

80 REMARKS

L1:.20 Male Condoms @ $0.28 = $5.60 + CDF 10% .56 = $6.16

L2: Foam 40 gm @ $0.20 = $8.00 + CDF 10% .80 = $8.80

Note

There is a $14.99 claim limit for all contraceptive supplies dispensed on a single date of service. For additional information and the Family PACT rate per unit, refer to the ***Drugs: Onsite Dispensing Price Guide*** (drug onsite) section of the PPBI manual.

For claim completion for contraceptive supplies and miscellaneous drugs, refer to the ***Claim Completion: CMS-1500*** (claim cms) section and ***Claim Completion: UB-04*** (claim ub) section in the PPBI manual.

Family PACT Case Study

Amanda

Amanda’s Visit

Amanda is a new Family PACT client enrolled on October 1,2021 and comes in for family planning services. She thinks her period is late and is also experiencing UTI symptoms. Amanda has a new client family planning office visit, including counseling on all contraceptive methods.

After being counseled on all FDA-approved contraceptives methods, Amanda decides she would like to try oral contraceptives.

Amanda provides her verbal consent to a pregnancy test. The pregnancy test is negative.

Amanda’s Visit

A dipstick urine test is performed in house for symptoms of a UTI, and it is confirmed she has a UTI. Amanda is given a written prescription for oral contraceptives and an antibiotic to treat the UTI.

The provider dispenses:

- (20) male condoms at $0.28 each [HCPCS code A4267])
- 40 gm of foam is dispensed at $0.20 [HCPCS code A4269U1]) for a quick start

Services Performed

Services performed at Amanda's visit:

- Evaluation & Management Office visit (new client)
- Education & Counseling (individual orientation)
- Prescription (oral contraceptives and antibiotic)
- Pregnancy Test
- Male condoms and Foam (dispensed as back-up method with OC's)
- Urine dip-stick test performed on-site

Provider is eligible for the clinic dispensing fee (CDF).The CDF is 10 percent of the total amount of contraceptive supplies dispensed onsite.

Acknowledgement Form

Note: Clients must sign an acknowledgement form or similar document when they provide a specimen per Welfare and Institutions Code (W&I Code), Section 14043.341. Providers are required to obtain and keep a record of Family PACT client signatures acknowledging the dispensing of a drug, device or supplies, or when obtaining a laboratory specimen.

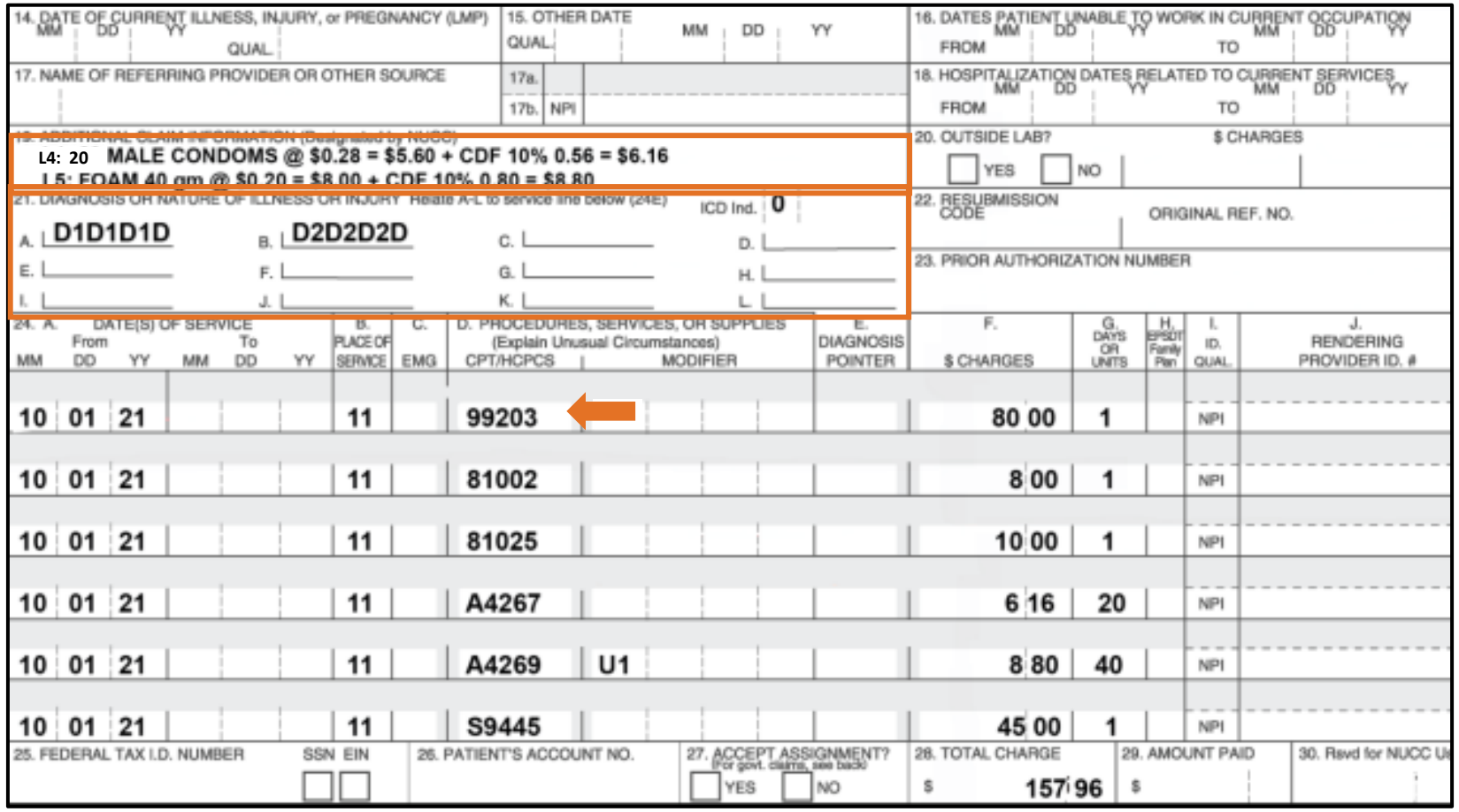
CPT, HCPCS and ICD-10-CM Codes

Items & Services	CPT/HCPCS Code	ICD-10-CM Code
Contraceptive Supplies	A4267 (male condoms) A4269U1 (foam)	D1D1D1D D2D2D2D
Drugs	None	D1D1D1D D2D2D2D
Lab	81025 (pregnancy test) 81002 (UA dipstick)	D1D1D1D D2D2D2D
Evaluation & Management	99203U6 30-44 minutes (Individual counseling time)	D1D1D1D D2D2D2D
Education & Counseling	S9445 (Individual orientation to Family PACT, only once by the same provider for the same client)	D1D1D1D D2D2D2D

Use the information provided on this table, to complete the partial *CMS-1500* claim form on workbook **page 57**, for Amanda's case example.

Amanda's Visit
Answer Key

Amanda's Claim Example



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

L4: 20 MALE CONDOMS @ $0.28 = $5.60 + CDF 10% 0.56 = $6.16

L5: FOAM 40 gm @ $0.20 = $8.00 + CDF 10% 0.80 = $8.80

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. D2D2D2D C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10	01	21				11		99203			80 00	1		NPI	
10	01	21				11		81002			8 00	1		NPI	
10	01	21				11		81025			10 00	1		NPI	
10	01	21				11		A4267			6 16	20		NPI	
10	01	21				11		A4269	U1		8 80	40		NPI	
10	01	21				11		S9445			45 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 157 96

29. AMOUNT PAID $

30. Rsvd for NUCC U

Resources

- Medi-Cal provider website (mcweb.apps.prd.cammis.medi-cal.ca.gov)
  - Provider Manuals
  - Provider Bulletins
  - Medi-Cal Subscription Service(MCSS)
  - Medi-Cal Learning Portal
- Telephone Services Center (TSC): 1-800-541-5555
- Provider Field Representatives
- Claims Assistance Room (CAR)
- Small Provider Billing Assistance and Training 1-916-636-1275

Additional Resources

The following **Reference Materials** provide Family PACT program billing information.

Family PACT Policies, Procedures and Billing Instructions (PPBI) manual

Family PACT Update bulletin

Medi-Cal Update bulletin

Medi-Cal Rx website

Family PACT website

Family PACT website: Forms

Family PACT email address: familypact@dhcs.ca.gov

Objectives Met

- Identified Family PACT categories of service
- Reviewed Family PACT approved contraceptive method
- Provided list of family planning & family planning-related ICD-10-CM diagnosis codes
- Detailed requirements for Family PACT complication services for *Treatment Authorization Requests (TARs)*
- Clarified Family PACT excluded services

Objectives Met

- Discussed evaluation and management/education & counseling services
- Reviewed sterilization policy and the *Sterilization Consent Form* (PM 330)
- Detailed claim documentation requirements for dispensing drugs and supplies
- Featured a case study and a claim example

Family Planning, Access, Care & Treatment (Family PACT) Billing

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES