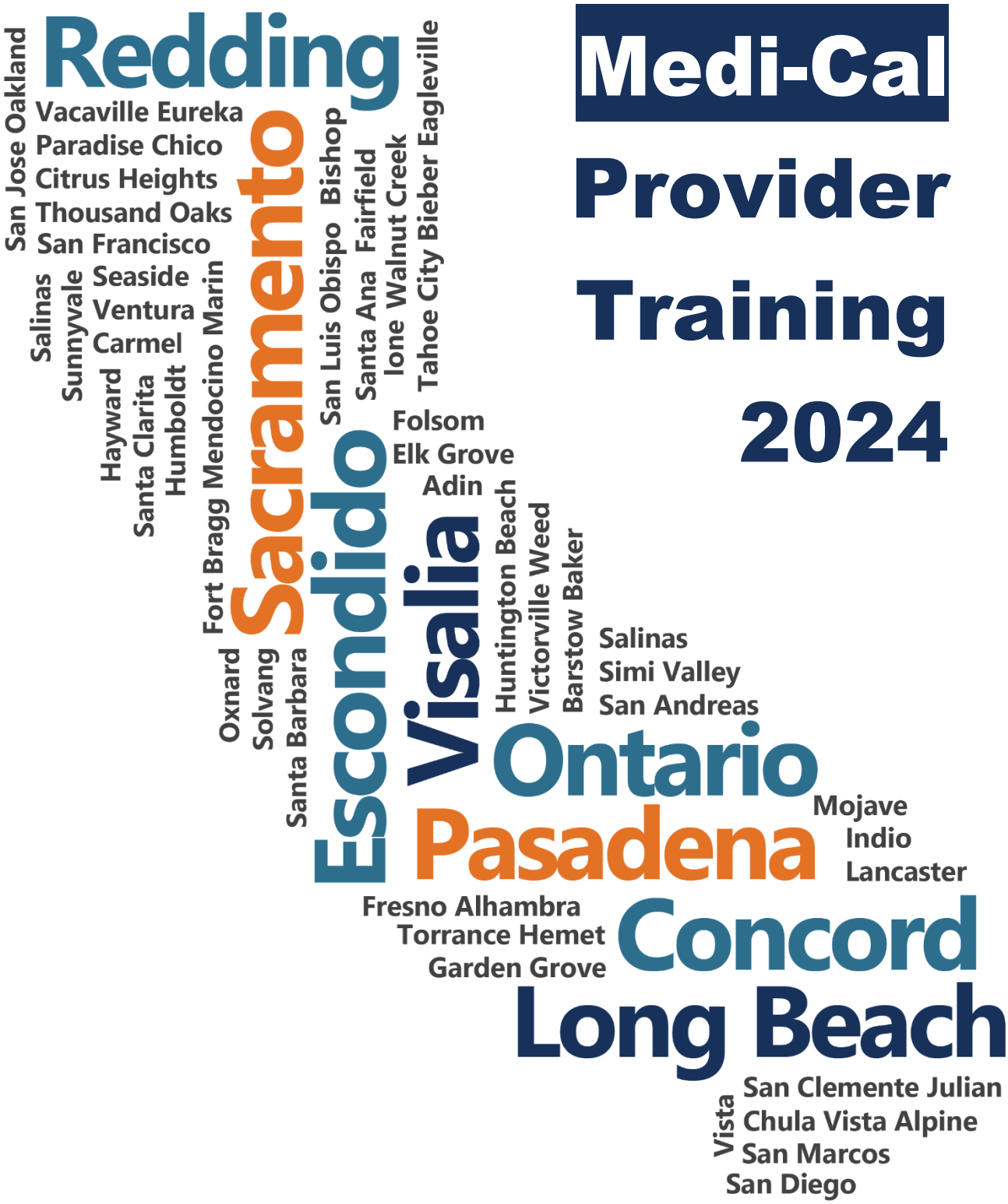

Medi-Cal Provider Training 2024

Health Access Programs

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at *www.learn.medi-cal.ca.gov.*
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on *www.medi-cal.ca.gov*.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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Page updated: May 2022

Obstetrics

Introduction

Purpose

The purpose of this module is to provide an overview of basic Medi-Cal Obstetrics (OB) billing. General billing and claim form documentation requirements will be discussed.

Module Objectives

- Clarify Medi-Cal OB benefits and limitations
- Identify when and how to bill the initial comprehensive office visit
- Define both per-visit and global services
- Review claim form billing completion requirements
- Discuss ultrasound benefits and billing documentation
- Explain OB ancillary services
- Highlight commonly used modifiers for OB services

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Description

This training module outlines the CPT, ICD-10-CM and HCPCS codes used to bill for services for providers who render obstetrical care.

Confirmation of Pregnancy

Evaluation and Management Codes

When a patient is first seen and the pregnancy has not yet been confirmed, an appropriate Evaluation and Management (E&M) code (CPT codes 99201 thru 99215) and 99417 should be billed with ICD-10-CM diagnosis reflecting the actual reason the patient was seen (for example, amenorrhea, ICD-10-CM diagnosis code N91.0 thru N91.2).

Office visits are not reimbursable with a pregnancy-related diagnosis. Claims submitted with an office visit and a pregnancy-related diagnosis will cause the claim to deny.

Verification of Pregnancy

County welfare departments will accept as verification of pregnancy, either self-attestation of pregnancy or a written statement from the physician, physician's assistant, certified nurse midwife, nurse practitioner or designated medical or clinic personnel with access to the patient's medical records. The statement must give the estimated date of confinement and provide sufficient information to substantiate the diagnosis. Pregnant patients applying for Medi-Cal must either self-attest to pregnancy or submit the written statement as part of their application.

Note: Pregnancy verification is not required for patient's applying for the Minor Consent Program.

A signature stamp, photocopy, or carbon copy is acceptable if initialed or counter-signed by the designated medical or clinic personnel providing the verification.

Refer to the *Pregnancy: Early Care and Diagnostic Services* section (preg early) in the appropriate Part 2 provider manual regarding these topics.

Pregnancy Care Office Visit: Antepartum Initial (Z1032)

Initial pregnancy-related office visit HCPCS code (Z1032) is considered to be the first prenatal visit and is billed after the pregnancy has been confirmed. This code is comparable to a high-complexity Evaluation and Management (E&M) code and must include a comprehensive history, physical examination, and medical decision-making of high complexity. If these components are not performed and documented in the medical record, HCPCS code Z1034 (antepartum follow-up office visit) should be billed.

When billing Z1032, one of the following pregnancy-associated diagnosis codes must be used: O09.00 thru O26.93, O29.011 thru O48.1, O98.011 thru O9A.519, Z34.00 thru Z34.93.

The following billing guidelines apply:

- Z1032 may be billed separately in conjunction with per-visit or global care.
- Limit to once in six months per provider, unless care is transferred to another physician during the same pregnancy or the provider certifies in the Remarks field (Box 80)/Additional Claim Information field (Box 19) that pregnancy has recurred within a six-month period.
- Indicate date of transfer or date of fetal demise and document in the *Additional Claim Information* field (Box 19) on the CMS-1500 claim form, or in the *Remarks* field (Box 80) on the UB-04 claim form.

Pregnancy Co-management (Z1032)

Consultants who co-manage a pregnancy without complete transfer of care should not bill with HCPCS code Z1032. Instead, E&M consultation codes 99242 thru 99245 should be used.

Only primary obstetrical providers are to bill codes Z1032 and Z1034. All other providers must bill with E&M consultation codes 99242 thru 99245.

Per-Visit Billing

Refer to the *Pregnancy: Per-Visit Billing* section (preg per) in the appropriate Part 2 provider manual regarding this topic.

Per-Visit Policy

A provider who does not render total obstetrical care during the recipient's entire pregnancy or who renders fewer than 13 antepartum visits must bill each visit or procedure separately. The initial pregnancy-related office visit (Z1032) may not be counted as one of the 13 visits. Each visit is subject to the six-month billing limit, and recipient eligibility must be verified for each month of service.

Antepartum Visits

HCPCS code Z1034 is used for billing antepartum visits and is reimbursable only when obstetrical care is billed on a per-visit basis. Reimbursement for antepartum visits is limited to 13 visits in a nine-month period for the total of all primary obstetrical providers. The exception to billing more than 13 antepartum visits in nine months is if the provider documents a second pregnancy within those nine months.

Delivery

Providers billing a vaginal delivery on a per-visit basis must use CPT code **59409** (vaginal delivery only) or **59612** (vaginal delivery only, after previous cesarean delivery). Providers billing a cesarean delivery on a per-visit basis must use CPT code **59514** (cesarean delivery only) or **59620** (cesarean delivery only, following attempted vaginal delivery, after previous cesarean delivery).

Reimbursement for a per-visit delivery includes:

- Hospital admission
- Patient history
- Physical examination
- Management of labor, vaginal or cesarean section delivery
- Hospital discharge
- All applicable postoperative care

Assistant at Surgery

Certified Nurse Midwife (CNMs) may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by a licensed physician or surgeon. Reimbursement is determined by the following:

- For “assistant at surgery” services performed by a CNM during a cesarean section, modifier AS is used to distinguish the CNMs services.
- The licensed physician and surgeon performing the cesarean section must state on the operative report that the CNM performed the function of an “assistant at surgery.”
- Only non-global cesarean section CPT codes 59514 (cesarean delivery only) or 59620 (cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery) are reimbursable when submitted with an appropriate assistant surgeon modifier (80).

Postpartum Visit

HCPCS Code Z1038 is used for billing the postpartum visit and can be reimbursed when billed in conjunction with one of the following per-visit delivery CPT codes: 59409, 59514, 59614, 59612, or 59620.

Code Z1038 may be billed either by the primary maternity care provider or by a provider who saw the patient for only the postpartum visit. Reimbursement is limited to one visit in a six-month period unless the individual has a medical or mental health postpartum complication or risk factor for postpartum complication.

An additional postpartum visit may be billed more than once in six months by documenting the postpartum complication or risk factor for postpartum complication in the *Remarks* field (Box 80)/*Attachment Claim Information* field (Box 19) of the claim for or in the attachment for reimbursement.

Postpartum Care Reminder

As part of the American Rescue Plan Act (ARPA) effective April 1, 2022, an individual eligible for pregnancy and postpartum care services under Medi-Cal or the Medi-Cal Access Program (MCAP) is entitled to a total 12 months of postpartum coverage.

Coverage shall include the full breadth of medically necessary services through the pregnancy and postpartum period, regardless of immigration status or how the pregnancy ends. These include but are not limited to prenatal care, delivery, postpartum care, and family planning services (including contraception).

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum individual for specialty care or other medically necessary care, providers should advise the specialist or other provider that the referral is for a medically necessary service and remind the specialist to include a pregnancy diagnosis code on the claim form to ensure reimbursement.

- Claims should be billed with either CPT E&M consultation codes 99242 thru 99245 or the most appropriate billing code for the service provided.
- Visits must not be billed with HCPC code Z1034 or E&M procedure codes 99202 thru 99215 (new or established outpatient visits) or 99417. This may cause the claim to be denied.

Per-Visit Billing Codes

Per-Visit Obstetrical Codes

HCPCS/CPT Code	Definition	Frequency Limit
Z1032	Initial comprehensive pregnancy-related office visit	1 in 6 months
Z1034	Antepartum office visit	13 in 9 months
Z1038	Postpartum office visit	1 in 6 months: **Note:** More than 1 in 6 months if documentation of complication is indicated in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.
59409	Vaginal delivery only	1 in 6 months
59514	Cesarean delivery only	1 in 6 months
59525	Subtotal or total hysterectomy after cesarean delivery	1 in 6 months (subtotal) or once in a lifetime (total)
59612	Vaginal delivery only, after previous cesarean with/without episiotomy, and/or forceps	1 in 6 months
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	1 in 6 months

Notes:

Knowledge Review 1

1. Office visits (E&M) codes are payable with a pregnancy-related diagnosis code.

   True □ False □

2. Pregnancy verification is not required for patient's applying for the Minor Consent Program.

   True □ False □

3. Consultants who co-manage a pregnancy can bill for HCPCS Z1032 without complete transfer of care

   True □ False □

4. More than 13 antepartum visits are allowed in 9 months if there is documentation of a second pregnancy.

   True □ False □

5. Postpartum visits (HCPCS code Z1038) can be billed by the primary maternity care provider or the provider who saw the patient for only the postpartum office visit.

   True □ False □

See the Appendix for the Answer Key.

Pasteurized Donor Human Breast Milk

Effective for dates of service on or after January 1, 2023, Medi-Cal covers medically necessary pasteurized donor human milk (PDHM) when obtained from a licensed and approved facility. There are two human milk banks in California:

San Jose

- Address: Mother's Milk Bank 1887 Monterey Road, Suite 110 San Jose, CA 95112
- Phone: 408 998-4550
- Email: recipient.coordinator@mothersmilk.org
- Website: https://mothersmilk.org/

San Diego

- Address: University of California Health Milk Bank 3636 Gateway Center Ave, Suite 102 San Diego, CA 92102
- Phone: 858 249-MILK (6455)
- Email: ucmilkbank@health.ucsd.edu
- Website: https://health.universityofcalifornia.edu/patient-care/milk-bank

Eligibility Criteria

Medi-Cal providers can arrange for the provision of PDHM for newborns if at least one of the following situations is true:

- A mother is unable to breast feed due to medical conditions;
- The infant cannot tolerate formula or has medical contra-indications to using formulas, including elemental formulas;
- The infant is born at a very low birthweight (less than1500 g) and very premature (less than 32 weeks gestation);
- The infant has a gastrointestinal anomaly, a metabolic/digestive disorder, or is in recovery from an intestinal surgery when digestive needs require additional support;
- The infant is diagnosed with failure to thrive (not appropriately gaining weight/growing);
- The infant has formula intolerance with documented feeding difficulty or weight loss;
- The infant has been diagnosed with hypoglycemia (low blood sugar), congenital heart disease, pre or post organ transplant, or another serious health condition when the use of banked donor human milk is medically necessary and supports the treatment and recovery of the infant; or
- The mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs.

Authorized Providers

Authorized providers who can prescribe PDHM are physicians and advanced practice nurses (Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives and Physician Assistants).

Prescription

3 ounces per unit, 35 ounces per day only good for 30 days.

Age of Infant

Coverage may be up to 12 months of age if it is medically necessary and appropriate.

Billing Codes

HCPCS Code	Description
T2101	Human breast milk processing, storage and distribution only, to be billed per ounce.
K1005	Disposable collection and storage bag for breast milk, any size, any type, each.

Depression Screening

Pregnant or Postpartum Individuals

Providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum. The combined total claims for screening pregnant or postpartum recipients using HCPCS codes **G8431** and/or **G8510** may not exceed two per year per recipient by any provider of prenatal or postpartum care. Providers must include a pregnancy or postpartum diagnosis code on all claims. Claims submitted without a pregnancy or postpartum diagnosis code may be denied.

Depression Screening Billing Codes

Modifier HD is used with G8431 and G8510 when billing for either a positive or negative depression screening for pregnant or postpartum recipients.

Depression Screening Codes

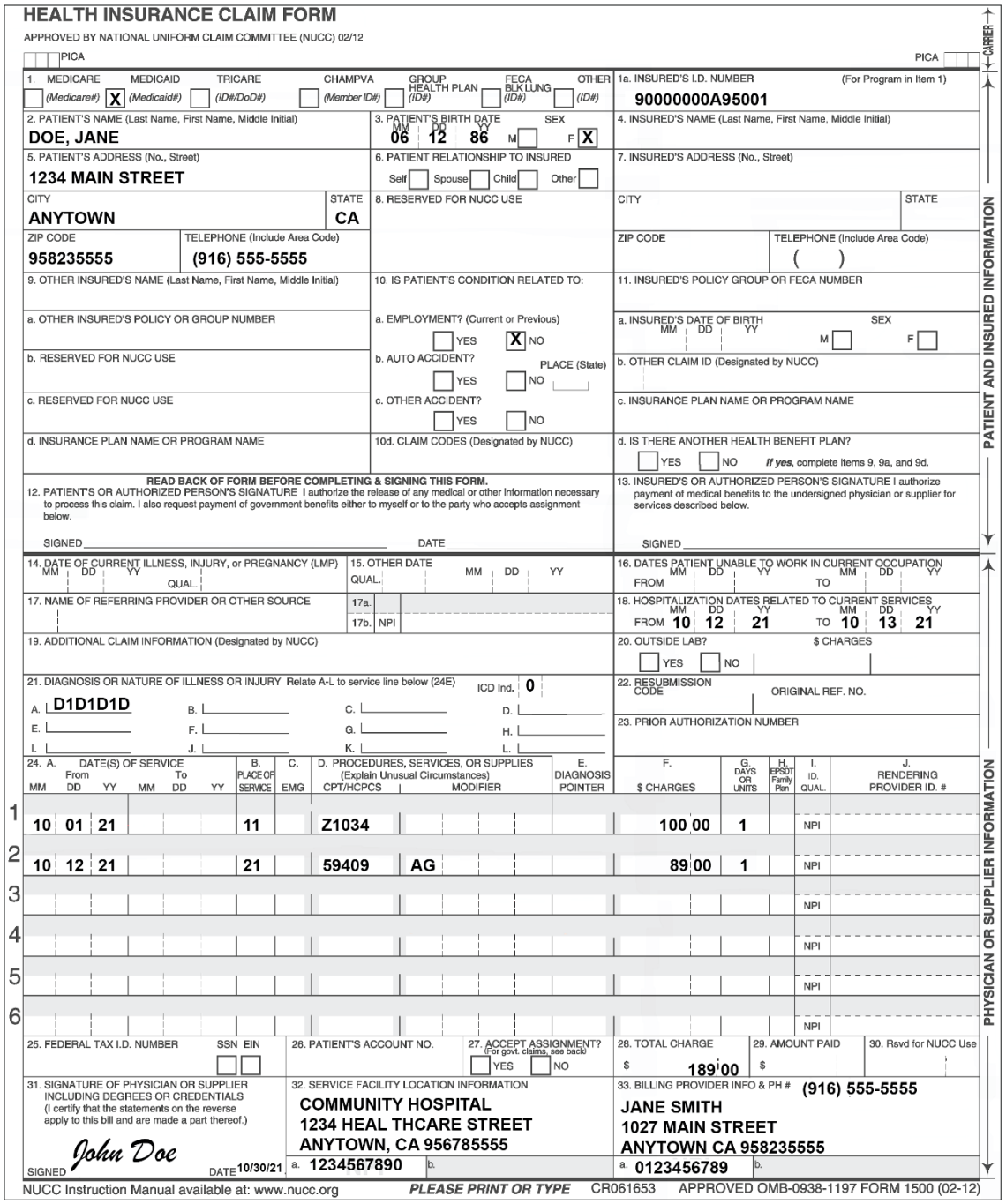
HCPCS Code	Description
G8431	Screening for depression is documented as being positive, and a follow-up plan is documented.
G8510	Screening for depression is documented as negative. A follow-up plan is not required.

For additional claim submission instructions, providers should refer to the "*Pregnancy: Early Care and Diagnostic Services*" and "*Pregnancy: Postpartum and Newborn Referral Services*" sections in the appropriate Part 2 manual.

CMS-1500 Claim Billing Example

Per-Visit Vaginal Delivery and Antepartum Office Visit

When billing for any medically necessary service during pregnancy or the postpartum period, providers should include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 86 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 12 21 TO 10 13 21

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. 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. #
1 10 01 21		11		Z1034			100 00	1		NPI	
2 10 12 21		21		59409	AG		89 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										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 $ 189 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED John Doe DATE 10/30/21

32. SERVICE FACILITY LOCATION INFORMATION

COMMUNITY HOSPITAL
1234 HEAL THCARE STREET
ANYTOWN, CA 956785555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

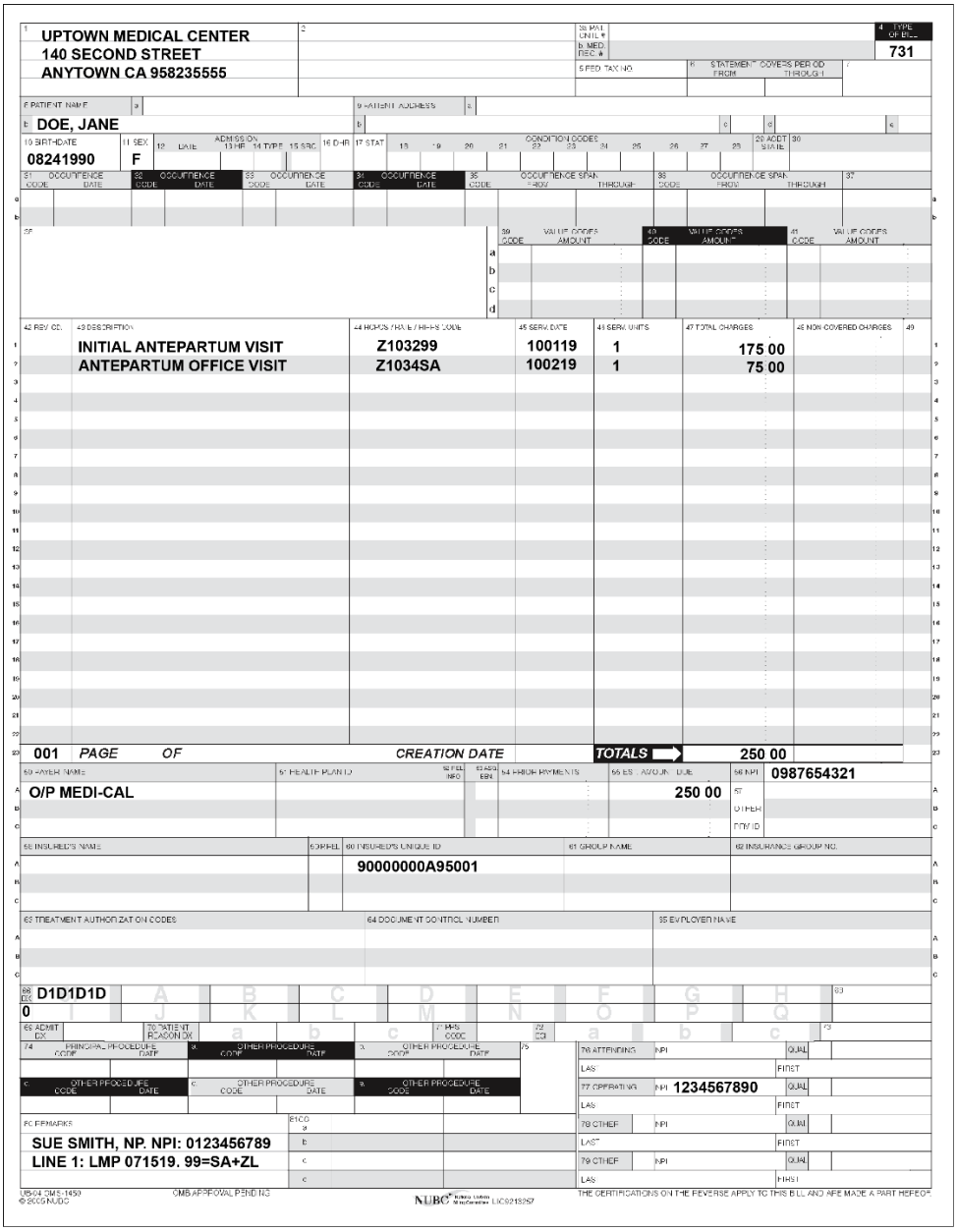
Sample: Per-Visit Billing – *CMS 1500* claim form. Adapt to your billing situation.

UB-04 Claim Billing Example

Per-Visit Initial OB visit and Antepartum Office Visit

When billing for any medically necessary service during pregnancy or the postpartum period, providers should include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

Per-Visit Billing Initial OB visit and Antepartum Office Visit



Sample: Per-Visit Billing – *UB-04* claim form. Adapt to your billing situation.

Global Billing for Pregnancy

Refer to the *Pregnancy: Global Billing* (preg glo) section in the appropriate Part 2 provider manual regarding this topic.

Policy

The intent of global billing (CPT codes 59400, 59610, and 59618) is to offer a convenient means of billing for providers who render total obstetrical care to an individual throughout their pregnancy. Global obstetrical (OB) billing consists of antepartum care, delivery, and post-partum care. Global billing also includes the following: hospital admission, patient history, physical examination, labor management, postpartum office visit, vaginal or cesarean delivery, vaginal or cesarean section delivery after previous cesarean delivery, hospital discharge and all applicable postoperative care.

Global Billing Requires 13 OB Visits

A provider who bills for global obstetrical care must render at least 13 antepartum OB visits and must document the visits in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment for reimbursement. The initial comprehensive pregnancy-related office visit may not be counted as one of the 13 visits. If fewer than 13 visits are rendered, the provider must bill services on a per-visit basis. Global OB billing is never to be used for recipients who have transferred care and have already received OB care and billing by another Medi-Cal provider.

Non-Reimbursable Global OB Services

Providers choosing the global billing method cannot separately bill per-visit antepartum visit Z1034 or postpartum office code Z1038 with the exception for the Medi-Cal initial antepartum visit code Z1032. Services not separately reimbursable on a global basis include:

- Antepartum visits (Z1034) paid to the same provider, for dates of service within the from-through period of the global billing or within 270 days prior to the global OB delivery date
- Hospital visits
- Postpartum visits (Z1038) for routine postpartum care, paid to the same provider and within the 45-day follow-up period of the global OB delivery date

Global Obstetrical Codes

HCPCS/CPT Code	Definition	Frequency Limit
59400	Global antepartum care, vaginal delivery and postpartum care.	1 in 6 months
59510	Global antepartum care, cesarean delivery and postpartum care.	1 in 6 months
59525	Subtotal or total hysterectomy after cesarean delivery.	1 in 6 months (subtotal) or once in a lifetime (total)
59610	Routine OB care vaginal delivery w/without episiotomy and/or forceps and postpartum care after previous cesarean delivery.	1 in 6 months
59618	Routine OB care cesarean delivery and postpartum care following attempted vaginal delivery after cesarean delivery.	1 in 6 months

Note: Refer to the CPT code book for complete procedure descriptions.

"From-Through" Billing

Global OB claims (CPT codes 59400, 59510, 59525, 59610, and 59618) must be billed in the "from-through" billing format on the CMS-1500 with modifier AG (primary surgeon). The "from" date of service is the first date the recipient was seen for this pregnancy, and the "through" or "to" date of service is the date of delivery.

Verifying Eligibility

To be reimbursed for global claims, providers must verify the recipient's eligibility for services during the month of delivery.

Transfer of Care

Providers who accept a Medi-Cal transfer patient must bill each antepartum visit separately, regardless of the number of times the provider sees the patient prior to delivery.

Providers who accept Medi-Cal transfer patients are not restricted to the number of visits for which they may be reimbursed (up to the Medi-Cal limit of one initial comprehensive and 13 antepartum visits for all primary obstetrical providers within nine months).

Global Billing: Cesarean with Tubal Ligation

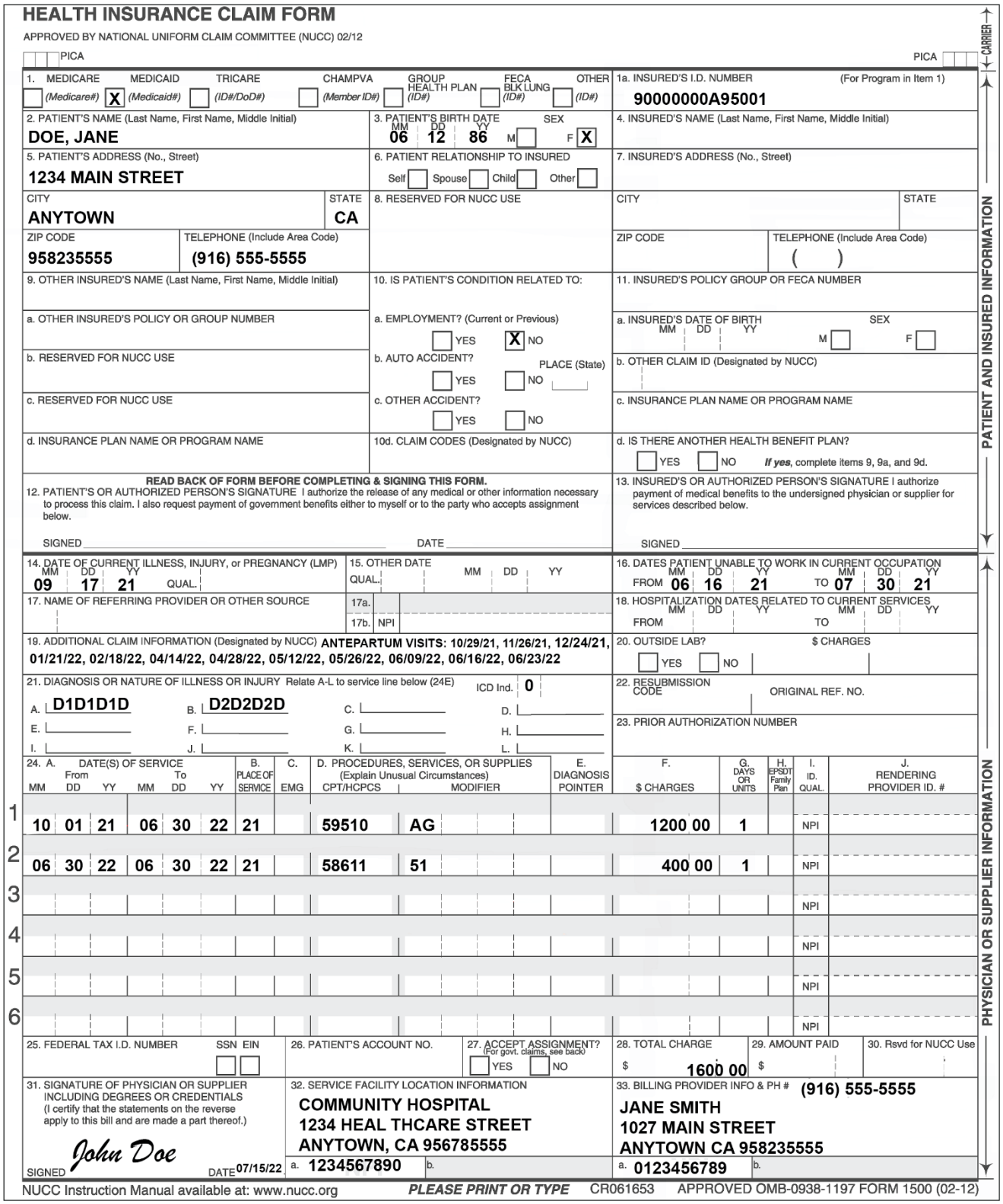
CMS-1500 Documentation Requirements

- Date of Last Menstrual Period (LMP) (Box 14)
- Hospitalization dates (Box 16)
- Dates of 13 antepartum visits must be documented in the *Additional Claim Information* field (Box 19)
- Primary and secondary diagnosis codes to support pregnancy and tubal ligation services fields (21A and B)
- Bill in “From-Through” format for cesarean delivery CPT code 59510 field (24A)
- Global delivery CPT code 59510 modifier AG field (24D)
- Intraoperative Tubal Ligation CPT code 58611 modifier 51 field (24D)
- Enter Usual and Customary Charges field (24F)
- Submission of sterilization *Consent Form* (PM 330)

Note: Delivery services performed in an inpatient setting must be billed on a *CMS-1500* claim form. The physician’s billing information is entered in the *Billing Provider Information & PH#* field (Box 33). Physician’s NPI is entered in Box 33a.

A Obstetrics

Page updated: May 2023



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ( ) (Medicare#) | MEDICAID (X) (Medicaid#) | TRICARE ( ) (ID#/DoD#) | CHAMPVA ( ) (Member ID#) | GROUP HEALTH PLAN ( ) (ID#) | FECA BLK LUNG ( ) (ID#) | OTHER ( ) (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 86 SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ( ) NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 17 21 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM 06 16 21 TO 07 30 21

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ANTEPARTUM VISITS: 10/29/21, 11/26/21, 12/24/21, 01/21/22, 02/18/22, 04/14/22, 04/28/22, 05/12/22, 05/26/22, 06/09/22, 06/16/22, 06/23/22

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. #
1 10 01 21	06 30 22	21		59510	AG		1200 00	1		NPI	
2 06 30 22	06 30 22	21		58611	51		400 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										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 $ 1600 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED John Doe DATE 07/15/22

32. SERVICE FACILITY LOCATION INFORMATION

COMMUNITY HOSPITAL
1234 HEAL THCARE STREET
ANYTOWN, CA 956785555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample: *CMS-1500* claim form. Adapt to your billing situation.

Ultrasound During Pregnancy

Policy

An ultrasound performed for routine screening during pregnancy is considered an integral part of the patient's care during pregnancy and its reimbursement is included in the obstetrical fee. Ultrasound during pregnancy is separately reimbursable only when used for the diagnosis or treatment of specific medical conditions.

Diagnosis, Frequency and Documentation Guidelines

Ultrasound services are reimbursable as defined below:

- Diagnosis on the claim must be appropriate for the CPT code being billed
- Frequency must meet the restrictions listed
- Some claims must have documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim to justify medical necessity.

Note: See the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for the most current list of codes, frequency limits and documentation.

Reimbursable Ultrasound Codes

Diagnosis, Frequency and Documentation Guidelines

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76801, 76805, 76811	O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9: Spontaneous abortion O09.511 thru O09.513: Elderly primigravida O09.521 thru O09.523: Elderly multigravida O10.011 thru O16.9: Edema, proteinuria and hypertensive disorders O20.0 thru O21.9 and O23.00 thru 029.93: Other maternal disorders O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity O60.00 thru O60.03: Preterm labor without delivery O98.011 thru O98.919: Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse Z33.2: Encounter for elective termination of pregnancy Z36.0 thru Z36.9: Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76802, 76810, 76812	O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9: Spontaneous abortion O04.5 thru O04.89: Complications following (induced) termination of pregnancy O09.511 thru O09.513: Elderly primigravida O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity O60.00 thru O60.03: Preterm labor without delivery O98.011 thru O98.919: Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse Z33.2: Encounter for elective termination of pregnancy Z36.0 thru Z36.9: Encounter for antenatal screening of mother	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Provider must document the number of fetuses in the *Remarks* field (Box 80/*Additional Claim Information* field (Box 19) of the claim.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76813	Z36.82 Encounter for antenatal screening for nuchal translucency	One per day. Requires documentation with the claim that states: The physician performing or supervising the ultrasound is credentialed by either the Nuchal Translucency Quality Review program or the Fetal Medicine Foundation.
76814	Z36.82 Encounter for antenatal screening for nuchal translucency	Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. Requires documentation with the claim that states: The physician performing or supervising the ultrasound is credentialed by either the Nuchal Translucency Quality Review program or the Fetal Medicine Foundation.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76815	O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9: Spontaneous abortion O04.5 thru O04.89: Complications following (induced) termination of pregnancy O09.511 thru O09.513: Elderly primigravida O09.521 thru O09.523: Elderly multigravida O10.011 thru O16.9: Edema, proteinuria and hypertensive disorders O20.0 thru O21.9 and O23.00 thru O29.93: Other maternal disorders O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity O60.00 thru O60.03: Preterm labor without delivery O98.011 thru O98.919: Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse Z33.2: Encounter for elective termination of pregnancy Z36.0 thru Z36.9: Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76816	O00.0 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9 Spontaneous abortion O04.5 thru O04.89 Complications following (induced) termination of pregnancy O09.511 thru O09.513 Elderly primigravida O09.521 thru O09.523 Elderly multigravida O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders O20.0 thruO21.9 and O23.00 thru O29.93 Other maternal disorders O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity O60.00 thru O60.03 Preterm labor without delivery O98.011 thru O98.919 Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89 Other maternal disease classifiable elsewhere O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36.0 thru Z36.9 Encounter for antenatal screening of mother	Once in 180 days (when billed without modifier 59), same provider. Additional claims may be reimbursed if documentation justifies medical necessity. For multiple gestations, bill procedure code 76816 in conjunction with modifier 59 (any modifier position 1-4). Code 76816 thru 59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the Remarks field (Box 80)/*Additional Claim Information* field (Box 19) of claim.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76817	O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9: Spontaneous abortion O04.5 thru O04.89: Complications following (induced) termination of pregnancy O09.511 thru O09.513: Elderly primigravida O09.521 thru O09.523: Elderly multigravida O10.011 thru O16.9: Edema, proteinuria and hypertensive disorders O20.0 thru O21.9 and O23.00 thru O29.93: Other maternal disorders O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity O60.00 thru O60.03: Preterm labor without delivery O98.011 thru O98.919: Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89 : Other maternal disease classifiable elsewhere O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse Z33.2: Encounter for elective termination of pregnancy Z36.0 thru Z36.9: Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76820	O36.5110 thru O36.5999: Maternal care for known or suspected poor fetal growth O41.00X0 thru O41.03X9: Oligohydramnios O43.021 thru O43.029: Fetus-to-fetus placental transfusion syndrome	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76821	O36.0110 thru O36.0999: Maternal care for rhesus isoimmunization O36.1110 thru O36.1999: Care for other isoimmunization O36.20X0 thru O36.23X9: Maternal care for hydrops fetalis O43.021 thru O43.029: Fetus-to-fetus placental transfusion syndrome O98.511 thru O98.519: Other viral diseases complicating pregnancy	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76825, 76827	O24.011 thru O24.02, O24.111 thru O24.12, O24.311 thru O24.32, O24.410 thru O24.429, O24.811 thru O24.82, O24.911 thru O24.919: Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 thru O35.9XX9: Maternal care for known or suspected fetal abnormality and damage O36.8310 thru O36.8399: Maternal care for abnormalities of the fetal heart rate or rhythm	Once in 180 days, same provider. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76826, 76828	O24.011 thru O24.02, O24.111 thru O24.12, O24.311 thru O24.32, O24.410 thru O24.429, O24.811 thru O24.82, O24.911 thru O24.919: Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 thru O35.9XX9: Maternal care for known or suspected fetal abnormality and damage O36.8310 thru O36.8399: Maternal care for abnormalities of the fetal heart rate or rhythm	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Ultrasound Common Billing Denial

Remittance Advice Details (RAD) code 9109: This service is not payable for the diagnosis billed.

Billing Tip: Verify the diagnosis code is valid for the procedure being billed.

Note: See the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary* (remit) section of the Part 1 provider manual. Select the link at the bottom of the page *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*.

Per-Visit Billing Antepartum Office Visit and Ultrasound

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **LINE 1: CNM MARTHA LOWE 1234567890**
LINE 2: SEE ATTACH. FOR ULTRASOUND JUSTIF.

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. C. D.
E. F. G. H.
I. J. K. L.

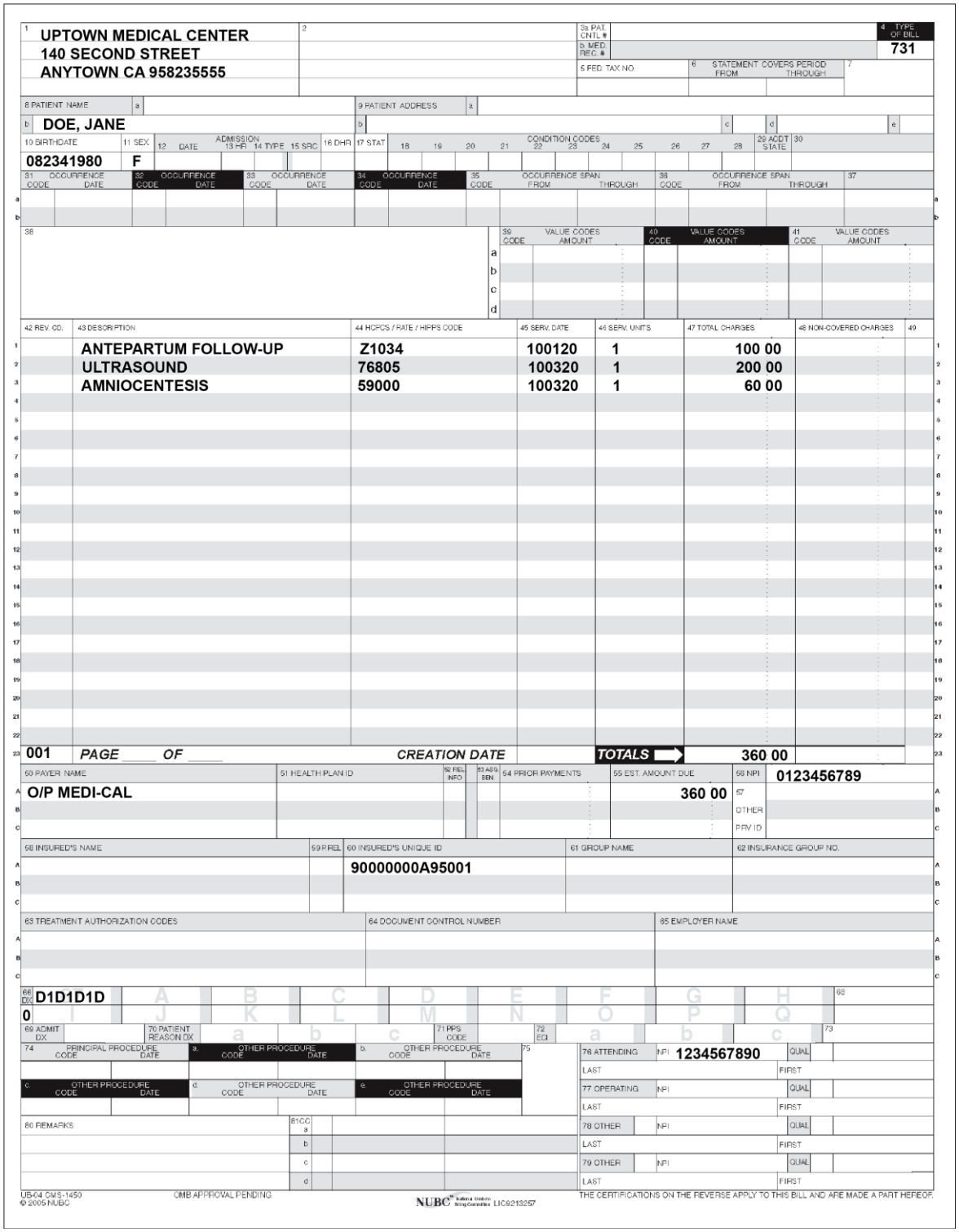
22. RESUBMISSION CODE ORIGINAL REF. NO.

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	20				11		Z1034	SB		100 00	1		NPI	
10	04	20				11		76805			200 00	1		NPI	
														NPI	
														NPI	

Sample: *CMS-1500* claim form. Antepartum visit rendered by a Nurse Midwife (SB). Please adapt to your billing situation.

Per-Visit Billing Antepartum Office Visit, Ultrasound and Amniocentesis



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 731

8 PATIENT NAME: DOE, JANE
10 BIRTHDATE: 082341980
11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	ANTEPARTUM FOLLOW-UP	Z1034	100120	1	100 00	
	ULTRASOUND	76805	100320	1	200 00	
	AMNIOCENTESIS	59000	100320	1	60 00	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	360 00	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 360 00
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI: 1234567890

Sample: ***UB-04*** claim form. Per-visit billing of antepartum visit, ultrasound, and amniocentesis. Please adapt to your billing situation.

Obstetrical Ancillary Services

Routine Urinalysis

Reimbursement for individual antepartum visits and global OB service includes routine urinalysis. Claims for routine urinalysis with a diagnosis related to pregnancy will be denied.

Claims for urinalysis, when billed with an ICD-10-CM diagnosis code for pregnancy, may be reimbursed if billed in conjunction with another diagnosis code other than Z00.00, Z00.8, Z01.00 thru Z01.01, Z01.10, Z01.110, Z01.118, Z01.89, Z02.1 or Z02.89. A pregnancy diagnosis code must be present on the claim form for reimbursement. A diagnosis code that establishes medical necessity of the urinalysis must also be present on the claim form to allow reimbursement, as outlined above.

Office Visits

Office visits for conditions not related to pregnancy must be billed using the appropriate office visit code (CPT codes 99202 thru 99215 or 99417) and a non-pregnancy-related diagnosis.

Non-Physician Medical Practitioners Supervision Changes

Refer to the *Non-Physician Medical Practitioners* section (non ph) in the appropriate Part 2 provider manual.

To comply with new legislative requirements, the Department of Health Care Services (DHCS) is making the following supervision changes for non-physician medical practitioners (NMPs):

- Supervision requirements are no longer required for Certified Nurse Midwives (CNM) and Licensed Midwives (LM).
- Nurse Practitioners (NPs) are confirmed to practice to the full extent of their education and training and authorities two newly created types of NPs
- Physician Assistant (PA) are authorized to perform medical services authorized by the Act if certain requirements are met, including that the medical services are rendered pursuant to a practice agreement, and the PA is competent to perform medical services.

Fetal Stress, Non-Stress Testing

Fetal Non-Stress Testing Benefit Guidelines

Reimbursement for CPT codes 59025 (fetal contraction stress test), 59025 (fetal non-stress test) and 76819 (fetal biophysical profile; without non-stress testing) is limited to high-risk pregnancies.

Billing

CPT code 59025 or 76819 is reimbursable when billed in conjunction with the appropriate antepartum high-risk ICD-10-CM diagnosis code within the range of O09.211 thru O9A.513.

Frequency Limit and ICD-10-CM Codes

Reimbursement for CPT code 76819 is limited to once per week. This code may be billed more than five times in nine months, and CPT code 59025 may be billed more than ten times in nine months when billed in conjunction with one of the ICD-10 diagnosis codes in the following table:

ICD-10-CM Diagnosis	Description
O09.212 – O09.293	Pregnancy with other poor reproductive history
O09.892, O09.893	Supervision of other high-risk pregnancy
O24.011 – O24.919	Diabetes mellitus of pregnancy
O36.5120 – O36.5939	Maternal care known or suspected poor fetal growth
O036.8920 – O36.8999	Maternal care for other specified fetal problems
O42.112, O42.113	Preterm premature rupture of membranes

Supplies used during fetal stress or non-stress testing are not separately reimbursable because they are considered an integral part of reimbursement rate for the procedure. Claims billed with modifier UA or UB will be denied.

CPT codes 59020, 59025 and 76819 may be split billed with modifier 26 or TC. When billing for both the professional and technical components, a modifier is not required nor allowed. These codes may not be billed with modifier 51 (multiple procedures).

Pregnancy Share of Cost (SOC)

Refer to the *Pregnancy: Share of Cost* section (preg share) in the appropriate Part 2 provider manual.

Global Billing

Providers who bill on a global basis for obstetrical services must plan to make arrangements with the patient to collect or obligate the SOC for the month of delivery only.

- However, arrangements must also be made to collect or obligate the SOC for the initial antepartum office visit (HCPCS code Z1032) and for non-global OB services (for example, sonogram or amniocentesis).
- When the intent to bill globally is prevented because the patient moves or leaves care, providers must bill on a fee-for-services basis and collect SOC for each month of service.

Per-Visit Billing

Providers who bill on a fee-for-service basis for obstetrical care, must collect the SOC for each month in which services were rendered.

SOC Common Billing Denial

Remittance Advice Details (RAD) code 0314: Recipient is not eligible for the month of service billed.

Billing Tip: Verify the recipient has a Share of Cost (SOC) and is eligible for the month of service.

Early Care and Diagnostic Services

Fetal Fibronectin Testing

Fetal fibronectin assay tests identify a subgroup of pregnant women who may require aggressive treatment with tocolytics, antibiotics, corticosteroids and other treatment measures to prevent pre-term delivery or to minimize complications during delivery. These tests are only recommended once every two weeks between the 24th and 35th weeks of gestation.

Fetal fibronectin testing is reimbursable when billed with the following:

- CPT code 82731 (fetal fibronectin, cervicovaginal secretions, semi-quantitative)
- ICD-10-CM diagnosis codes O60.02 and O60.03 (premature labor after 22 weeks, but before 37 completed weeks of gestation without delivery)

Preventing Preterm Births

Hydroxyprogesterone caproate injections are administered to prolong pregnancy for pregnant patients with documented histories of spontaneous preterm births (less than 37 weeks gestation) and a current singleton pregnancy. Both HCPCS codes J1726 10 mg and J1729 250 mg injections are limited to one injection every seven days between 16 and 36 weeks of gestation.

Claims must include ICD-10 diagnosis code from the range of O09.211 thru O09.219 (supervision of pregnancy with history of pre-term labor). Modifiers SA and UD are allowed. Modifier UD is used by Section 340B providers to denote drugs purchased under this program.

Refer to the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for more information.

Obstetric Panel Frequency Restriction

CPT codes 80055 (obstetric panel) and 80081 (obstetrical panel [includes HIV testing]) are restricted to once in nine months for the same provider.

Providers may only be reimbursed for either code 80055 **or** 80081 in a nine-month period. The provider may be reimbursed for second or subsequent obstetric panel within the nine-month period if there is documentation to justify medical necessity or documentation of a different pregnancy.

Gender Is Not Barrier to Pregnancy Services

All persons, regardless of gender identity, may request eligibility for pregnancy services when applying for Medi-Cal or other health insurance affordability programs.

A doctor must submit a *Treatment Authorization Request* (TAR) explaining that the services requested are medically necessary. The TAR overrides gender differences on procedure codes and allows a person with a gender other than female who is reporting a pregnancy to receive pregnancy services.

Notes:

Knowledge Review 2

1. Providers have the option when billing globally to choose either the UB-04 or CMS-1500 claim form to bill for services.

   True □ False □

2. When billing for per-visit services, eligibility should be verified each time services are rendered.

   True □ False □

3. For Depression Screening services, providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum.

   True □ False □

4. Ultrasounds performed for routine screening during pregnancy are considered an integral part of patient care, and its reimbursement is included in the obstetrical fee.

   True □ False □

5. Supplies used during fetal stress or non-stress testing can be billed separately.

   True □ False □

See the Appendix for the Answer Key.

Tobacco Cessation Counseling

Providers must offer one face-to-face smoking/tobacco cessation counseling session and a referral to tobacco cessation quit line to pregnant and postpartum recipients.

Counseling and referral services must be offered without cost sharing. These services are required during the prenatal and postpartum period (the end of the month in which the 60-day period following termination of the pregnancy ends).

Commonly Used Modifiers

Modifier	Description
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
59	Distinct procedural service (use only with CPT-4 code 76816, transabdominal ultrasound)
80	Assistant surgeon
99	Multiple modifiers
AG	Primary physician
AS	Certified nurse midwives may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by licensed physician or surgeon.
FP	Family planning services
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Certified nurse midwife service (when not billing as an independent provider)
TC	Technical component
TH	Obstetrical treatment/services, prenatal or postpartum
U7	Services rendered by Physician Assistant (PA)

Resource Information

References

Provider Manual References

Part 1
Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit) and Select Link: *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*.

Part 2
Modifiers: Approved List (modif app)
Non-Physician Medi-Cal Practitioners (non-ph)
Pregnancy Determination (preg determ)
Pregnancy: Early Care and Diagnostic Services (preg early)
Pregnancy Examples: CMS-1500 (preg ex cms)
Pregnancy Examples: UB-04 (preg ex ub)
Pregnancy: Fetal Monitoring, Labor and Delivery Services (preg fetal)
Pregnancy: Global Billing (preg glo)
Pregnancy: Global Billing Codes (preg glo cd)
Pregnancy: Per-Visit Billing (preg per*)*
Pregnancy: Per-Visit Billing Codes (preg per cd)
Pregnancy: Postpartum and Newborn Referral Services (preg post)
Pregnancy: Share of Cost (preg share)
Remittance Advice Details (RAD) (remit adv)

Knowledge Review 1: Answer Key

Question 1: Office visits (E&M) codes are payable with a pregnancy-related diagnosis code.

Answer 1: False

Question 2: Pregnancy verification is not required for patient's applying for the Minor Consent Program.

Answer 2: True

Question 3: Consultants who co-manage a pregnancy can bill for HCPCS Z1032 without complete transfer of care.

Answer 3: False

Question 4: More than 13 antepartum visits are allowed in 9 months if there is documentation of a second pregnancy.

Answer 4: True

Question 5: Postpartum visits (HCPCS code Z1038) can be billed by the primary maternity care provider or the provider who saw the patient for only the postpartum office visit.

Answer 5: True

Knowledge Review 2: Answer Key

Question 1: Providers have the option when billing globally to choose either the UB-04 or CMS-1500 claim form to bill for services.

Answer 1: False

Question 2: When billing for per-visit services, eligibility should be verified each time services are rendered.

Answer 2: True

Question 3: Depression Screening services, providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum.

Answer 3: True

Question 4: Ultrasounds performed for routine screening during pregnancy are considered an integral part of patient care, and its reimbursement is included in the obstetrical fee.

Answer 4: True

Question 5: Supplies used during fetal stress or non-stress testing can be billed separately.

Answer 5: False

Comprehensive Perinatal Services Program

Introduction

Purpose

The Comprehensive Perinatal Services Program (CPSP) is a benefit of the Medi-Cal program. This module will familiarize participants with the wide range of services available to pregnant Medi-Cal recipients enrolled in CPSP from pregnancy through 60 days after the month of delivery. Recipient and provider participation is voluntary.

Module Objectives

- Determine who can offer CPSP services
- Identify CPSP reimbursement bonuses
- Recognize CPSP services and billing codes
- Demonstrate claim forms billing requirements
- Clarify the *Treatment Authorization Request* (TAR) process
- Review the CPSP summary billing form
- Provide the link for a current listing of Perinatal Services Coordinators (PSCs)

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Description

The CPSP provides a wide range of services to pregnant women, from pregnancy through 60 days after the month of delivery. Medi-Cal fee-for-service providers may apply to enroll as a CPSP provider. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education. This approach has shown a reduction in both low-birth weight prevalence and health care costs for women and infants.

Notes:

CPSP Provider Participation

Eligibility

A CPSP provider must be in one of the categories listed below:

- Physician in general practice, family practice, obstetrics (OB)/gynecology, or pediatrics
- Group medical practice, if at least one member is one of the physician types identified above
- Certified Nurse Midwife (CNM)
- Clinic (FQHC, hospital, community or county)
- Alternative Birthing Center

Participation Requirements

Providers must meet the following prerequisites:

- Possess a current provider number/National Provider Identifier (NPI).
- Complete an application to participate as a CPSP provider.

Suggested provider and/or staff:

- Complete the “Provider Overview” and “Steps to Take” training courses.

Note: Refer to the CPSP website (*www.cdph.ca.gov/programs/cpsp*) for information about training for new CPSP providers and new staff of existing CPSP providers.

Notes:

_____

_____

_____

_____

_____

_____

_____

Enrollment Process

To receive information regarding CPSP services, providers should contact their local PSC at the local health jurisdiction (county health department). Refer to the CPSP website (*www.cdph.ca.gov/programs/cpsp*) for more information.

CPSP Administration

Perinatal Services Coordinator (PSC)

CPSP services are rendered by enrolled fee-for-service providers and Medi-Cal managed care providers. PSCs play a major role in administrating CPSP within their local health jurisdictions (LHJs). PSCs are employed by 61 LHJs and perform the following:

- Inform potential providers regarding the CPSP program and provider training
- Distribute, review and make recommendations to complete CPSP provider applications
- Make recommendations to the California Department of Public Health, Maternal Children and Adolescent Health Division regarding provider enrollment approval
- Conduct outreach services to eligible women regarding CPSP
- Provide technical assistance regarding CPSP implementation to providers
- Monitor the implementation of CPSP through quality assurance activities

Update to CPSP Practitioner Definition

The definition of a Comprehensive Perinatal Services Program (CPSP) practitioner has been updated. It is now defined in *Welfare and Institutions Code* (W&I Code), Section 14134.5 and *California Code of Regulations* (CCR), Title 22, Section 51179.7.

W&I Code Section 14134.5 states a comprehensive perinatal provider means any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above named providers, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section. Section 14134.5 also states that, except where existing law prohibits the employment of physicians, a health care provider may employ or contract with all of the following medical and other practitioners for the purpose of providing comprehensive services delineated in this section;

- Physicians, including a general practitioner, a family practice physician, a pediatrician, or an obstetrician-gynecologist
- Certified nurse-midwives
- Licensed midwives
- Nurses
- Nurse practitioners
- Physician assistants
- Social workers
- Health and childbirth educators
- Registered dietitians

CCR, Title 22, Section 51179.7 states a comprehensive perinatal practitioner means any one of the following:

- A physician who is either:
  - A general practice physician, or
  - A family practice physician, or
  - A pediatrician, or
  - An obstetrician-gynecologist.
- A Certified Nurse Midwife as defined in Section 51170.2.
- A Registered Nurse who is licensed as such by the Board of Registered Nursing and who has one year experience in the field of Maternal and Child Health.
- A Nurse Practitioner as defined in Section 51170.3.
- A Physician's Assistant as defined in Section 51170.1.
- A social worker who either:
  - Holds a Master's Degree or higher in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year of experience in the field of Maternal and Child Health, or
  - Holds a Master's Degree in psychology or Marriage, Family and Child counseling and has one year of experience in the field of Maternal and Child Health, or
  - Holds a Baccalaureate Degree in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year experience in the field of Maternal and Child Health.
- A health educator who either has:
  - A Master's Degree (or higher) in Community or Public Health Education from a program accredited by the Council on Education for Public Health and who has one year of experience in the field of Maternal and Child Health, or
  - A Baccalaureate Degree with a major in Community or Public Health Education and who has one year of experience in the field of Maternal and Child Health.

- A childbirth educator who is:
  - Licensed as a Registered Nurse by the Board of Registered Nursing and has one year experience in a program which complies with the “Guidelines for Childbirth Education” (last published in 1981), herein incorporated by reference in its entirety and available from the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, South West, Suite 300 East, Washington, D.C., 20024-2588 or
  - A Certified Childbirth Educator who has completed a training program and is currently certified to teach that method of childbirth education by the American Society for Psychoprophylaxis in Obstetrics, or Bradley, or the International Childbirth Education Association.
- A dietitian who is registered, or is eligible to be registered by the Commission on Dietetic Registration, the credentialing agency of the American Dietetic Association, with one year of experience in the field of perinatal nutrition.
- A comprehensive perinatal health worker who:
  - Is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of full-time paid practical experience in providing perinatal care.
  - Provides services in a clinic that is either licensed or exempt from licensure under Section 1200 et. seq. and 1250 et seq. of the Health and Safety Code, under the direct supervision of a comprehensive perinatal practitioner as defined in Section 51179.7 (a) (1).
- A licensed vocational nurse who is licensed under Section 2516 of the Business and Professions Code and who has one year of experience in the field of Maternal and Child Health.
- A licensed midwife as defined in Section 51191.

Case Coordinator

The case coordinator must be a trained CPSP practitioner who can ensure that the client receives optimal prenatal care by promoting ongoing communication with all of the health care team members. Case coordination includes the following:

- Coordination and development of an Individualized Care Plan (ICP) for the client
- Modification of care plan as needed
- Assisting the client with practical arrangements such as transportation, referrals and special appointments when necessary

Verifying all of the client’s documentation in the chart is complete, up-to-date and available to all team members

CPSP Policies

Supervision Requirements for CPSP Services Delivery

CPSP services must be provided by or under the personal supervision of a physician. The CCR, Title 22, Section 51179.5, defines personal supervision as “evaluation in accordance with protocols, by a licensed physician, of services performed by others through direct communication, either in person or through electronic means.”

Note: Each provider’s protocols must define how personal supervision by a physician occurs and is documented.

Tobacco Cessation Counseling for Pregnant and Postpartum Women

Providers must offer one, face-to-face smoking/tobacco cessation counseling session and a referral to a tobacco cessation quitline to pregnant and postpartum recipients, as recommended in *Treating Tobacco Use and Dependence: 2008 Update*, a U.S. Public Health Service Clinical Practice Guideline.

Such counseling and referral services must be provided to pregnant and postpartum recipients without cost sharing. These services are required during the prenatal period through the postpartum period (on the last day of the month in which the 60th day following delivery occurs).

General Guidelines

The following policies apply to CPSP:

- CPSP services are not intended to be provided to inpatients.
- CPSP services are in addition to, not a replacement for, the services that are part of the American College of Obstetrics and Gynecology (ACOG) visit standards.
- Only the Medi-Cal provider enrolled in CPSP may bill for services.
- Reimbursement is made directly to the CPSP provider only.
- Reimbursement for nutritional, psychosocial and health education services is made on an itemized basis (per visit) and must not be billed globally.
- An approved TAR is required to bill for nutritional, psychosocial and health education services in excess of the maximum units of service allowable.
- Medi-Cal may recoup payment if a recipient's records lack documentation to establish that services were provided as billed.
- CPSP participation is voluntary for the recipient and the provider.

Reimbursement of Services

Only Medi-Cal providers enrolled in CPSP can be reimbursed for the following CPSP services:

- Nutritional, psychosocial and health education services
- Vitamin and mineral supplements
- Client orientation
- Case coordination

Program Benefits Comparison (Obstetrics Services vs. CPSP Services)

Obstetrical Services Maximum Allowable Reimbursement Table

Obstetrical Services Rendered	Maximum Allowable Reimbursement
Z1032 (initial comprehensive antepartum office visit)	$126.31
Z1034 (antepartum office visit) – $60.48 per visit x 13 visits	$786.24
59409 (vaginal delivery)	$544.28
Z1038 (postpartum office visit)	$60.48
Allowable Reimbursement:	$1,517.31

CPSP Reimbursement Bonus Services Maximum Allowable Reimbursement Table

CPSP Reimbursement Bonus Services Rendered	Maximum Allowable Reimbursement
Early entry into care “ZL” Modifier (within 16 weeks of LMP)	$56.63
Total Available Bonuses:	$56.63

CPSP Support Services Rendered Maximum Allowable Reimbursement Table

CPSP Support Services Rendered	Maximum Allowable Reimbursement
Initial support services: Z6200, Z6300, Z6402 ($16.83 each x 3)	$50.49
Individual support services: $33.64 per hour (up to 21.5 hours)	$723.26
Group classes: $11.24 per patient per hour (up to 27 hours)	$303.48
Coordination fee: $85.34	$85.34
Vitamin/mineral supplements: 30-day supply. Restricted to 10 in 9 months.	$30.00
Allowable Reimbursement:	$1,192.57

Note: Maximum reimbursement for routine OB and CPSP services (before TAR) = $2,766.51

Note: The coordination fee is only reimbursable if all three initial assessments and the initial pregnancy-related office visit are provided within four weeks of entry into care.

Note: Maximum allowable reimbursement without authorization if all support services are provided and billed. In high-risk circumstances, additional support services may be requested through the TAR process.

CPSP Billing

Reimbursement Bonus Services

Modifier ZL (Early entry into care)

1. Modifier ZL must be billed with HCPCS code Z1032 and certifies that the recipient was seen within 16 weeks of her Last Menstrual Period (LMP).
   True ☐ False ☐
2. Enter the LMP date in _____ on the *CMS-1500* claim form or in _____ _____ on the *UB-04* claim form.
3. To be reimbursed for modifier ZL, providers must add $56.63 to their usual and customary fee for Z1032.
   True ☐ False ☐
4. Modifier ZL is restricted to CPSP providers and will only be reimbursed _____ per recipient, per pregnancy.

See the Appendix for the Answer Key

Billing Example: Reimbursement Bonuses (Modifier ZL)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 15 18 QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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. 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. #
1	10	01	18			11		Z1032	ZL		18294	1		NPI	
2														NPI	
3														NPI	
4														NPI	

OR SUPPLIER INFORMATION

Sample: *CMS-1500* claim form

Non-Physician Medical Practitioners

Non-Physician Medical Practitioners are identified with specific modifiers:

Practitioner	Modifier	Multiple Modifier
Physician assistant	U7	99
Nurse Practitioner	SA	99
Certified Nurse Midwife	SB	99

When billing Z1032 and the bonus modifier ZL, use the modifier 99 (multiple modifiers) for non-medical practitioners.

Example:

99 = U7 + ZL – Physician Assistant

99 = SA + ZL – Nurse Practitioner

99 = SB + ZL – Certified Nurse Midwife

Billing Example: Non-Physician Medical Practitioner (Modifier 99)

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 731

8 PATIENT NAME: DOE, JANE
10 BIRTHDATE: 08241980
11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	INITIAL OFFICE VISIT	Z103299	100118	1	18294	
	COMBINED ASSESSMENTS	Z6500	100118	1	13583	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	31877	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 31877
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI: 1234567890

80 REMARKS
SUE SMITH, NP. NPI: 0123456789.
LINE 1: LMP 010118. 99 = SA + ZL.
LINE 2: PSYCHOLOGICAL ASSESSMENT 100118.
HEALTH ASSESSMENT 100118.
NUTRITION ASSESSMENT 101118.

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: *UB-04* Claim Form

Combined Assessment Billing (HCPCS Code Z6500)

1. This code can only be billed if all _____ initial assessments and the initial pregnancy-related office visit code _____ are rendered within a _____-_____ _____.
2. The date of the last assessment must be shown as the date of service.
   True ☐ False ☐
3. Z6500 is reimbursable once in ____ _____ unless the provider certifies on the claim that the recipient has become pregnant again within the _____-_____ period.
4. If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, you must bill the initial assessments separately.
   True ☐ False ☐

See the Appendix for the Answer Key

Billing Example: Combined Assessments (HCPCS Code Z6500)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **NUTRITION, HEALTH EDUCATION AND PSYCHOSOCIAL ASSESSMENTS PROVIDED ON 101418**

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. 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. #
1	10	01	18				11		Z1032	ZL		18294	1		NPI	
2	10	14	18				11		Z6500			13583	1		NPI	
3															NPI	
4															NPI	

33. BILLING PROVIDER INFO & PH # | PIN# | GRP# | NPI

Sample: *CMS-1500* Claim Form

Individual Assessment Billing (Z6200, Z6300 and/or Z6402)

1. If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, the provider must bill for the actual assessments performed using the individual assessment codes.

   True □ False □

Sequence of Services

The sequence for providing the initial assessments (nutrition, health education and psychosocial) and the initial pregnancy-related office visit code (Z1032) may be rendered in _____ _____ and at ____ _____ during the patient's care.

Intervention Services

The provider must complete the initial assessment within the discipline area (nutrition, health education or psychosocial) _____ rendering any intervention services within that discipline.

Exception: Client orientation (Z6400) and/or group perinatal education (Z6412) may be rendered before the initial health education assessment is completed.

See the Appendix for the Answer Key

Breastfeeding-Related Services

Nutrition, psychosocial and health education counseling services related to breastfeeding are reimbursable using the following codes:

- Nutrition services: HCPCS codes Z6200 thru Z6208
- Psychosocial services: HCPCS codes Z6300 thru Z6308
- Health education services: HCPCS codes Z6400 thru Z6414

Reimbursable conditions include, but are not limited to, the following:

- Breastfeeding education following the CPSP “Steps to Take” guidelines
- Persistent discomfort to the woman while breastfeeding
- Infant weight-gain concerns
- Milk extraction
- Suck dysfunction of the infant

Billing Tip: When billing these services to CPSP, the appropriate HCPCS code should be entered in the *Procedures, Services or Supplies* field (Box 24D) of the *CMS-1500* claim form or the *HCPCS/Rate* field (Box 44) of the *UB-04* claim form.

Treatment Authorization Requests (TAR)

Additional CPSP Services

Providers may submit TARs for nutrition, psychosocial or health education services in excess of the basic allowances if the provider documents that additional services are medically necessary.

TARs for additional services must be completely filled out and include the following information:

- Amount of time/number of services being requested
- Anticipated benefit or outcome of additional services
- Clinical findings of the high-risk factors involved in the pregnancy
- Description of the services being requested
- Expected Date of Delivery (EDD)
- Explanation of why the basic CPSP services will not be sufficient

TAR Example for Reimbursement of Excess Services

STATE USE ONLY

SERVICE CATEGORY

5

TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TYPEWRITER ALIGNMENT Elite Pica

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO.

2 TYPE OF SERVICE REQUESTED: DRUG [ ] OTHER [X]

REQUEST IS RETROACTIVE? YES [ ] NO [X]

IS PATIENT MEDI-CAL ELIGIBLE? YES [ ] NO [X]

PROVIDER PHONE NO. (916) 555-5555

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS
- MARY BROWN
- 1456 MAIN STREET
- ANYTOWN CA 958235555

3. PROVIDER NUMBER XYZ123456

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)
4 DOE, JANE

MEDI-CAL IDENTIFICATION NO.
5 90000000A95001 6

SEX 7 F AGE 35 DATE OF BIRTH 8 052180

STREET ADDRESS 1234 MAIN STREET

CITY, STATE, ZIP CODE ANYTOWN CA 98523

PHONE NUMBER AREA (916) 555-5555

PATIENT STATUS: [X] HOME [ ] BOARD & CARE [ ] SNF / ICF [ ] ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION: DIABETES MELLITUS IN PREGNANCY

ICD-9-CM DIAGNOSIS CODE D1D1D1

MEDICAL JUSTIFICATION:
35-YEAR-OLD GRAV IV, PARA III, EDC 10-2-18 WITH HISTORY OF GESTATIONAL DIABETES. HAS MAINTAINED MARGINAL LEVELS OF ACCEPTABLE BLOOD SUGAR THROUGHOUT PREGNANCY. NEEDS ONE HOUR VISITS WEEKLY OF NUTRITIONAL FOLLOW-UP FOR REMAINDER OF PREGNANCY TO ASSURE ADEQUATE DIET, CONTROLLED BLOOD. ADDITIONAL SERVICES WILL PROVIDE NECESSARY SUPPORT SO PREGNANCY OUTCOME IS OPTIMIZED.

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:
1 [X] APPROVED AS REQUESTED [ ] DENIED [ ] DEFERRED
2 [ ] APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) [ ] JACKSON VS RANK PARAGRAPH CODE

BY Sue Smith
MEDI-CAL CONSULTANT I.D. # 34 67 DATE 35 10 08 18 REVIEW COMMENTS INDICATOR 44

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)
36 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

LINE NO.	AUTHORIZED Y / N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9 Y	10 32	FOLLOW-UP ANTEPARTUM NUTRITIONAL INTERVENTION	32	11 Z6204	12 32	$ 26912
2	13	14			15	16	$
3	17	18			19	20	$
4	21	22			23	24	$
5	25	26			27	28	$
6	29	30			31	32	$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

Mary Brown — SIGNATURE OF PHYSICIAN OR PROVIDER | MD — TITLE | 100618 — DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED
37 FROM DATE 06 07 18 38 TO DATE 10 02 18

TAR CONTROL NUMBER
39 OFFICE 01 SEQUENCE NUMBER 23456789 PI 1

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY 50-1 03/07

Sample: *Treatment Authorization Request* Form

TARs for FQHCs, RHCs and IHS/MOAs

TARs are not required for FQHCs, RHCs and IHS/MOAs. Claims for CPSP services provided that exceed the basic allowances will not be denied for the absence of a TAR. However, FQHCs, RHCs and IHS/MOAs must meet the same documentation requirements that would otherwise be necessary to obtain a TAR. This information must be maintained in the client's medical record and be available for review by the Department of Health Care Services (DHCS). Required documentation should include:

- EDD
- Clinical findings of the high-risk factors
- Explanation as to why the basic CPSP services are not sufficient
- Description of services being requested
- Anticipated benefit or outcome for the additional services, etc.

Share of Cost (SOC)

Recipients who choose to participate in the CPSP program and receive CPSP services are required to _____ or _____ their SOC _____ _____ even if the obstetrical services are billed globally.

See the Appendix for the Answer Key

CPSP Support Services

Calculating Billing Units

- CPSP support services are billed in units. One unit equals ____ _____.
- Fractions of units are calculated as shown below:
  - 00 thru 07 minutes equals 0 units, not billable
  - 08 thru 22 minutes equals 1 unit
  - 23 thru 37 minutes equals 2 units
  - 38 thru 51 minutes equals 3 units, etc.
- Exceptions: Z6200, Z6300 and Z6402 are billed in 30-minute units.

CPSP Billing Codes

Initial assessments must be rendered prior to billing any follow-up assessments.

CPSP Billing Codes Table

Service	HCPCS Code	Description	Maximum Units of Service
Office Visits	Z1032 ZL	Initial comprehensive pregnancy-related office visit performed within 16 weeks of LMP	1
Initial Comprehensive Services	Z6500	Initial comprehensive nutrition, psychosocial and health education assessments and development of care plan; first 30 minutes each assessment (total 90 minutes), (includes ongoing coordination of care); the three assessments must be completed within four weeks of the “initial visit” (either the pregnancy-related visit or any one of the three initial assessments)	1
Nutrition Services	Z6200	Initial nutrition assessment and development of care plan; first 30 minutes	1
Nutrition Services	Z6202	Each subsequent 15 minutes (max. 1½ hours)	6
Nutrition Services	Z6204	Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (max. 2 hours)	8
Nutrition Services	Z6206	Group, per patient, each 15 minutes (max. of 3 hours)	12
Nutrition Services	Z6208	Postpartum nutritional assessment, treatment and/or intervention, including development of care plan, individual, each 15 minutes (max. 1 hour)	4
Nutrition Services	S0197	Prenatal vitamin-mineral supplement, 30-day supply. Restricted to 10 in 9 months.	10

CPSP Billing Codes Table (continued)

Service	HCPCS Code	Description	Maximum Units of Service
Comprehensive Psychosocial Services	Z6300	Initial psychosocial assessment and development of care plan; first 30 minutes	1
Comprehensive Psychosocial Services	Z6302	Each subsequent 15 minutes (max. 1½ hours)	6
Comprehensive Psychosocial Services	Z6304	Follow-up antepartum psychosocial assessment, treatment, and/or intervention; individual, each 15 minutes (max. 3 hours)	12
Comprehensive Psychosocial Services	Z6306	Follow-up antepartum psychosocial assessment, treatment and/or intervention, group, per patient, each 15 minutes (max. 4 hours)	16
Comprehensive Psychosocial Services	Z6308	Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (max. 1½ hours)	6

CPSP Billing Codes Table (continued)

Service	HCPCS Code	Description	Maximum Units of Service
Comprehensive Health Education Services	Z6400	Client orientation (health education) each 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6402	Initial health education assessment and development of care plan, first 30 minutes	1
Comprehensive Health Education Services	Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6406	Follow-up antepartum health education assessment, treatment, and/or intervention, individual, each 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6408	Follow-up antepartum health education assessment, treatment, and/or intervention, group, per patient, each 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6410	Perinatal education, individual, each 15 minutes (max. 4 hours)	16
Comprehensive Health Education Services	Z6412	Perinatal education group per patient, each 15 minutes (max. 16 units per day) 72 units per pregnancy	16 per day
Comprehensive Health Education Services	Z6414	Postpartum health education assessment, treatment and/or intervention, including development of care plan, individual, each 15 minutes (max. 1 hour)	4

Notes:

Billing Code Summary

Patient Billing

Type of Billing – Physician Services	Billing Code	Number of Units Used (1 Unit = 15 Minutes) Initial and Date Each Unit Used per Visit
Obstetrical (# Visits)		
Initial Comprehensive Office Visit	**Z1032**	
Early Entry LMP Reimbursement Bonus	**ZL**	**Use with Z1032 only**
Antepartum Office Visit – 13 Visits	**Z1034**	1 2 3 4 5 6 7 8 9 10 11 12 13
Postpartum Office Visit	**Z1038**	
Prenatal Vitamins – 30 day supply, 10 in 9 months	**S0197**	1 2 3 4 5 6 7 8 9 10
CPSP Services		
Initial Comprehensive Assessment	**Z6500***	*** All 3 completed within**
1. Health Education – 30 min	*Date:*	**4 weeks of initial visit (Z1032)**
2. Nutrition – 30 min	*Date:*	
3. Psychosocial – 30 min	*Date:*	
Nutrition		
Initial Assessment – Individual 30 min	**Z6200**	**Don't use if Z6500 is billed**
Additional Initial Assessment – 1.5 hrs	**Z6202**	1 2 3 4 5 6
Follow-up Intervention/Reassessment – 2 hrs	**Z6204**	1 2 3 4 5 6 7 8
Follow-up Intervention – Group 3 hrs	**Z6206**	1 2 3 4 5 6 7 8 9 10 11 12
Postpartum – Individual 1 hr	**Z6208**	1 2 3 4
Psychosocial		
Initial Assessment – Individual 30 min	**Z6300**	**Don't use if Z6500 is billed**
Additional Initial Assessment – 1.5 hrs	**Z6302**	1 2 3 4 5 6
Follow-up Intervention/Reassessment – 3 hrs	**Z6304**	1 2 3 4 5 6 7 8 9 10 11 12
Follow-up Intervention – Group 4 hrs	**Z6306**	1 2 3 4 5 6 7 8 9 10 11 12
		13 14 15 16
Postpartum – Individual 1.5 hrs	**Z6308**	1 2 3 4 5 6
Health Education		
Client Orientation – Individual 2 hrs	**Z6400**	1 2 3 4 5 6 7 8
Initial Assessment – Individual 30 min	**Z6402**	**Don't use if Z6500 is billed**
Additional Initial Assessment – 2 hrs	**Z6404**	1 2 3 4 5 6 7 8
Follow-up Intervention/Reassessment – 2 hrs	**Z6406**	1 2 3 4 5 6 7 8
Follow-up Education Assessment /Intervention Group – 2 hrs	**Z6408**	1 2 3 4 5 6 7 8
Perinatal Education – Individual 4 hrs	**Z6410**	1 2 3 4 5 6 7 8 9 10 11 12
		13 14 15 16
Group Education – 18 hrs	**Z6412**	1 2 3 4 5 6 7 8 9 10 11 12
		13 14 15 16 17 18 19 20 21 22 23 24
		25 26 27 28 29 30 31 32 33 34 35 36
		37 38 39 40 41 42 43 44 45 46 47 48
		49 50 51 52 53 54 55 56 57 58 59 60
		61 62 63 64 65 66 67 68 69 70 71 72
Postpartum – Individual 1 hr	**Z6414**	1 2 3 4

FQHC/RHC/IHS-MOA Billing Code Summary

RHC/FQHC billing codes:

Straight Medi-Cal and Emergency/Pregnancy only – Revenue Code: **0521 and HCPCS Code T1015**

Medi-Cal Managed Care billing codes:

Revenue Code 0521 and HCPCS Code T1015 SE

IHS-MOA billing codes:

Straight Medi-Cal and Emergency/Pregnancy only – Revenue Code: **0520 and HCPCS Code T1015**

Note: IHS-MOA provider type does not bill for the managed care wrap as of August 2018

	Fee for Service Code	Billing Code	Number of Units Used (1 Unit = 15 Minutes) Please Initial and Date Each Unit Used per Visit											
Obstetrical Care														
Initial Antepartum	**Z1032**	**T1015**	1											
Antepartum – 13 visits	**Z1034**	**T1015**	1	2	3	4	5	6	7	8	9	10	11	12	13
Postpartum	**Z1038**	**T1015**	1											
NOTE: All provider types are restricted to Medi-Cal frequency limits for OB care (fee-for-service, FQHC, RHC, IHS)														
Nutrition														
Initial Assessment	**Z6200**	**T1015**		1	**30 minutes**									
Additional Assess – 1.5 hrs	**Z6202**	**T1015**	1	2	3	4	5	6						
Follow-Up (F/U) Intervention/Reassessment – Individual 2 hrs	**Z6204**	**T1015**	1	2	3	4	5	6	7	8				
F/U Intervention – Group 3 hrs	**Z6206**	**T1015**	1	2	3	4	5	6	7	8	9	10	11	12
Postpartum – Individual 1 hr	**Z6208**	**T1015**	1	2	3	4								
Psychosocial														
Initial Assessment	**Z6300**	**T1015**		1	**30 minutes**									
Additional Init Assess 1.5 hrs	**Z6302**	**T1015**	1	2	3	4	5	6						
F/U Intervention/Reassessment – Individual 3 hrs	**Z6304**	**T1015**	1	2	3	4	5	6	7	8	9	10	11	12
F/U Intervention – Group 4 hrs	**Z6306**	**T1015**	1	2	3	4	5	6	7	8	9	10	11	12
			13	14	15	16								
Postpartum – Individual 1.5 hrs	**Z6308**	**T1015**	1	2	3	4	5	6						
Health Education														
Client Orientation – Indiv. 2 hrs	**Z6400**	**T1015**	1	2	3	4	5	6	7	8				
Initial Assessment – Individual 30 min	**Z6402**	**T1015**		1	**30 minutes**									
Add'l Init Assessment – 2 hrs	**Z6404**	**T1015**	1	2	3	4	5	6	7	8				
F/U Intervention/Reassessment – Individual 2 hrs	**Z6406**	**T1015**	1	2	3	4	5	6	7	8				
F/U Ed Assess/Intervention – Group 2 hrs	**Z6408**	**T1015**	1	2	3	4	5	6	7	8				
Perinatal Education – Individual 4 hrs	**Z6410**	**T1015**	1	2	3	4	5	6	7	8	9	10	11	12
			13	14	15	16								
Group Education – 18 hrs	**Z6412**	**T1015**	1	2	3	4	5	6	7	8	9	10	11	12
			13	14	15	16	17	18	19	20	21	22	23	24
			25	26	27	28	29	30	31	32	33	34	35	36
			37	38	39	40	41	42	43	44	45	46	47	48
			49	50	51	52	53	54	55	56	57	58	59	60
			61	62	63	64	65	66	67	68	69	70	71	72
Postpartum – Individual 1 hr	**Z6414**	**T1015**	1	2	3	4								

Special Appendix

HIPAA-Compliant CPSP Billing Code Conversions

DHCS will discontinue the use of current Medi-Cal interim codes Z1032, Z6200, Z6202, Z6204, Z6206, Z6208, Z6210, Z6300, Z6302, Z6304, Z6308, Z6400, Z6402, Z6404, Z6408, Z6410, Z6412, Z6414 and Z6500 for CPSP services. These interim codes will be replaced by HIPAA-compliant codes and HCPCS code modifiers to comply with the provisions of HIPAA of 1996, Public Law 104-91, *Code of Federal Regulations*, Title 45, Part 162.1000. Watch for these code and effective date changes in the monthly Medi-Cal provider bulletins and *NewsFlash* articles.

Resource Information

References

The following reference materials provide Medi-Cal billing and policy information.

Provider Manual Reference

Part 2

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health)

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes (ind health cd)

Pregnancy: Comprehensive Perinatal Services Program (CPSP) (preg com)

Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – CMS-1500 (preg com exc)

Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – UB-04 (preg com exu)

Comprehensive Perinatal Services Programs (CPSP) List of Billing Codes (preg com lis)

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural)

Other References

CPSP website: (*www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/default*)

Note: For a list of CPSP Perinatal Services Coordinators (PSCs), click “Contact your Local Coordinator” under “Providers.”

Family Planning, Access, Care & Treatment (Family PACT) Program Eligibility

Introduction

Purpose

The purpose of this module is to provide participants with an overview of the administrative functions of the Family Planning, Access, Care and Treatment (Family PACT) Program.

Module Objectives

- Identify eligible Family PACT provider types
- Clarify Family PACT Program policies
- Review client eligibility criteria
- Explain the importance of the *Health Access Programs Family PACT Program Client Eligibility Certification* (CEC) form (DHCS 4461)
- Discuss the *Health Access Programs Family PACT Program Retroactive Eligibility Certification* (REC) form (DHCS 4001)
- Highlight Health Access Program (HAP) cards and activation options

Acronyms

A list of current acronyms is in the *Appendix* section of each complete workbook.

Family PACT Overview

The Family PACT Program is designed to assist individuals who 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 pregnancies and to allow clients to establish the number and spacing of their children, as well as maintain optimal reproductive health.

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

Provider Enrollment

Eligible providers are licensed/certified medical personnel with family planning skills, competency and knowledge who provide the full range of services covered by the program, as long as these services are within the provider's scope of licensure and practice. Clinical providers electing to participate in the Family PACT Program must be enrolled Medi-Cal providers in good standing. Eligible providers applying for enrollment must provide the scope of comprehensive family planning services, either directly or by referral, consistent with Family PACT Standards. In addition, providers agree to abide by program policies and administrative practices.

Notes:

Solo providers, group providers or primary care clinics are eligible to apply for enrollment in the Family PACT Program if they currently have a National Provider Identifier (NPI) and are enrolled in Medi-Cal in good standing. An Affiliate Primary Care Clinic's (APCC) enrollment in the Family PACT Program is dictated by *Welfare and Institutions Code* (W&I Code), Section 24005(t) (1) and (2). Intermittent clinics and mobile clinics must apply for enrollment in the Family PACT Program using their organization NPI. The organizational NPI must be enrolled in Medi-Cal in good standing.

Anesthesiologists, laboratories, pharmacies and radiologists who are enrolled as Medi-Cal providers are not required to enroll in the Family PACT Program.

Providers electing to enroll into the Family PACT Program must submit a completed *Family PACT Provider Application* (DHCS 4468) application to the Office of Family Planning. This is the first form in the application process. Providers will receive additional forms after approval of the DHCS 4468. The complete Family PACT program application packet contains the following forms:

- *Family PACT Provider Application* (DHCS 4468)
- *Family PACT Program Provider Agreement* (DHCS 4469)
- *Family PACT Program Practitioner Participation Agreement* (DHCS 4470)

The DHCS 4468 is available for download on the Family PACT website or the DHCS Forms, Laws & Publications web page.

Non-Physician Medical Practitioners (NMPs) employed by a Medi-Cal provider who are applying to enroll in the Family PACT Program and who will be delivering Family PACT services, must be identified on the DHCS 4468 form and complete a DHCS 4470 form. The DHCS 4470 is not required to be completed by an APCC, nonprofit community clinic or Primary Care Clinics (PCC), or Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics. All other provider types must submit the DHCS 4470 form including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). NMPs eligible to participate in the Family PACT Program include Nurse Practitioners (NPs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs). Registered Nurses (RNs) are not eligible to enroll.

All forms must be completed, signed and returned to the program before enrollment is approved.

Provisional Enrollment

Family PACT provider applicants, new provider locations and/or Family PACT provider applicants recertifying their enrollment, will be provisionally certified for enrollment in the Family PACT Program after the provider is enrolled in the Family PACT Program and until an eligible representative completes a legislatively mandated Provider Orientation as determined by DHCS. The Provider Orientation must be completed within six months of the date of initial Family PACT enrollment for the provisional certification to be lifted. Failure to complete the orientation within six months will result in disenrollment. A provider who has been previously disenrolled for this reason may re-enroll in the Family PACT Program but will not be granted provisional enrollment.

Each provider location is required to be certified for enrollment in the Family PACT Program. Each provider location must designate one eligible representative to be the site certifier. The site certifier cannot certify multiple sites. The Medical Director (MD), Certified Nurse Practitioner (CNP) or CNM responsible for overseeing the family planning services rendered at the location to be enrolled is eligible to certify the site.

The site certifier must complete all required Provider Orientation trainings as determined by DHCS. The site certifier must ensure that all clinical personnel rendering services on behalf of the Family PACT program have completed OFP required trainings.

Provider Orientation

Medi-Cal providers applying to become a Family PACT provider are required to attend a Provider Orientation per W&I Code, section 24005(k). The Provider Orientation training is delivered online and in person. The training includes information on comprehensive family planning, family planning-related services, program benefits and services, client eligibility, provider responsibilities and compliance.

New site certifiers and/or rendering providers administering the Family PACT Program must complete the Provider Orientation trainings within 60 days of hire.

Provider Orientation details and registration information is posted on the Family PACT Learning Management System (LMS) at www.ofpregistration.org or contact Family PACT at (916) 650-0414.

Please contact the OFP by phone at (916) 650-0414 or by email at ProviderServices@dhcs.ca.gov if you have any questions regarding the orientation process.

Provider Responsibility for Client Eligibility Determination

Through the Family PACT provider enrollment process, the Family PACT provider accepts the responsibility for appropriate onsite determination of eligible clients according to program guidelines and administrative practices. Only enrolled Family PACT Program providers may determine client eligibility and enroll Family PACT clients. Medi-Cal pharmacies and laboratories may not perform eligibility determination or enroll clients.

Automated Eligibility System Guidelines

Providers with automated systems for determining eligibility for multiple recipient programs must obtain approval from the Office of Family Planning (OFP) to ensure that all required information is obtained to verify eligibility for Family PACT, including confirmation that the client has been provided all of the information and notices that are included on the CEC form (DHCS 4461) and REC form (DHCS 4001) if applicable. Requests must be made on provider or clinic letterhead and must include the NPI, the service site address and the provider owner's signature. Mail to:

Department of Health Care Services
Office of Family Planning
MS 8400
P.O. Box 997413
Sacramento, CA 95899-7413

Eligibility Period

Family PACT Program eligibility begins the date the client is certified by the Family PACT provider as meeting the eligibility requirements and the Health Access Programs (HAP) card is activated. Family PACT clients are certified for the program for a maximum of 12 months or until the client's eligibility status changes. Certification for 12 months represents 365 days. A new *Health Access Programs Client Eligibility Certification* (CEC) form (DHCS 4461) must be completed in person on an annual basis for the client to continue to be enrolled if the client continues to meet all eligibility criteria. Family PACT must not be billed for services provided prior to the date of a client's certification.

Affirming Eligibility Each Visit

A provider or designee must affirm client eligibility at each visit. A client's income, family size and health insurance status must be reaffirmed. If there is a change in any information listed on the CEC form (DHCS 4461), the provider must make the updates in the HAP system. Whenever a client is determined to be no longer eligible for Family PACT, providers must deactivate the HAP card and advise the client of ineligibility.

Eligibility Requirements for BCCTP Applicants

Breast and Cervical Cancer Treatment Program (BCCTP) applicants must be denied full-scope Medi-Cal prior to the final BCCTP eligibility determination. Applying for Medi-Cal is a BCCTP eligibility requirement. Every Woman Counts (EWC) and Family PACT beneficiaries found to have a qualifying diagnosis, who have not applied to Medi-Cal within the last 30 days, should be instructed to apply for Medi-Cal.

Applicants eligible for Medi-Cal will not be enrolled into BCCTP. This requirement includes applicants who may not otherwise be eligible for full-scope Medi-Cal, such as undocumented individuals. Providers can continue to enroll qualified beneficiaries into BCCTP; they will remain in the BCCTP initial aid code until the Medi-Cal eligibility decision is completed by the county.

Notes:

Effective 4/1/2023, Medi-Cal redeterminations resumed. BCCTP sent annual redetermination packets to recipients to determine if they may continue receiving treatment coverage. Included in the annual packet is the Physician Statement and Certification (PSC) form that required the treating physician to complete, sign, and certify if the patient is still in need of breast and/or cervical cancer treatment. The PSC must be completed and signed by the treating physician (Doctor of Medicine (MD) or Doctor of Osteopathic medicine (DO) only) and returned to the recipient or BCCTP within 20 days.

Note: Family PACT clients found to have a qualifying diagnosis, who have not applied to Medi-Cal within the last 30 days, should be instructed to apply for Medi-Cal. Family PACT Providers are required per Welfare and Institutions Code (W&I Code), Section 24005(u), providers or the enrolling entity shall make available to all applicants, prior to or concurrent with enrollment, information on the manner in which to apply for insurance affordability programs. The CEC form has been updated to include an acknowledgement line for the applicant to confirm that they received information about insurance affordability programs.

Notes:

Client Eligibility Determination

To be eligible for Family PACT benefits, clients must meet all of the following criteria:

1. **Be a Resident of California**

   The client must be a resident of California.

2. **Have a Total Taxable Family Income at or Below 200 Percent of the Federal Poverty Guidelines**

   - The client must have a total taxable family income at or below 200 percent of the federal poverty guidelines. The client's self-declaration must be accepted without further verification.
   - The "basic family unit" must be taken into account when determining family size. The "basic family unit" consists of the applicant, spouse (including common-law) and minor children, if any, related by blood, marriage, or adoption, and residing in the same household.
   - Adults 18 years of age or older, other than spouses, residing together are considered a separate family. This applies to the parents of an adult client, adults living with their parents, unless the parents claim the adult child as a tax dependent. If this is the case and the client, an applicant is claimed as a tax dependent by the client's applicant's spouse or parents, the client's applicant's basic family unit includes the client, applicant's spouse if living together, the tax filer and the tax filer's other tax dependents.
   - The federal poverty guidelines are updated annually by the federal government. Providers are notified of annual changes in the *Family PACT Update Bulletin*.

More information regarding the determination of family size can be found in the *Client Eligibility* section of the *Family PACT Policies, Procedures and Billing Instructions* (PPBI) provider manual.

Note: The state of California recognizes "common-law" marriages established in other states (where common-law marriages are legally recognized) but does not recognize common-law marriages occurring in California for the purposes of eligibility determination.

3. **No Other Health Coverage**

   The client must have no other source of health care coverage for family planning services, or meet the criteria specified below for eligibility with Other Health Coverage (OHC).

   - OHC does not cover <u>any</u> family planning contraceptive methods.
   - Client is a student who has no health care coverage for any contraceptive methods. Seeking a specific method or brand of birth control not offered by OHC is not a criterion for Family PACT eligibility.
   - OHC requires an annual deductible that the client is unable to meet on the date of service.
   - Clients with barrier to access. A barrier to access is when a client's OHC does not ensure provision of family planning services to a client without his or her spouse, partner or parents being notified or informed.
   - Client has a Medi-Cal unmet Share of Cost (SOC) on the date of service.
   - Client has limited scope Medi-Cal that does not cover family planning

4. **Have a Medical Necessity for Family Planning Services**

   - The client must have a medical necessity for family planning services

Clients Enrolled in Medi-Cal Managed Care

For members who are enrolled in Medi-Cal Managed Care and who are seeking family planning care outside of a designated health plan, the health plans are required to reimburse out-of-plan providers for covered clinical, laboratory and pharmacy services. Family PACT providers should serve Medi-Cal Managed Care clients and then bill the Managed Care health plan rather than enrolling clients into Family PACT.

Income Eligibility Guidelines

The federal poverty guidelines are published annually by the federal government. Providers are to use the following income eligibility guidelines when determining client eligibility. Providers are notified of annual changes in the *Family PACT Update Bulletin*. Providers should disregard all previous income eligibility guideline charts.

Family PACT Income Eligibility Guidelines
200 Percent of the 2023 Federal Poverty Guidelines
Effective April 1, 2023

Number of Persons in Family/Household	Monthly Income	Annual Income
1	$2,430	$29,160
2	$3,287	$39,440
3	$4,143	$49,720
4	$5,000	$60,000
5	$5,857	$70,280
6	$6,713	$80,560
7	$7,570	$90,840
8	$8,427	$101,120
For each additional member, add:	$857	$10,280

Clients with Benefits Identification Cards (BICs)

If a client has a Benefits Identification Card (BIC), the provider must determine if the client is eligible for Medi-Cal family planning benefits on the date of service and if the client has met any required Share of Cost (SOC). Clients who have met their SOC and have no barrier to access, should not be enrolled into Family PACT.

Note: These BIC cards are valid.

Sample: BIC cards

Client Eligibility Guide

The following table assists providers in determining client eligibility. For more information, refer to the *Client Eligibility* (client elig) section in the PPBI.

Client Information	Family PACT Eligibility	Action Taken
Client has full-scope Medi-Cal with no Share of Cost (SOC).	No	No activation – Bill to Medi-Cal
Client has Medi-Cal with an unmet SOC.	Yes	Issue and activate HAP card
Client has Medi-Cal with an unmet SOC and requests confidentiality because a barrier to access exists.	Yes	Issue and activate HAP card
Client has restricted services Medi-Cal (no coverage of contraceptive methods).	Yes	Issue and activate HAP card
Client has OHC (covers contraceptive methods) with no deductible.	No	No activation – Bill insurance
Client has OHC, including Medi-Cal fee-for-service and Medi-Cal managed care (covers contraceptive methods), without deductible, but a barrier to access exists.	Yes	Issue and activate HAP card
Client has OHC (covers contraceptive methods) with an unmet deductible.	Yes	Issue and activate HAP card
Client has no health care coverage.	Yes	Issue and activate HAP card
Client is enrolled in Medi-Cal managed care but requests out-of-plan family planning services.	No	No activation – provide services, bill fee-for-service to plan

Note: See “Eligible Clients with Other Health Coverage (OHC)” section for more information.

Family PACT Program Standards

Program Standards are the program framework and parameters for expected provider performance, service delivery and quality improvement. The standards are subdivided by the following service areas of the program including:

Informed Consent

Informed consent shall include client participation in the process of eligibility determination as well as onsite enrollment in the Family PACT program. Notwithstanding any other provision of law, the provision of family planning services does not require the consent of anyone other than the person who is to receive services. In determining eligibility for minors, the State will exclude parental income. Minors may apply for family planning services based on their need for these services, without parental consent, according to *California Family Code*, Section 6925(a) and W&I Code, Section 24003(b).

If a client is 17 years of age or younger, the client is considered a minor. A minor who is 12 years of age or older may consent to medical care related to the diagnosis and/or treatment of sexually transmitted infections (STIs) according to *California Family Code*, Section 6926.

Confidentiality

All information about personal facts obtained by the provider shall be treated as privileged communications, shall be held confidential, and shall not be disclosed without the client's written consent, except as required by law or if necessary to provide emergency services to the client or by the Department of Health Care Services (DHCS) to administer the Family PACT program.

Cultural and Linguistic Competency

All services shall be provided in a culturally sensitive manner and communicated in a language understood by the client.

Access to Care

All services shall be provided to eligible clients without bias based upon gender, sexual orientation, age (except for sterilization), race, marital status, parity or disability.

A barrier to access is when a client's OHC does not ensure provision of services to a client without his or her parent, partner or spouse being notified or informed. For clients who indicate on the CEC form (DHCS 4461) that their concern of a partner, spouse or parent learning about their family planning appointment may keep them from using their OHC, there is a barrier to access, and the clients are eligible for Family PACT benefits if they meet all other eligibility criteria.

Availability of Covered Services

Only licensed personnel with family planning skills, knowledge and competency may provide the full range of family planning medical services covered under Family PACT in accordance with W&I Code, Section 24005(b). Clinical providers electing to participate in the Family PACT program shall provide the full scope of family planning, education, counseling and medical services specified by Family PACT, either directly or by referral.

Clinical and Preventive Services

Clinicians providing care to Family PACT clients shall practice evidence-based medicine using nationally recognized clinical practice guidelines. The Family PACT program provides family planning and family planning-related services to eligible women and men when the care is provided coincident to a visit for the management of a family planning method.

Family Planning Services:

- Contraceptive services for women and men
- Limited fertility services
- Specified reproductive health screening tests

Family Planning-Related Services:

- Cervical Cancer Screening
- Management of STIs
- Management of Urinary Tract Infections (UTI)
- Management of Cervical Abnormalities and Pre-invasive Cervical Lesions

Education and Counseling Services

Client-centered health education and counseling is considered integral to Family PACT and must be incorporated throughout the family planning visit. Regardless of the type of visit, provision of reproductive health education and counseling is required for all Family PACT clients including:

- A practice setting that is appropriate for discussion of sensitive topics
- Ongoing individualized client assessment and focused communication
- Topics and behaviors that promote personal choice, risk reduction and optimal reproductive health practices

For additional information on Program Standards, refer to the *Program Standards* (prog stand) section of the PPBI.

Eligibility Certification Process

Client Eligibility Form

The Health Access Programs client enrollment system for the Family PACT Program has been updated. As a result, the CEC form (DHCS 4461) and REC form (DHCS 4001) have also been updated. Previous versions of the Family PACT eligibility forms should not be used on or after May 3, 2021.

Links to the forms can be found on the Medi-Cal Provider Forms web page under the Family PACT drop-down menu and on the Family PACT Forms web page.

The CEC form (DHCS 4461) is a legal document that is used to certify a client as eligible for Family PACT.

The CEC form is available in both English and Spanish and can be downloaded from the Forms page on the Family PACT Forms web page or the DHCS Forms web page.

These are official DHCS forms and must be reproduced without alteration and must not be pre-populated. The signed hard copy CEC form must be kept on file for three years.

These forms can be stored either electronically or by hard copy.

If a client was previously determined ineligible and returns to a Family PACT provider for an enrollment, new CEC form (DHCS 4461) must be completed to determine eligibility. If the client is eligible, the provider must update any changes in the HAP system using the prior HAP card number, if applicable.

The HAP client enrollment system has **added** the following data elements:

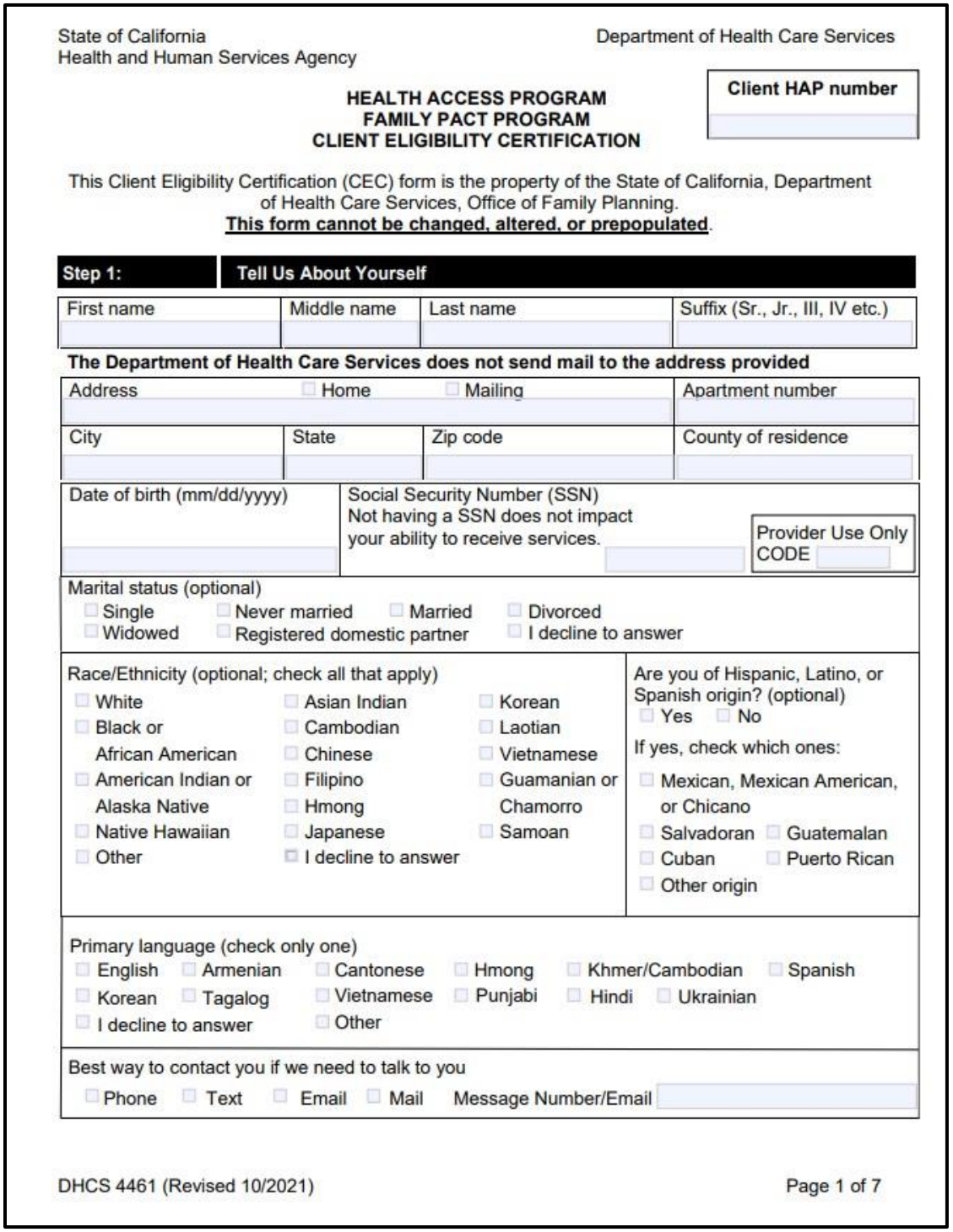
- Address, Apartment, City, State and Address Type.
- Marital Status.
- Race/Ethnicity Codes Expanded.
- Updated Language Codes.
- Contact information.

Family PACT will also begin to collect sexual orientation and gender identity (SOGI) data pursuant to Assembly Bill (AB) 959: Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act (Chiu,) 2015). AB 959 requires DHCS to collect voluntary self-identification information pertaining to SOGI in the regular course of collecting other types of demographic data.

The HAP client enrollment system has **removed** the following data elements:

- Number of Live Births.
- Place of Birth.
- State of Birth Codes.
- Country of Birth Codes.
- First Name, Middle Name and Last Name at Birth.
- Mother’s First Name at Birth.
- Current Name Same as Name at Birth.

Client Eligibility Certification (CEC) Form (DHCS 4461)



State of California
Health and Human Services Agency

Department of Health Care Services

HEALTH ACCESS PROGRAM
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION

Client HAP number

This Client Eligibility Certification (CEC) form is the property of the State of California, Department of Health Care Services, Office of Family Planning.
This form cannot be changed, altered, or prepopulated.

Step 1: Tell Us About Yourself

First name	Middle name	Last name	Suffix (Sr., Jr., III, IV etc.)

The Department of Health Care Services does not send mail to the address provided

Address ☐ Home ☐ Mailing			Apartment number
City	**State**	**Zip code**	**County of residence**

Date of birth (mm/dd/yyyy)

Social Security Number (SSN)
Not having a SSN does not impact your ability to receive services.

Provider Use Only
CODE

Marital status (optional)
☐ Single ☐ Never married ☐ Married ☐ Divorced
☐ Widowed ☐ Registered domestic partner ☐ I decline to answer

Race/Ethnicity (optional; check all that apply)
☐ White ☐ Asian Indian ☐ Korean
☐ Black or African American ☐ Cambodian ☐ Laotian
☐ Chinese ☐ Vietnamese
☐ American Indian or Alaska Native ☐ Filipino ☐ Guamanian or Chamorro
☐ Hmong
☐ Native Hawaiian ☐ Japanese ☐ Samoan
☐ Other ☐ I decline to answer

Are you of Hispanic, Latino, or Spanish origin? (optional)
☐ Yes ☐ No
If yes, check which ones:
☐ Mexican, Mexican American, or Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other origin

Primary language (check only one)
☐ English ☐ Armenian ☐ Cantonese ☐ Hmong ☐ Khmer/Cambodian ☐ Spanish
☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Punjabi ☐ Hindi ☐ Ukrainian
☐ I decline to answer ☐ Other

Best way to contact you if we need to talk to you
☐ Phone ☐ Text ☐ Email ☐ Mail Message Number/Email

DHCS 4461 (Revised 10/2021) Page 1 of 7

Figure 1.1: CEC form (DHCS 4461) page 1 of 7.

State of California
Health and Human Services Agency

Department of Health Care Services

What is your sex? (required)

☐ Female ☐ Transgender: Male to Female
☐ Male ☐ Transgender: Female to Male

Sexual orientation and gender identity

The following information is optional and confidential.
It will not be used to determine eligibility.

What is your gender?
(check box that best describes your current gender identity)

☐ Female
☐ Male
☐ Transgender: male to female
☐ Transgender: female to male
☐ Non-binary (neither male or female)
☐ Another gender identity
☐ I decline to answer

Do you think of yourself as:

☐ Straight or heterosexual
☐ Gay or lesbian
☐ Bisexual
☐ Queer
☐ Another sexual orientation
☐ Unknown
☐ I decline to answer

What sex was listed on your original birth certificate?

☐ Female ☐ Male ☐ I decline to answer

Step 2:	**Other Health Coverage**
I have had out of pocket expenses for family planning/reproductive health services covered by the Family PACT Program in the three months immediately preceding enrollment in the Family PACT Program.	☐ YES ☐ NO
I currently receive Medi-Cal benefits. If you know your Medi-Cal card number, write the number and date issued in the boxes. If you do not know, write UNKNOWN in the box. Medi-Cal Card Number _____ Issue Date _____	☐ YES ☐ NO
I have Medi-Cal with an unmet Share of Cost.	☐ YES ☐ NO
I have restricted Medi-Cal (such as "Emergency Medi-Cal") that does not cover contraceptive methods.	☐ YES ☐ NO
I have Other Health Coverage that covers contraceptive methods. Other Health Coverage may include Medi-Cal Managed Care plans, Commercial Health Plans (Kaiser, BlueCross, Health Net) or student health insurance.	☐ YES ☐ NO
I do not know if I have other health coverage (check box if you do not know).	☐
I have health insurance through Medi-Cal or Other Health Coverage on my date of service, but I cannot use my insurance because I am concerned that my spouse, partner or parent(s) may be notified or informed of my family planning visit (this is called a barrier to access).	☐ YES ☐ NO Provider Use Only CODE _____

DHCS 4461 (Revision 03/2021)

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Figure 1.2: CEC form (DHCS 4461) form page 2 of 7.

State of California
Health and Human Services Agency

Department of Health Care Services

Taxable Income

List yourself and your family members (spouse and children) who live with you, and the taxable income sources for each person.

If someone claims you on their taxes, list everyone claimed on that person's tax form. Sources of income includes employment, self-employment, social security (even if not taxable), tips, spousal support received, unemployment benefits, etc. Request additional pages as needed.

If you are 17 years of age or younger, your parents income is excluded. A provider can talk with you more and help you find out your family size.

Name	Relationship To You	Age	Source of Income	Taxable Monthly Income
	(Self)			

Family size: Total taxable family income:

Step 3: Please Read And Sign Application

California Health Insurance Eligibility

I received information on how to apply and enroll for insurance affordability programs. ☐ YES ☐ NO
Please visit www.CoveredCA.com or call 1-800-300-1506 for assistance with completing the application for these programs.

I declare under penalty of perjury under the laws of the state of California that the foregoing information on this form is true and correct. I understand that giving false information may make me ineligible for this program.

Applicant Signature (or mark)	Date Signed

Privacy Statement (Civil Code § 1798 et seq.)

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

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Figure 1.3: CEC form (DHCS 4461) form page 3 of 7.

State of California
Health and Human Services Agency

Department of Health Care Services

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program shall have a right to a hearing regarding eligibility or receipt of services. An applicant or recipient does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

First Level Review: If you wish to appeal either your denial of eligibility or receipt of services, please send your name, telephone number, address, and reason why you are requesting a First Level Review to the address below. A request for a first level review must be postmarked within 20 working days of the denial of eligibility or services. The Office of Family Planning may request additional information by telephone or in writing from the provider or the applicant before issuing a decision.

Formal Hearing: You may request a formal hearing within 90 days from the day you were notified that you were not eligible or the services you wanted will not be provided or have been discontinued. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, your request may still be scheduled. Provide all requested information such as your full name, telephone number, address, and the reason for the Formal Hearing and mail it to the Formal Hearing address below. If you wish, you may attach a letter as well and explain why you believe the action taken is not correct. You may also call the Public Inquiry and Response number below. If you have trouble understanding English, be sure to state your language so arrangements can be made to have language assistance at the hearing. If you have chosen an authorized representative, be sure to state his/her name, phone number and address. Keep a copy of your hearing request for your records. You may submit your formal hearing request in one of two ways:

First Level Review
Department of Health
Care Services
Office of Family Planning
P.O. Box 997413,
Mail Station 8400
Sacramento, CA 95899-7413

Formal Hearing
California Department of
Social Services
State Hearings Division
P.O. Box 944243,
Mail Station 9-17-37
Sacramento, CA
94244-2430

or Toll-Free Call
Department of Social Services
State Hearings Division
Public Inquiry and Response
1-800-952-5253 or
1-800-743-8525
TDD 1-800-952-8349
Fax: (916) 651-5210

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Figure 1.4: CEC form (DHCS 4461) form page 4 of 7.

State of California
Health and Human Services Agency

Department of Health Care Services

Nondiscrimination Policy

Section 1557 of Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities. In effect since 2010, section 1557 builds on long-standing federal civil rights laws: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

Effective July 18, 2016, the Health and Human Services (HHS) Office for Civil Rights issued its final rule implementing section 1557 at Title 45 Code of Federal Regulations (CFR) Part 92. The rule applies to any health program or activity, any part of which receives federal financial assistance, an entity established under Title I of the ACA that administers a health program or activity, and HHS. In addition to other requirements, Title 45 CFR Part 92.201, requires:

- **Language assistance services requirements:** Language assistance services required under paragraph (a) of Part 92.201 must be accurate, timely and provided free of charge, and protect the privacy and independence of the individual with limited English proficiency.
- **Specific requirements for interpreter and translation services:** Subject to paragraph (a) of Part 92.201.
  - A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency.
  - A covered entity shall use a qualified translator when translating written content in paper or electronic form.

For more information about the application and requirements of the final rule implementing section 1557, providers should contact their representative professional organizations. They may also visit the section 1557 of the Patient Protection and Affordable Care Act page of the HHS website to find sample materials and other resources.

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Figure 1.5: CEC form (DHCS 4461) form page 5 of 7.

State of California
Health and Human Services Agency

Department of Health Care Services

Language Services Notice

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 541-800-55551 (رقم هاتف الصم والبكم: 711 TTY.[Arabic]

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-541-5555 TTY：711 [Chinese]

ध्यान द□: य□द आप □हदी बोलते ह □तो आपके ि◌लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-800-541-5555 TTY: 711 पर कॉल कर□। [Hindi]

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-541-5555 TTY: 711 [Hmong]

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-541-5555 TTY: 711 お電話にてご連絡ください。[Japanese]

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-541-5555 TTY: 711 번으로 전화해 주십시오.[Korean]

ប្រយ័ត្ន៖ បើសិន□អ□កនិ□យ □□ខ□, បស□ជំនួយផ□ក□□ ប□យមិនគិតឈ□□ល គឺ□ច□ឱ្យសំ□ប់បំបែ□អ□ក ចូរ ទូរស័ព□ 1-800-541-5555 TTY: 711 [Cambodian]។

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ□ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ□ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-541-5555 TTY: 711 [Punjabi] 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-541-5555 телетайп: 711 [Russian]

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-541-5555 TTY: 711 [Tagalog]

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-541-5555 TTY: 711 [Thai]

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-541-5555 TTY: 711 [Vietnamese]

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Figure 1.6: CEC form (DHCS 4461) form page 6 of 7.

State of California
Health and Human Services Agency

Department of Health Care Services

Step 4: **PROVIDER USE ONLY**

Provider certification:
- ☐ Eligible for Family PACT Program
- ☐ Ineligible for Family PACT Program (Give Fair Hearing Rights)

Why client is ineligible: _____

Medi-Cal client eligible for Family PACT verified:
☐ Limited scope ☐ Unmet share-of cost ☐ Barrier to Access

DECLARATION

My signature attests that based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this form is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of the CEC form which includes the Fair Hearing Rights. I also certify that the client was 1) informed of California health insurance eligibility programs through Covered California, 2) offered and received (or declined) a copy of the Notice of Privacy Practices, Nondiscrimination Policy and 3) if applicable, provided a Retroactive Eligibility Certification Form (DHCS 4001).

Print name	Signature	Date
Deactivation: If client is deactivated (no longer eligible)	Date	Reason code Provider Use Only CODE

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Figure 1.7: CEC form (DHCS 4461) form page 7 of 7.

Client Eligibility Certification Codes

The Family PACT Program Client Eligibility Certification Codes table is used to complete specific items on the CEC form (DHCS 4461). Accurately entering the corresponding code is necessary when activating eligibility, updating HAP records or recertifying client eligibility.

County of Residence

County	Code
Alameda	01
Alpine	02
Amador	03
Butte	04
Calaveras	05
Colusa	06
Contra Costa	07
Del Norte	08
El Dorado	09
Fresno	10
Glenn	11
Humboldt	12
Imperial	13
Inyo	14
Kern	15
Kings	16
Lake	17
Lassen	18
Los Angeles	19
Madera	20
Marin	21
Mariposa	22
Mendocino	23
Merced	24
Modoc	25
Mono	26
Monterey	27
Napa	28
Nevada	29
Orange	30

County of Residence

County	Code
Placer	31
Plumas	32
Riverside	33
Sacramento	34
San Benito	35
San Bernardino	36
San Diego	37
San Francisco	38
San Joaquin	39
San Luis Obispo	40
San Mateo	41
Santa Barbara	42
Santa Clara	43
Santa Cruz	44
Shasta	45
Sierra	46
Siskiyou	47
Solano	48
Sonoma	49
Stanislaus	50
Sutter	51
Tehama	52
Trinity	53
Tulare	54
Tuolumne	55
Ventura	56
Yolo	57
Yuba	58
Unknown	99

Social Security Number Not Provided

Definition	Code
Client does not know SSN	01
Client does not have SSN	02
Client declined to answer	03

Other Health Coverage Codes

Definition	Code
Yes	01
No	02

Figure 2.1: Client Eligibility Certification Codes Table.

Retroactive Eligibility

Once a client is certified as eligible for the Family PACT program, the provider should ask the client if she or he has received Family PACT covered family planning and/or reproductive health services during the three-month period prior to the month the client enrolled in the Family PACT program. If the client indicates yes, the provider will give the client retroactive eligibility information and the REC form (DHCS 4001) for completion. The Family PACT provider determines if the client was eligible for services during the prior three-month period.

Retroactive eligibility is determined separately for each of the three calendar months preceding the month of certification. Eligibility is for the entire month. For example, if retroactive eligibility is determined for a client on April 15, 2021, the client may be eligible back to January 1, 2021.

Note: Only the client is responsible for claim submission.

For more information or to file a claim, the client may call the Beneficiary Service Center – Family PACT at (916) 403-2007 TDD: (916) 635-6491.

Accessing Family PACT Forms

Open an internet browser, type mcweb.apps.prd.cammis.medi-cal.ca.gov in the address bar and press enter.

1. From the Resources drop-down menu, select **References**.

Figure 3.1: Medi-Cal Providers website homepage – Resources drop-down menu.

2. Next, scroll down to **Forms** and select the link.

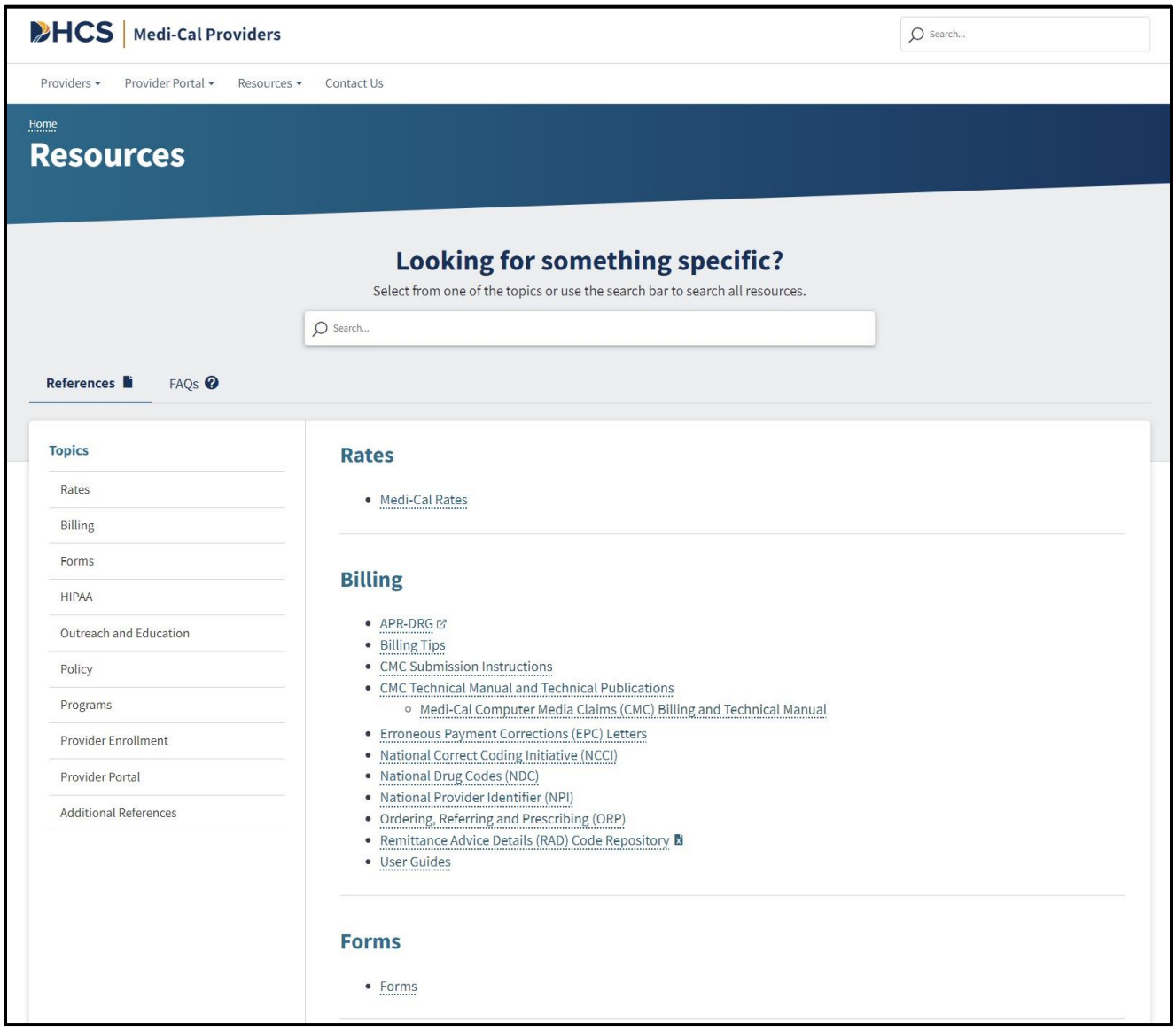


Figure 3.2: Forms link.

3. Select **Family PACT** to view and download the available Family PACT forms.
   - Family PACT Provider enrollment forms.
   - Application to participate in the *Family PACT Program* (DHCS 4468).
   - CEC form (DHCS 4461) and REC form (DHCS 4001) forms.

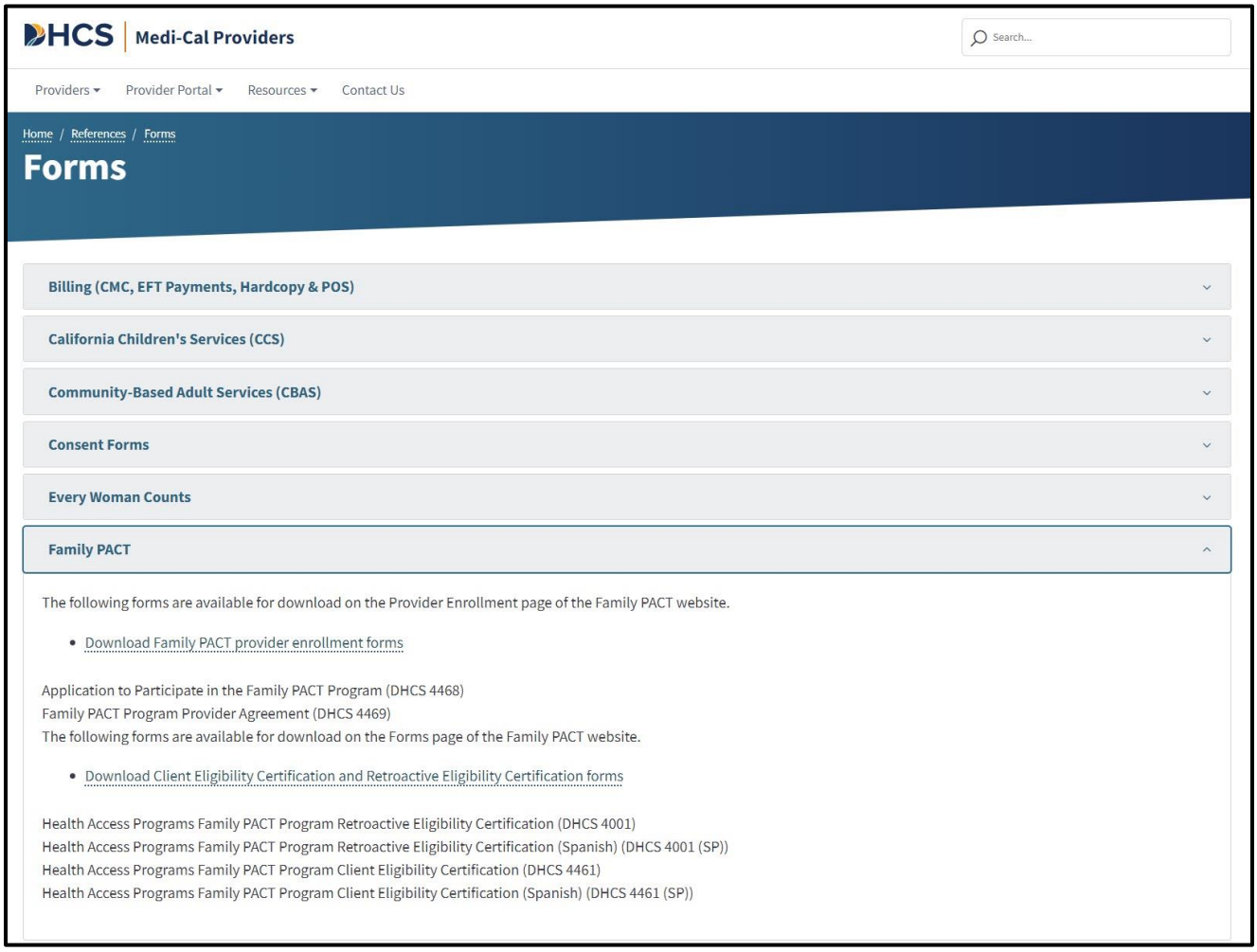
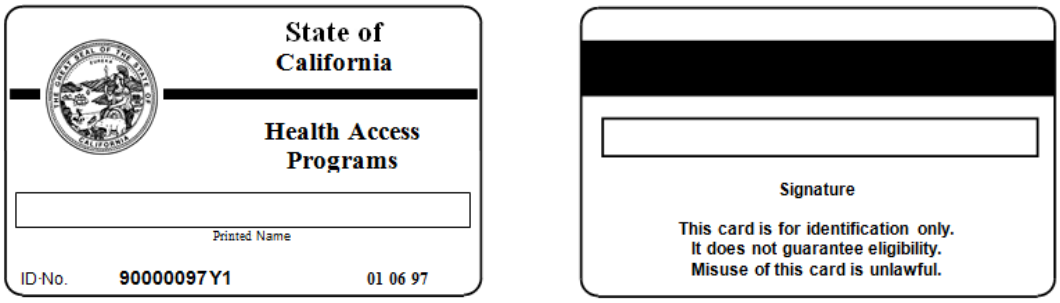


Figure 3.3: Family PACT forms can be found on the Forms page.

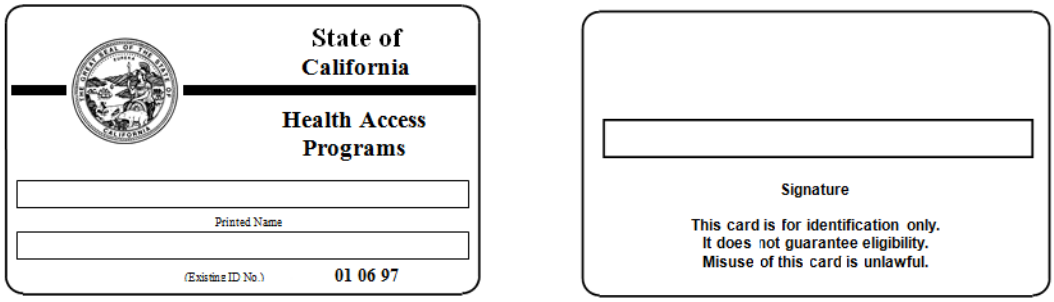
Note: Family PACT forms are also available for download from the Family PACT website and the DHCS website..

HAP Card



Sample: HAP Initial Teal Card

Replacement Card



Sample: HAP Replacement Teal Card

HAP Card Terms and Conditions

The HAP card must be issued and activated at the time a client is enrolled. Activation must be on the date of service for new clients. Eligibility extends for 365 days and must be recertified annually. Clients who possess a HAP card may present their HAP card to any Family PACT provider in California.

HAP card issuance and activation must occur exclusively at the service site (enrolled address) represented by the enrolled Family PACT provider's NPI to whom the sequential cards were distributed. HAP cards may not be provided or activated at health fairs, outreach events or anywhere other than the assigned site in which the cards were requested and distributed. Failure to adhere to this policy will result in disenrollment from Family PACT.

Replacement Card

If the client loses their HAP card, attempt to contact the previous Family PACT provider for the HAP card number. Family PACT providers must maintain a record of the original HAP card number issued to each client. Do not issue another pre-numbered HAP card. Providers must write the client's name and original HAP number from the client's CEC form onto a blank replacement card. Family PACT tracks blank cards issued to a provider.

HAP Card Distribution

All new providers are issued 200 pre-numbered, sequential HAP cards and 50 blank replacement cards. HAP cards shall be distributed only to provider locations enrolled in the Family PACT program.

Additional HAP Cards

The Office of Family Planning (OFP) reviews all requests for additional HAP cards, and the number of additional cards approved will be on a case-by-case basis. Additional HAP cards may be requested by calling the Telephone Service Center (TSC) at 1-800-541-5555.

Lost or Stolen Card

Providers are responsible for the safekeeping of the HAP cards and must store them securely. OFP tracks sequential cards by activation and date of service. Cards issued and activated are traced and will determine the ability of a provider to receive additional cards when requested. Lost or stolen HAP cards must be reported immediately to the TSC at 1-800-541-5555.

Unused HAP Cards

Unused HAP cards must be returned to the Fiscal Intermediary (FI) at the time of voluntary or involuntary disenrollment from Family PACT. Unused cards must be packaged with a cover letter, including the provider number or National Provider Identifier (NPI) used to order the cards, and returned by UPS to the FI at:

California MMIS Fiscal Intermediary
Attn: Print and Distribution Center
830 Stillwater Road
West Sacramento, CA 95605

Accessing Medi-Cal's HAP Eligibility System

1. From the Provider Portal drop-down menu, select **Transaction Services**.

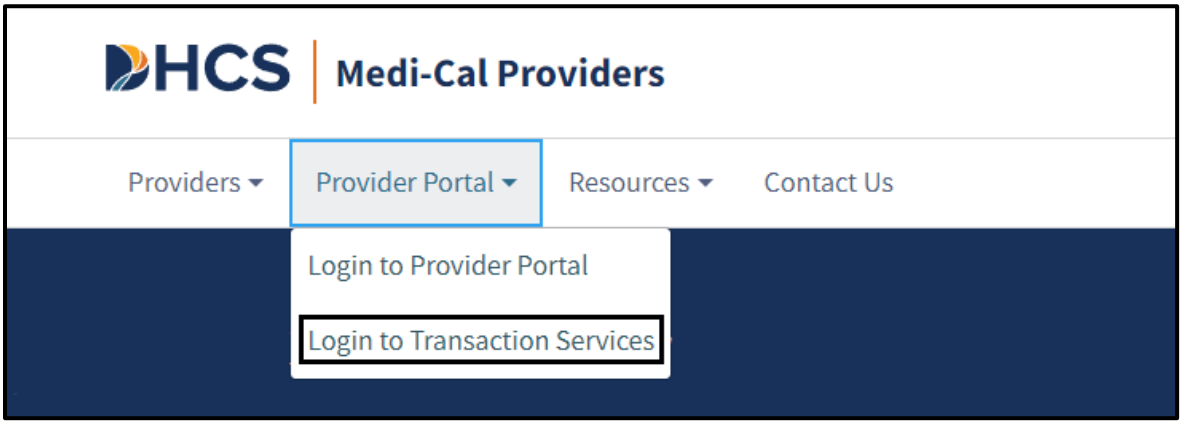


Figure 4.1: Medi-Cal Provider Portal tab drop-down menu.

2. On the Login screen, enter the password and select **Log In**.

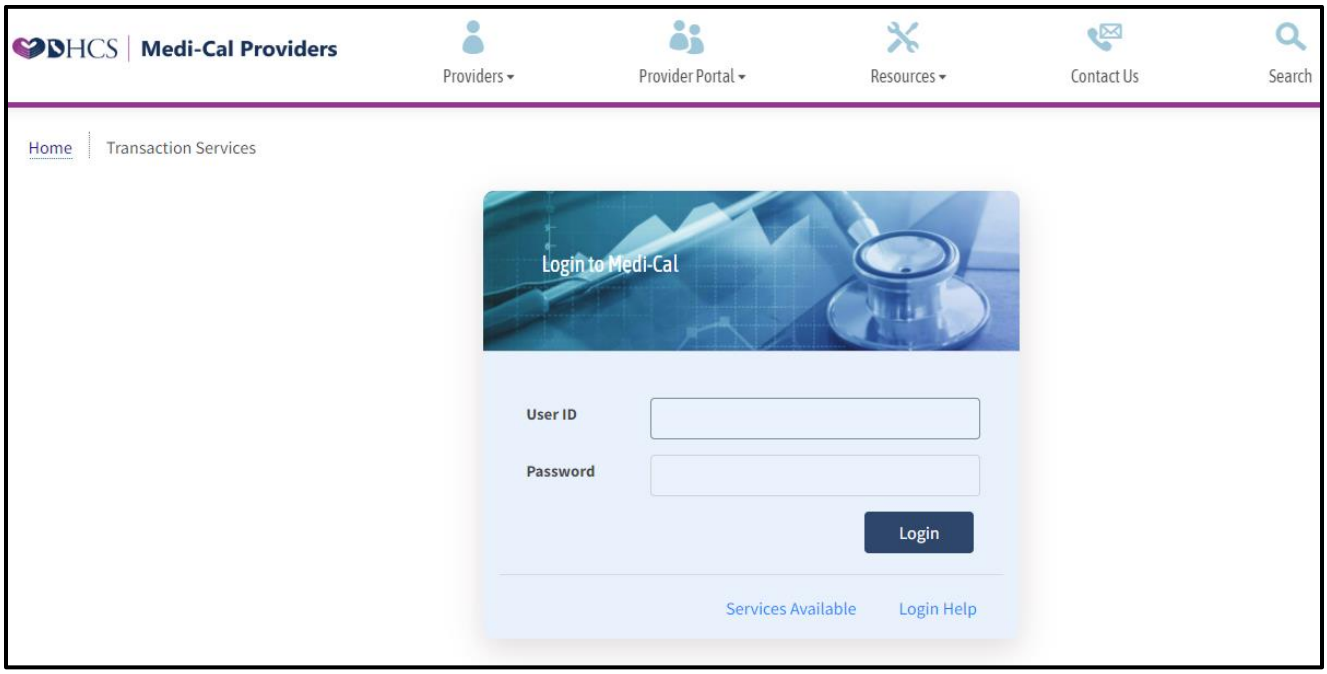


Figure 4.2: Medi-Cal Transactions Login Page.

3. Once logged into Transaction Services, navigate to the **Enrollment** section and select **Family PACT**.

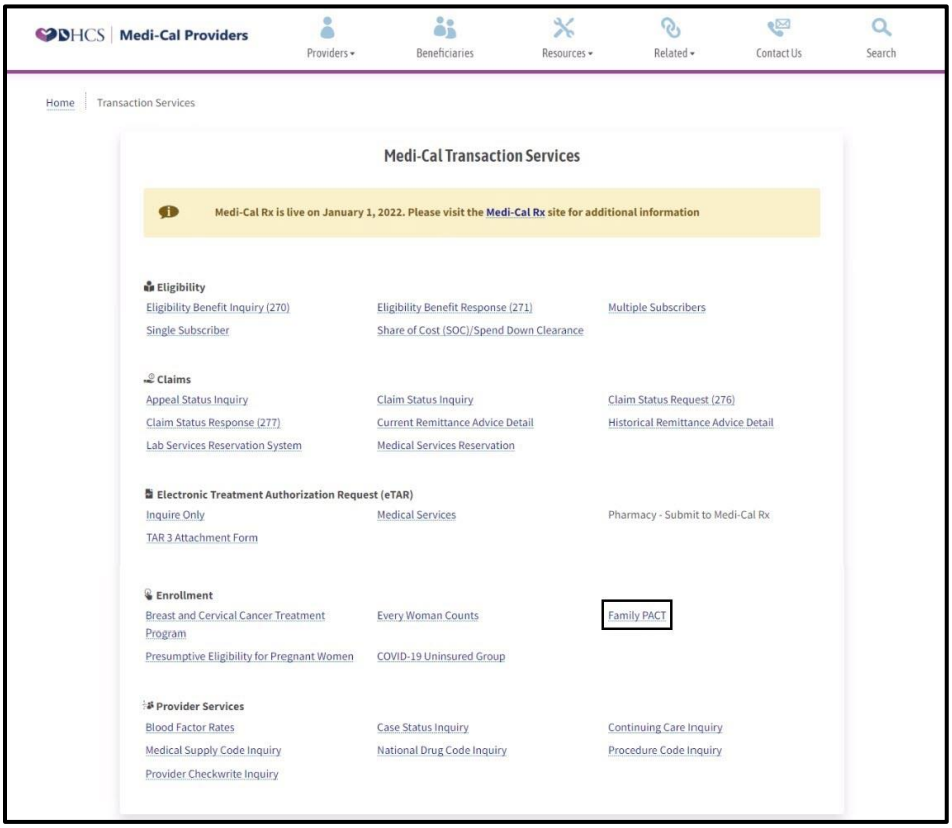


Figure 14: Medi-Cal Transaction Services.

4. Select a Family PACT transaction from the available option buttons. Enter a valid HAP ID and the Date of Birth for all transactions. Select the **Submit** button.

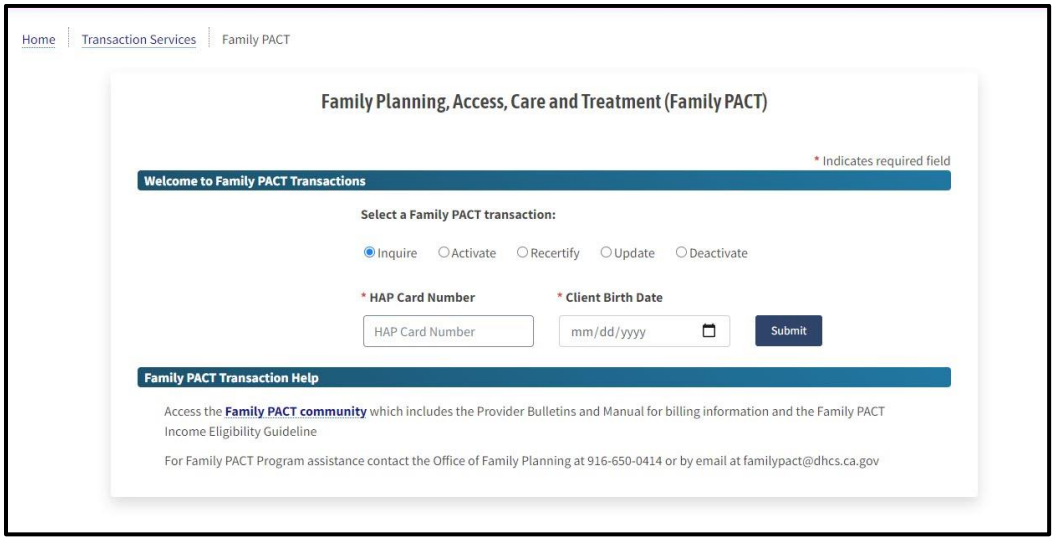


Figure 15: Family PACT transactions menu.

HAP Client Eligibility System

Providers use the HAP onsite client enrollment system for certifying clients as eligible and for activating the clients' s HAP card. Effective March 1, 2021, Family PACT Program providers will no longer be able to use the telephone Automated Eligibility Verification System (AEVS) to verify client eligibility. AEVS is an interactive voice (IVR) response system accessed through a touch-tone telephone.

Providers with a valid provider number (NPI) and Provider Identification Number (PIN) will continue to perform eligibility transactions through Transaction Services on the Medi-Cal Provider website: www.medi-cal.ca.gov.

The HAP system allows providers and/or designees to perform the following functions:

Activate, Inquire, Update, Recertify and Deactivate.

HAP Card Activation

The HAP card must be issued and activated immediately upon certification of eligibility using the internet transaction screen. Failure to activate the card will result in denial of payments to providers, laboratories and pharmacies. Providers who neglect to activate a card upon certification of a client are responsible for covered services rendered or ordered by a pharmacy, laboratory, or clinical providers to whom the client is referred. Providers will not receive reimbursement until the HAP card is activated. Clients must not be charged for Family PACT services after certification is complete.

HAP Card Deactivation

When it is determined that a client is no longer eligible for Family PACT services, the provider must deactivate the HAP card and advise the client of ineligibility. Providers should select the appropriate “deactivation” option using the internet transaction screen, indicate the reason for deactivation using the deactivation code, and refrain from billing Family PACT for services.

Deactivation Codes Table

Code	Description
01	Not a resident of California
02	Over 200 percent of the poverty level guidelines
03	Sterilized, no longer contracepting
04	Health insurance coverage for Family Planning Services
05	Full-scope Medi-Cal (does not have an unmet SOC)
06	Permanent deactivation of HAP card (lost/stolen)

Additional Information for Sterilization and Pregnancy Deactivation Codes

Permanent Sterilization (Code 03)

Clients who undergo permanent sterilization are no longer eligible for Family PACT services and the HAP card must be deactivated using deactivation code 03.

Pregnancy (Code 05)

If the client is determined to be pregnant, the client is no longer eligible for Family PACT services. The HAP card should be deactivated using deactivation code 05 on the day following the visit at which the diagnosis of pregnancy was determined. The HAP card may be retained in the client’s file for future use by the client.

Note: Do not deactivate the client’s HAP card until the end of the designated post-operative period; earlier deactivation can occur if the clinician determines that the client is no longer at risk for pregnancy or causing pregnancy.

Knowledge Review

1. Retroactive eligibility may be offered to all Family PACT clients. _____
   a. True
   b. False
2. Clients must be recertified how often? _____
   a. Every time they choose a new provider
   b. Every year
   c. Every six months
3. Clients must report any changes pertinent to their eligibility status such as? _____
   a. Family size/income
   b. California residency
   c. Health insurance coverage changes
   d. All of the above
4. Can providers obtain signatures and store CEC/RECs electronically. _____
   a. True
   b. False
5. Providers must maintain the completed CEC form in the client's medical record for a period of: _____
   a. One year
   b. At least four years
   c. Three years
6. The provider determines the total family size and total taxable monthly income based on information provided by the client. _____
   a. True
   b. False

7. Clients who have been determined ineligible for Family PACT services must be offered a copy of the completed CEC form, which includes a “Fair Hearing Rights” notification. _____
   a. True
   b. False
8. Failure to adequately certify the client or to sign and date the CEC form may result in the provider being disenrolled. _____
   a. True
   b. False
9. A client may have more than one HAP card activated at any given time. _____
   a. True
   b. False
10. Providers must remember to clarify accessing services for reasons of “barrier to access” with all clients prior to completing the CEC form. _____
    a. True
    b. False

See the Appendix for the Answer Key

Page updated: September 2020

Resource Information

References

The following reference materials provide Family PACT Program and eligibility information.

Provider Manual References

Family PACT Policies, Procedures and Billing Instructions (PPBI) Manual Sections and Forms

Client Eligibility (client elig)

Family PACT Program Overview (fam)

Health Access Programs (HAP) Cards (hap cards)

Health Access Programs Family PACT Program Client Eligibility Certification (CEC) form (DHCS 4461)

Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC) form (DHCS 4001)

Program Standards (prog stand)

Provider Enrollment (prov enroll)

Provider Responsibilities (prov res)

Bulletins

Family PACT Update

Medi-Cal Update

Other References

Family PACT website

Medi-Cal Providers website

Appendix

Acronyms

Acronym	Description
AEVS	Automated Eligibility Verification System
APCC	Affiliate Primary Care Clinics
BCCTP	Breast and Cervical Cancer Treatment Program
BIC	Benefits Identification Card
CE	Childbirth Educator
CEC	Client Eligibility Certification
CDPH	California Department of Public Health
CHDP	Child Health and Disability Prevention
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
COS	Category of Service
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
DOS	Date of Service
E&M	Evaluation and Management
EDD	Expected Date of Delivery
EIN	Employer Identification Number
EPT	Expedited Partner Therapy
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FPACT	Family Planning, Access, Care and Treatment
FPG	Federal Poverty Guidelines
FQHC	Federally Qualified Health Centers
HAP	Health Access Program

Acronym	Description
HCPCS	Healthcare Procedure Coding System
HE	Health Educator
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICP	Individualized Care Plan
IHS-MOA	Indian Health Services Memorandum of Agreement
LCSW	Licensed Clinical Social Worker
LMP	Last Menstrual Period
LMS	Learning Management System
LVN	Licensed Vocational Nurse
MFCC	Marriage, Family and Child Counselor
NFP	Natural Family Planning
NMP	Non-Physician Medical Practitioner
NP	Nurse Practitioner
NPI	National Provider Identifier
OB	Obstetrics
OFP	Office of Family Planning
OHC	Other Health Coverage
PA	Physician Assistant
PACT	Planning, Access, Care and Treatment
PCC	Primary Care Clinics
PE	Presumptive Eligibility
PPBI	Policies, Procedures and Billing Instructions
PSC	Perinatal Services Coordinator
RAD	Remittance Advice Details
RD	Registered Dietician
REC	Retroactive Eligibility Certification
RHC	Rural Health Clinics
RN	Registered Nurse

Acronym	Description
SOC	Share of Cost
SOGI	Sexual Orientation Gender Identity
STI	Sexually Transmitted Infection
TAR	Treatment Authorization Request
TIN	Taxpayer Identification Number
TSC	Telephone Service Center
UTI	Urinary Tract Infection
W&I Code	Welfare and Institutions Code

Module A Answer Key

Knowledge Review 1

Question 1: Reimbursement for antepartum visit (HCPCS code Z1034) is limited to _____ visits in a nine-month period.

Answer 1: B

Question 2: More than 13 antepartum visits are allowed in nine months if there is documentation of a second pregnancy.

Answer 2: True

Question 3: If providers bill one antepartum (HCPCS code Z1034), they _____ bill globally.

Answer 3: B cannot

Question 4: If a provider bills per-visit CPT code 59409, 59612 (vaginal delivery only), 59514 or 59620 (cesarean delivery only), the provider must bill all antepartum visits separately.

Answer 4: True

Question 5: Postpartum visits (HCPCS code Z1038) may be billed by the primary maternity care provider or provider who saw the patient for only the postpartum office visit.

Answer 5: True

Knowledge Review 2

Question 1: The postpartum office visit (HCPCS code Z1038) is restricted to once in six months. True or False.

Answer 1: False

Question 2: Providers who accept Medi-Cal transfer-of-care patients are restricted to the one initial visit (HCPCS code Z1032) and a total of 13 antepartum visits (HCPCS code Z1034) in nine months by all primary obstetrics providers

Answer 2: False

Question 3: Which claim form allows providers to choose to bill per-visit or bill globally?

Answer 3: B

Question 4: Can the initial pregnancy office visit (HCPCS code Z1032) count as one of the 13 visits when billing globally?

Answer 4: No

Module B Answer Key

Knowledge Review 1:

Question 1: Modifier ZL must be billed with HCPCS code Z1032 and certifies that the recipient was seen within 16 weeks of her Last Menstrual Period (LMP). True or false?

Answer 1: True

Question 2: Enter the LMP date in _____ _____ on the *CMS-1500* claim form or in _____ _____ on the *UB-04* claim form.

Answer 2: Box 14, Box 80 Remarks

Question 3: To be reimbursed for modifier ZL, providers must add $56.63 to their usual and customary fee for Z1032. True or false?

Answer 3: True

Question 4: Modifier ZL is restricted to CPSP providers and will only be reimbursed _____ per recipient, per pregnancy.

Answer 4: Once

Knowledge Review 2

Question 1: This code can only be billed if all _____ initial assessments and the initial pregnancy-related office visit code _____ are rendered within a _____-_____ _____.

Answer 1: Three, Z1032, four-week period

Question 2: The date of the last assessment must be shown as the date of service. True or false?

Answer 2: True

Question 3: Z6500 is reimbursable once in ____ _____ unless the provider certifies on the claim that the recipient has become pregnant again within the _____-_____ period.

Answer 3: Six months, six-month

Question 4: If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, you must bill the initial assessments separately. True or false?

Answer 4: True

Knowledge Review 3

Question 1: If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, the provider must bill for the actual assessments performed using the individual assessment codes. True or false?

Answer 1: True

Question 2: The sequence for providing the initial assessments (nutrition, health education and psychosocial) and the initial pregnancy-related office visit code (Z1032) may be rendered in _____ _____ and at ____ _____ during the patient's care.

Answer 2: Any order; any time

Question 3: The provider must complete the initial assessment within the discipline area (nutrition, health education or psychosocial) _____ rendering any intervention services within that discipline.

Answer 3: Before

Knowledge Review 4

Question 1: Recipients who choose to participate in the CPSP program and receive CPSP services are required to _____ or _____ their SOC _____ _____ even if the obstetrical services are billed globally.

Answer 1: pay, obligate; each month; 15 minutes

Module C Answer Key

Knowledge Review 1

Question 1: Retroactive eligibility may be offered to all Family PACT clients.

Answer 1: b

Question 2: Clients must be recertified how often?

Answer 2: b

Question 3: Clients must report any changes pertinent to their eligibility status such as?

Answer 3: d

Question 4: Can providers obtain signatures and store CEC/RECs electronically?

Answer 4: a

Question 5: Providers must maintain the completed CEC form in the client's medical record for a period of:

Answer 5: c

Question 6: The provider determines the total family size and total taxable monthly income based on information provided by the client.

Answer 6: a

Question 7: Clients who have been determined ineligible for Family PACT services must be offered a copy of the completed CEC form, which includes a "Fair Hearing Rights" notification.

Answer 7: a

Question 8: Failure to adequately certify the client or to sign and date the CEC form may result in the provider being disenrolled.

Answer 8: a

Question 9: A client may have more than one HAP card activated at any given time.

Answer 9: b

Question 10: Providers must remember to clarify accessing services for reasons of "barrier to access" with all clients prior to completing the CEC form.

Answer 10: a

Page updated: September 2020

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