

Medi-Cal Provider Training 2016

Health Access Programs





The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing 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 SPBU 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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Presumptive Eligibility for Pregnant Women

Introduction

Purpose

The purpose of this module is to provide participants with an overview of the Presumptive Eligibility (PE) for Pregnant Women program, including eligibility requirements, program benefits and program reporting requirements.

Module Objectives

- Provide an overview of PE for Pregnant Women
- Review how to become a PE for Pregnant Women Qualified Provider (QP)
- Explain the PE for Pregnant Women patient enrollment process
- Understand the PE for Pregnant Women program benefits
- Discuss PE for Pregnant Women reporting requirements

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference provides Medi-Cal program and eligibility information.

Provider Manual Reference

Part 2

Presumptive Eligibility (presum)

Other References

Medi-Cal website (www.medi-cal.ca.gov). Under the “Programs” tab, select the “Presumptive Eligibility” tab.

DHCS PE for Pregnant Women website (www.dhcs.ca.gov/services/medi-cal/eligibility/pages/pe.aspx)

Acronyms

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

Description

The PE for Pregnant Women program allows QPs to grant immediate temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income pregnant patients, pending their formal Medi-Cal application. The PE for Pregnant Women program is for California residents who believe they are pregnant and do not have Medi-Cal coverage for prenatal care.

NOTES

Provider Qualifications

Providers wishing to apply to participate as a QP, for the purpose of offering PE to pregnant patients, must be:

- A current Medi-Cal provider in good standing with the Department of Health Care Services (DHCS) Provider Enrollment Division and able to render prenatal services
- A Primary Care Clinic waiting to be approved as a Medi-Cal provider

NOTE

Assembly Bill (AB) 2307 allows Primary Care Clinics to apply for PE for Pregnant Women participation while waiting to be approved as a Medi-Cal provider. For more information regarding AB 2307, please refer to the “Programs” tab on the Medi-Cal website (www.medi-cal.ca.gov).

Application Process

Form Requirements

Providers must complete the following two-page form (MC 311):

- *Qualified Provider Application for Presumptive Eligibility Participation*
- *Presumptive Eligibility Qualified Provider Responsibilities and Agreement*

Form Processing

Mail, fax or email the application and responsibilities agreement to:

PE for Pregnant Women Support
Department of Health Care Services
Medi-Cal Eligibility Division, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

Fax: 916-440-5666

Email: PE@dhcs.ca.gov

Approval Notification

Once the provider’s application for PE for Pregnant Women has been approved, the provider receives a welcome letter and packet from PE Support containing the provider’s PE provider number. The welcome letter should be kept on file for reference when ordering additional forms. An initial shipment of program participation forms is automatically sent to the provider.

4 Presumptive Eligibility for Pregnant Women

State of California—Health and Human Services Agency

Department of Health Care Services

QUALIFIED PROVIDER APPLICATION FOR PRESUMPTIVE ELIGIBILITY PARTICIPATION

Presumptive Eligibility Support Unit
MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417
1-800-824-0088
1-800-409-1498 (FAX)

This is an application to become a Qualified Provider for Presumptive Eligibility participation for the purposes of offering Presumptive Eligibility (temporary Medi-Cal) to your pregnant patients. **You must provide prenatal services to qualify for Presumptive Eligibility participation.** Please complete, sign, and return this application to the Presumptive Eligibility Support Unit.

If you have questions about this application or the Presumptive Eligibility (PE) for pregnant women program, contact the PE Support Unit at: 1-800-824-0088. For general information about PE for pregnant women, visit the web site at www.medi-cal.ca.gov.

FOR OFFICIAL USE ONLY

Date Received: _____

PE Number: _____

Authorization Code: _____

PART I

Check only one:

- PRIMARY CARE CLINIC THAT IS NOT YET A MEDI-CAL PROVIDER:** AB 2307 (Chapter 1, Statutes of 2004 [effective July 1, 2005]) allows Primary Care Clinics to apply for Presumptive Eligibility participation while waiting to be determined as a Medi-Cal provider. No provider number is needed at the time of this application, or
- MEDI-CAL PROVIDER:** When applying, you must include your provider number here:

NOTE: This number must match the site applying for PE participation. The provider at this site must be a provider in good standing. If you do not have a provider number, contact the Department of Health Care Services Provider Enrollment Division at (916) 323-1945.

PART II

1. Name of provider

Other name (if any used for provider services)

2. County

Telephone number
()

FAX number
()

3. Mailing address (no P.O. Box) for Site

City

ZIP Code

4. Contact person

Telephone number
()

FAX number
()

5. Please estimate the number of pregnant patients your practice sees each month that are not covered by health insurance or Medi-Cal at the time of their initial pregnancy visit.

Of this number, how many do you expect will need Spanish language forms?

PART III

1. Do you participate in the Comprehensive Perinatal Services Program (CPSP)? Yes No

NOTE: If you are not currently a CPSP provider, you may get information on how to enroll by contacting the Department of Health Care Services, Maternal and Child Health Branch at (916) 650-0401.

2. Do you participate in the Family PACT (Planning, Access, Care, and Treatment) Program? Yes No

NOTE: If you are not currently a Family PACT provider, you may get information on how to enroll by contacting the Department of Health Care Services at (800) 541-5555.

PART IV

CERTIFICATION

I hereby certify that all the above information is true and accurate to the best of my knowledge.

Signature

Title of Authorized Agent

Date

All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government Code, Section 6250, et seq.

If you have questions about becoming a qualified provider for the PE pregnant women program, please contact the (PE) Support Unit at 1-800-824-0088.

Sample: Qualified Provider Application for Presumptive Eligibility Participation

**PRESUMPTIVE ELIGIBILITY
QUALIFIED PROVIDER RESPONSIBILITIES AND AGREEMENT**

I understand that my responsibilities as a Qualified Provider include:

- Offering the Presumptive Eligibility (PE) program to my pregnant patients without health coverage or Medi-Cal;
- Screening interested patients for income eligibility via the prescribed PE forms and guidelines;
- Issuing eligible applicants a PE card and the one-page Medi-Cal application form, issuing replacement cards to recipients upon request;
- Renewing the PE card when the woman presents a copy of her timely application for Medi-Cal or California Work Opportunity and Responsibility to Kids (CalWORKs);
- Informing the pregnant patient at the time of the PE determination that she must file her Medi-Cal (or CalWORKs) application at her local county welfare office within a specified period of time in order for her PE to continue;
- Assisting the pregnant patient in completing her one-page Medi-Cal application if needed;
- Providing a written statement to the applicant if she is ineligible for PE, and informing her that she may still file for Medi-Cal (or CalWORKs) at the county welfare department;
- Notifying the Department of Health Care Services within five working days with the required information on those patients eligible for Presumptive Eligibility and those not eligible due to a negative pregnancy test;
- Maintaining organized records of PE applications for three years from the last date of billing, making these records available to the Department of Health Care Services upon request, and permitting periodic Department review of the records with adequate notice from the Department;
- Attending PE training and keeping current with changes affecting PE through provider bulletins, notices and/or further training.

I, (print name) _____, agree to cooperate with the Department of Health Care Services in complying with the above Qualified Provider responsibilities. I am aware that if I do not comply with these responsibilities and the PE guidelines as outlined in the Medi-Cal Provider Manual, I may lose my status as a Qualified Provider. I agree to notify the Department of Health Care Services in writing of any changes in my application information at least 10 days prior to the effective date of the change.

Signature

Title of Authorized Agent

Date

Form Acquisition Procedures

- Include the National Provider Identifier (NPI) number and PE provider number on the MC 285 *Forms Order*.
- MC 263 – PE for Pregnancy packages are pre-numbered and cannot be copied. All other forms are available for download from the Medi-Cal website and may be photocopied.
- Providers may fax orders to (916) 364-6612 or email to medpublicationorders@maximus.com.
- Allow two to four weeks to receive PE for Pregnancy package orders. Providers should not call before the allotted time for the PE for Pregnancy packages to be printed.
- If a provider has waited longer than four weeks for materials, there is most likely a problem with the order and the contact information given to PE for Pregnant Women Support. For assistance providers should contact PE for Pregnant Women Support email PE@dhcs.ca.gov.
- Multiple calls to PE for Pregnant Women Support are unnecessary unless a provider has additional information.

NOTE

Providers who have issues requiring immediate assistance may email:

Presumptive Eligibility for Pregnant Women Program Analyst
Cynthia Cannon
Cynthia.Cannon@dhcs.ca.gov

PE for Pregnant Women forms are available on the Medi-Cal website (www.medi-cal.ca.gov) by clicking the “Forms” link. Providers unable to access the Internet or download these forms may contact PE for Pregnant Women Support by calling (916) 552-9499. A set of forms is mailed to the provider’s office.

State of California—Health and Human Services Agency

Department of Health Care Services

**FORMS ORDER
PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN PROGRAM**

ORDER THE PE FOR PREGNANT WOMEN APPLICATION PACKAGE (MC 263) BY FAX OR EMAIL:

Fax: (916) 364-6612 or EMAIL: medpublicationorders@maximus.com

Provider Name	NPI Number		PE Provider Number	
Office Name				
Shipping Address (Number, Street) (No P.O. Boxes)	City	State	County	Zip Code
Provider Telephone Number	CA			
Contact Person				

NOTE: Please remember, when indicating the number of MC 263 PE for Pregnant Women Application packages requested, that these packages are pre-numbered and **cannot** be photocopied.

	Quantity
English	
Spanish	

The following supplemental PE forms are available from the Medi-Cal or DHCS website:

MC 285	Forms Order – Presumptive Eligibility (PE)	MC 263–SR	Statement of Residency
MC 264	Patient Fact Sheet	MC 265	Directions for PE Application
MC 266	Directions for Medi-Cal Application	MC 267	Explanation of Ineligibility for PE
MC 283	Weekly PE Enrollment Summary	MC 286	Provider Fact Sheet for PE

Medi-Cal www.medi-cal-ca.gov DHCS www.dhcs.ca.gov

If you are unable to download the above forms from the websites, please call PE Support toll free at 1-800-824-0088, email at PE@dhcs.ca.gov, or fax (916) 440-5666 or 1-800-409-1498 for assistance.

MC 285 (02/2012) – Forms Order

Recipient Enrollment

Eligibility Criteria

Criteria 1: A patient believes she is pregnant.

- The patient has no _____.

Criteria 2: The patient must complete the *Statement of California Residency* form declaring whether or not she is a resident of California and plans to continue to live in California.

- _____ the patient must complete.
- The patient's declaration of California residency is all that is required. The PE for Pregnant Women provider is _____ for verifying California residency. The county will require the PE for Pregnant Women recipient to establish her California residency when she formally applies for Medi-Cal.
- If the patient refuses to sign the *Statement of California Residency*, or declares she is not a resident, you may _____ offer her PE for Pregnant Women program benefits. Complete the bottom portion of the *Statement of California Residency*, titled "Why You Cannot Get Presumptive Eligibility Benefits (Residency)," and give a copy to the patient. Keep the original for your records.

Criteria 3: The patient must meet the self-declared family size and income criteria.

- Income must be at or below _____ for the patient's declared family size.
- "Family Income" for patients younger than 21:
 - Unmarried and living on her own, only _____ is counted.
 - Unmarried and living with parents, _____ is counted.
 - Married, _____ is counted.
 - Married and living with her parents, _____ are counted.
- "Family Members" for persons living in the patient's household:
 - _____ of the patient.
 - _____, _____, or _____ of the patient.
 - The _____ is counted as a member of the family.
 - _____ if she is under 21, unmarried and living with her parents.

Answer Key: 1) Medi-Cal coverage; 2) First form; not responsible; not; 3) 213 percent of the federal poverty guidelines (FPG); her income; her and her parents' income; her and her spouse's income; her, her spouse's and her parents' income; Spouse; Natural, adopted, stepchildren; unborn child; Parents of the patient

Criteria 4: A minor who is younger than 21, unmarried, and does not know her parents' income, or cannot obtain their income because she does not want them to know about her PE for Pregnant Women application, should not be enrolled in the PE for Pregnant Women program.

- Refer the minor to the _____.
- This program provides basic benefits, including _____ - _____ based solely on her income.
- Minor's parents are _____ contacted or included in the determination of services.

Criteria 5: Proof of a full Medi-Cal application is not needed to get PE extensions. Self-attestations are accepted.

- Providers should accept the beneficiary's self-attestation that she has submitted an application for _____ or _____.
- Qualified providers should extend the PE coverage until a _____.

Answer Key: 4) Minor Consent Program; pregnancy-related services; not; 5) Medi-Cal insurance affordability programs; full eligibility determination is made.

STATEMENT OF CALIFORNIA RESIDENCY

(Supplement to Application for Presumptive Eligibility Only—MC 263)

1. Name	Date of Birth
---------	---------------

2. Do you now live in California and plan to continue living here?

Yes, and I can prove this when I apply for Medi-Cal.

No, I do not live in California and I do not plan to stay in California.

If you answered "No" to question 2, or did not answer at all, you cannot get Presumptive Eligibility for Pregnant Women program benefits.

I certify I have read and understand this form. I declare that the information I have given is true, correct, and complete.

Signature or mark of applicant (or legal guardian)	Date
Signature or witness to mark of applicant (or legal guardian)	Date

FOR PROVIDER USE ONLY

INSTRUCTIONS TO PROVIDER: *If your patient answers "Yes" to question 2, you may proceed with the Presumptive Eligibility for Pregnant Women program determination. You must attach this form to the Application for Presumptive Eligibility Only (MC 263 PE for Pregnancy).*

If your patient answers "No" to question 2, or does not answer at all, you cannot offer Presumptive Eligibility for Pregnant Women coverage to the patient.

You must complete the section below and give a copy of this form to the patient.

WHY YOU CANNOT GET PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN BENEFITS (RESIDENCY)

You cannot get Presumptive Eligibility benefits because when you were asked to answer question 2 above:

- You said you do not live in California and do not plan to stay in this state, or
- You did not answer question 2 at all.

Even though you cannot get Presumptive Eligibility for Pregnant Women benefits, you may still apply for Medi-Cal at your county social services office, by telephone at 1-800-880-5305 or on-line through <http://www.benefitscal.org/BenefitsPortal/landing.html> or www.healthapp.net

Provider Signature	Provider Printed Name	Date
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DECLARACIÓN DE RESIDENCIA EN CALIFORNIA

(Complemento de la Solicitud de Presumptive Eligibility Únicamente MC 263)

1. Nombre	Fecha de Nacimiento
2. ¿Vive actualmente en California y piensa seguir viviendo aquí? <input type="checkbox"/> Sí, y puedo comprobar esto cuando solicite Medi-Cal. <input type="checkbox"/> No, vivo en California y no pienso quedarme en California. Si usted respondió que "No" a la pregunta 2 o no la contestó, no puede recibir los beneficios del programa Presumptive Eligibility for Pregnant Women.	
<i>Certifico que he leído y entiendo este formulario. Declaro que la información que he proporcionado es verdadera, correcta y completa.</i>	
Firma o marca del solicitante (o tutor)	Fecha
Firma del testigo de la marca del solicitante (o tutor)	Fecha
FOR PROVIDER USE ONLY	
<i>INSTRUCTIONS TO PROVIDER:</i> <i>If your patient answers "Yes" (Si) to question 2, you may proceed with the Presumptive Eligibility for Pregnant Women program determination. You must attach this form to the Application for Presumptive Eligibility Only (MC 263 PE for Pregnancy).</i> <i>If your patient answers "No" to question 2, or does not answer at all, you cannot offer Presumptive Eligibility for Pregnant Women coverage to the patient.</i> <i>You must complete the section below and give a copy of this form to the patient.</i>	

POR QUÉ NO PUEDE RECIBIR USTED LOS BENEFICIOS DE ELEGIBILIDAD PRESUNTA PARA MUJERES EMBARAZADAS (RESIDENCIA)

Usted no puede recibir beneficios de Presumptive Eligibility porque cuando se le pidió responder la pregunta 2, más arriba:

- Usted dijo que no vivía en California y que no pensaba quedarse en este estado, o
- Usted no respondió la pregunta 2.

A pesar de que usted no puede recibir los beneficios de Presumptive Eligibility for Pregnant Women, podría aún solicitar Medi-Cal en la oficina de servicios sociales de su condado, por teléfono al 1-800-880-5305 o en línea a través de <http://www.benefitscal.org/BenefitsPortal/landing.html> o www.healthapp.net

Provider Signature	Provider Printed Name	Date / /
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Case Scenario

Susie is a single woman who is pregnant with twins and has two other children, Mary and Johnny, from a previous marriage. Johnny lives with his dad. Susie's gross monthly income is \$2,100, which includes alimony from her previous marriage. Susie's live-in boyfriend, Tom, brings home \$1,500 from his job. Susie's sister, Amanda, and her 21-year-old niece, Kimberly, recently moved into Susie's home. Amanda receives \$550 a month from Social Security and Kimberly is currently unemployed.

Income Eligibility Guidelines

213 Percent of Federal Poverty Guidelines by Family Size

Effective April 1, 2015 through March 31, 2016

Number of Persons	Gross Monthly Income	Gross Annual Income
2	\$2,828	\$33,931
3	\$3,566	\$42,792
4	\$4,305	\$51,653
5	\$5,043	\$60,514
6	\$5,782	\$69,375
7	\$6,520	\$78,235
8	\$7,258	\$87,096
9	\$7,997	\$95,957
10	\$8,735	\$104,818
For each additional family member add:	\$739	\$8,861

Brainteaser

- For PE for Pregnant Women purposes, how many people will be counted in Susie's household?

- Is Tom, who is Susie's live-in boyfriend, counted in the family size? If not, why?

- Does Susie need to include Amanda and niece Kimberly in her family size? What about Amanda's monthly \$550 in Social Security? If not, why?

- According to PE for Pregnant Women eligibility guidelines, is Susie eligible?
Yes or No?

Answer Key: 1) Four; 2) No, boyfriends are not included in family size; 3) No, Amanda and niece Kimberly are not counted as family members according to eligibility criteria nor is Amanda's income counted; 4) Yes

Application Process

Forms and Documents

Documents are pre-printed with the QP's name, address and ID number, along with the patient ID number, on "carbonless copy" paper. The PE for Pregnancy package includes these documents:

PE for Pregnancy Package
Proof of Eligibility
PE for Pregnancy Application
Medi-Cal Application

Application for Presumptive Eligibility Only

- The Social Security Number (SSN) is optional.
- The signature of the applicant is required.
- The PE ID number is the patient's temporary ID number.
- The Qualified Providers should extend the PE coverage until a full eligibility determination is made.

Proof of Eligibility Card

- The Proof of Eligibility card is issued once PE for Pregnant Women eligibility is determined.
- The signature of the patient is required on the card.
- The patient is eligible for PE until a full eligibility determination is made.

Medi-Cal Application

- Providers should assist the patient, if requested. The patient has the responsibility of submitting a Medi-Cal application to their county Social Services Agency.
- Providers may fax the Medi-Cal application to the county where the patient resides using the fax number provided on the PE for Pregnant Women Web page. Only the Medi-Cal application should be faxed.

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State of California – Health and Human Services Agency

Department of Health Care Services

APPLICATION FOR PRESUMPTIVE ELIGIBILITY ONLY

If you need help filling out this form, please ask your provider for help.

APPLICANT INFORMATION				
Last Name	First Name	Middle	Date of Birth	
Your Social Security number if you have one: _____ -- _____ -- _____				
Home address:	Number	Street	City	Zip Code
Mailing address (if different):	Number	Street	City	Zip Code
Telephone number(s):	Home	Work	Message	
If homeless, tell us where you can be reached:				
MEDI-CAL OR OTHER HEALTH INSURANCE				
Do you have Medi-Cal or other health insurance now? <input type="checkbox"/> Yes <input type="checkbox"/> No				
FAMILY MEMBERS				
Please list all family members below. (This includes your spouse and any children under age 21 living with you)				
Name: Last,	First,	Middle Initial	Relationship	
			Self	
No need to list names for the unborn.			Unborn (If expecting multiple births, how many?)	
			Spouse	
			Child	
			Child	
If you need more space to answer, please write on the back of this form or a sheet of paper and check this box. <input type="checkbox"/>				
MONTHLY INCOME				
Please include money you or family members listed on this application get from jobs, tips, commissions, pensions, Social Security, child and/or spousal support, gifts, disability, VA, or unemployment benefits, etc.			\$ _____	
<i>I CERTIFY I HAVE READ AND UNDERSTOOD THIS FORM.</i>				
<i>I DECLARE THAT THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT, AND COMPLETE.</i>				
Signature or mark of applicant (or legal guardian)			Date	
Signature of witness to mark of applicant (or legal guardian)			Date	
THIS COMPLETES YOUR APPLICATION FOR PRESUMPTIVE ELIGIBILITY				
FOR PROVIDER USE ONLY				
Total Family Income: _____		Number in Family: _____		Income Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No
		PE ID#: 12-7G-ZA34567-8-90		
		FIRST GOOD THRU DATE:		
		SECOND GOOD THRU DATE:		
		THIRD GOOD THRU DATE:		
PE Provider Name: _____		PATIENT NAME:		
		DOB (MM/DD/YYYY):		
PE Provider Signature: _____		Pregnancy Test Results? <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
PE Provider Title: _____		Date: _____ E.D.C.: _____		

MC 263 PE FOR PREGNANCY - APPLICATION (09/2011)

Sample: Application for Presumptive Eligibility Only

Pregnancy Testing

If the patient meets the income criteria for PE for Pregnant Women, the QP may conduct a pregnancy test only if the beneficiary requests one.

Medical Verification of Pregnancy is not Necessary

The MC 263 – PE for Pregnancy Provider instructions does not require the provider to ask for medical verification of pregnancy for purposes of enrollment into the PE for Pregnant Women Program.

If the patient does not meet the income criteria, or if the pregnancy test is negative, she is ineligible for PE for Pregnant Woman, but the office visit and pregnancy test are still reimbursable. Issue the patient an *Explanation of Ineligibility for Presumptive Eligibility* form and report her ineligibility to DHCS to bill for the visit and pregnancy test.

Eligibility Limitations

Eligibility for PE for Pregnant Women is limited to one per pregnancy. If PE for Pregnant Women is granted to a patient and she is not eligible for Medi-Cal, she should not be re-evaluated for the PE for Pregnant Women program during that pregnancy. If her Medi-Cal application is denied, providers may arrange for private payments.

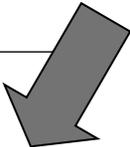
State of California – Health and Human Services Agency	Department of Health Care Services
Provider Name	Provider Telephone Number
Provider Address	
Patient Name	
Patient Address	
Date	
<p><i>EXPLANATION OF INELIGIBILITY FOR THE PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN PROGRAM</i></p> <p>This is to advise you that based on the information you provided, you are not eligible for the Presumptive Eligibility for Pregnant Women program because of the reason checked below:</p> <p><input type="checkbox"/> Your total family income is more than 200 percent of the Federal Poverty Level for your family size.</p> <p><input type="checkbox"/> You are not pregnant.</p>	
Signature	
Name of person completing determination	Title
<p>NOTICE: You may be eligible for the regular Medi-Cal program or other county medical programs. You may apply in person at the social services agency in your county, by telephone at 1-800-880-5305 or online at http://www.benefitscal.org/BenefitsPortal/landing.html or www.healthapp.net.</p>	
MC 267 (09/2011) Explanation of Ineligibility	

Sample: Explanation of Ineligibility for Presumptive Eligibility

Enrollment Approval

PE for Pregnant Women Card Issuance

- Patient’s name, date of birth, valid month with year and “patient eligible until final eligibility is determined” must be completed on the Proof of Eligibility (PE ID) card.
- The “First Good-Thru” date is no longer entered on the PE ID card.
- Patients must be informed that the PE ID card can be used for ambulatory prenatal care and pharmacy services only.

PROOF OF ELIGIBILITY		
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN PROGRAM		
DO NOT DESTROY THIS FORM/NO DESTRUYA ESTA FORMA		
PATIENT SIGNATURE FIRMA PACIENTE _____	DATE/FECHA: _____	
VALID FOR AMBULATORY PRENATAL AND PHARMACY SERVICES ONLY (PROVIDERS MUST MANUALLY BILL MEDI-CAL FOR ALL SERVICES PROVIDED)		
PE ID# 12-7G-ZA34567-8-90 FIRST GOOD THRU DATE: SECOND GOOD THRU DATE: THIRD GOOD THRU DATE:	 <p style="text-align: center;">Patient Eligible until final eligibility determined</p>	
<table border="1" style="margin: auto;"> <tr> <td style="padding: 5px;"> PATIENT NAME JANE DOE DOB (MM/DD/YY) </td> </tr> </table>		PATIENT NAME JANE DOE DOB (MM/DD/YY)
PATIENT NAME JANE DOE DOB (MM/DD/YY)		
PE Provider Name: _____		
PE Provider Signature: _____		
PE Provider Title: _____	Date: _____	

Medi-Cal Identification Card Presumptive Eligibility

Example: Jane Doe calls in on January 7, 2016. She thinks she might be pregnant and you have an opening the same day. Jane comes in that afternoon. You do a pregnancy test and it’s positive. She has no insurance and she meets all of the PE for Pregnant Women eligibility criteria.

Providers will no longer issue 1st, 2nd or 3rd good-thru dates on PE ID cards. In the space provided for your dates you instead write the following: **Patient eligible until final eligibility is determined.** PE coverage extends throughout pregnancy until the patient voluntarily tells the provider she has been approved for Medi-Cal, Covered California or has been denied coverage.

Medi-Cal Application

After the patient applies for Medi-Cal, her PE eligibility continues until the county determines if she is eligible for Medi-Cal.

State of California – Health and Human Services Agency

Department of Health Care Services

APPLICATION FOR MEDI-CAL PROGRAM ONLY

You must apply for Medi-Cal by the end of the month after your PE starts in order for your PE for Pregnant Women to continue after that. Take this form to your local County Social Services Agency and tell the receptionist you wish to apply for Medi-Cal and retroactive coverage. You can also apply by telephone at 1-800-880-5305 or on-line at <http://www.benefitscal.org/BenefitsPortal/landing.html> or www.healthapp.net

Please complete items 1 through 9 and sign the Certification below.

1. Last name		First Name	Middle	2. Date of Birth	COUNTY USE ONLY
3. Home address: (number/street/city/Zip code)					
Mailing address, if different: (number/street/city/Zip code)					COUNTY OF APPLICATION
4. Telephone number(s): (home/work/message)					
5. If homeless, tell us how you can be reached:					
6. Social Security number (SSN) if you have one:					
7. Has anyone in your household ever asked for or gotten aid anywhere? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, explain: under what name, where, when, and type(s) of aid.					
If you need more space to answer, please write on the back of this form or a sheet of paper and check this box. <input type="checkbox"/>					
8. Does anyone in your household have a personal emergency: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what kind? <input type="checkbox"/> Medical <input type="checkbox"/> Child Abuse <input type="checkbox"/> Spousal Abuse <input type="checkbox"/> Other Is anyone pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", does she have Presumptive Eligibility for Pregnant Women benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have another kind of emergency which threatens your health or safety? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, explain:					
9. The law says we must get your ethnic group and primary language. This won't affect your eligibility.					
A. Ethnic Group (Everyone must also answer B) If you do not complete these items, the county will do it for you. Are you Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO					
B. Race / Ethnic Origin: Check all boxes that apply to you. <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian (If checked please select one or more of the following): <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (If checked please select one or more of the following): <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other (specify) _____					
C. Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign <input type="checkbox"/> Cantonese <input type="checkbox"/> Cambodian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify) _____					
I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents given are correct and true to the best of my knowledge and belief.					
I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.					
Signature (or mark) of applicant or authorized representative				Date signed	
Signature of witness to mark or interpreter				Date signed	

MC 263 PE FOR PREGNANCY - MEDI-CAL APPLICATION (09/2011)

Sample: Application for Medi-Cal Program Only

Helping Patients Submit a Medi-Cal Application

Qualified provider (QPs) for the PE for Pregnant Women Program have the option of helping patients to complete and submit the short Medi-Cal application included as part of the MC 263 PE for Pregnancy Application Package. At the provider's option, patients may complete the Medi-Cal application and have the provider fax it directly to the recipient's Medi-Cal office using the fax numbers provided below. The fax numbers are specifically for the Medi-Cal application contained in the PE for Pregnancy Application Package.

County	Fax
Alameda	(510) 293-0265
Alpine	(530) 694-2252
Amador	(209) 257-0242
Butte	(530) 538-2164
Calaveras	(209) 754-4536
Colusa	(530) 458-0492
Contra Costa	(925) 706-4589
Del Norte	(707) 465-1783
El Dorado	(530) 295-2672
Fresno	(559) 453-4343
Glenn	(530) 934-6521
Humboldt	(530) 269-3598
Imperial	(760) 337-5716
Inyo	(760) 872-4950
Kern	(661) 631-6573
Kings	(559) 585-0346
Lake	(707) 995-4204
Lassen	(530) 251-8370
Los Angeles	(562) 908-0593
Madera	(559) 675-7983
Marin	(415) 473-3556
Mariposa	(209) 966-8251
Mendocino	(707) 463-7859
Merced	(209) 354-2505
Modoc	(530) 233-2136
Mono	(760) 924-5431
Monterey	(831) 755-8408
Napa	(707) 253-6095
Nevada	(530) 265-9860
Orange	(714) 435-4625
Placer	(916) 784-6100

County	Fax
Plumas CWD Office	(530) 283-6368
Riverside	(951) 413-5549
Sacramento	(916) 874-2729
San Benito County	(831) 637-9754
San Bernardino	(909) 475-8550
San Diego	(858) 467-9088
San Francisco	(415) 555-1977
San Joaquin	(209) 932-2662
San Luis Obispo	(805) 781-1944
San Mateo	(650) 622-9884
Santa Barbara	(805) 346-8366
Santa Clara	(408) 295-9248
Santa Cruz	(831) 786-7100
Shasta	(530) 225-5228
Sierra	(530) 993-6767
Siskiyou	(530) 843-2723
Solano	(707) 553-5408 (Vallejo and Benicia)
Solano	(707) 421-4748 (All other Areas)
Sonoma	(707) 565-3578
Stanislaus	(209) 558-2189
Sutter	(530) 822-7212
Tehama	(530) 527-5410
Trinity	(530) 623-1250
Tulare	(559) 713-5180
Tuolumne	(209) 533-5714
Ventura	(805) 658-4530
Yolo	(530) 661-2781
Yuba	(530) 749-6797

Faxing the Medi-Cal Application

For documentation purposes, the provider's fax receipt can be used as verification that the recipient has submitted a Medi-Cal application.

Replacement Card

If the patient loses her PE for Pregnant Women card, the following conditions apply:

- Providers must inform the patient to apply for a replacement card with the QP that initially determined her PE for Pregnant Women eligibility.
- The initial QP must check the patient's records to verify that she was determined eligible for PE for this pregnancy then issue a new card with a new number.
- Patient may be instructed that she may apply for Medi-Cal at the county Social Services office and receive a Medi-Cal card once her Medi-Cal eligibility is determined.

Reminders

- Providers must write the word "Replacement" and the original 14-digit ID number on the new card.
- Providers must report the replacement on the *Weekly Presumptive Eligibility (PE) for Pregnant Women Enrollment Summary* (MC 283) within 10 working days to PE for Pregnant Women Support by either faxing the form to (916) 440-5666, emailing to PE@dhcs.ca.gov or mailing to the following address:

DHCS
PE for Pregnant Women Support – MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

- Any claims submitted after the patient is issued a replacement card must be billed with the new 14-digit number.

Scope of Coverage

The tables below list the scope of coverage for Presumptive Eligibility for Pregnant Women. PE for Pregnant Women services follows Medi-Cal policy. Prescription drugs for conditions related to pregnancy are also reimbursable.

NOTE

Medication to treat the H1N1 virus is a benefit of PE for Pregnant Women.

Reimbursable CPT-4 Codes

CPT-4 Code	Description
01965 *, 01966 *	Anesthesia for abortion procedures
58301	Removal of intrauterine device (IUD)
59000 *	Amniocentesis
59012	Cordocentesis
59020	Fetal contraction stress test
59025	Fetal non-stress test
59812	Treatment of spontaneous abortion
59820, 59821	Treatment of missed abortion
59830	Treatment of septic abortion
59840 – 59857 †	Induced abortion
76801 *, 76802 *, 76805 *, 76810 – 76817 *	Ultrasound
76825 *	Fetal echocardiography
80055	Obstetric panel

* Medical justification is required for these codes. See the *Pregnancy: Early Care and Diagnostic Services* section (preg early) in the appropriate Part 2 manual for applicable policy and billing information.

† Refer to the *Abortions* section (abort) in the appropriate Part 2 manual for specific billing information.

Reimbursable CPT-4 Codes

CPT-4 Code	Description
80163	Digoxin; free
80165	Valproic acid; free
80300	Drug screen, any number of drug classes from drug class list A; any number of non-TLC devices or procedures, capable of being read by direct optical observation, including instrumented-assisted when performed, per date of service
80301	single drug class method, by instrumented test systems, per date of service
80302	Drug screen, presumptive, single drug class from drug class list B, by immunoassay or non-TLC chromatography without mass spectrometry, each procedure
80303	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; thin layer chromatography procedure(s), per date of service
80304	not otherwise specified presumptive procedure, each procedure
80320	Alcohols
80321	Alcohol biomarkers; 1 or 2
80322	3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	3 or 4
80326	5 or more
80327	Anabolic steroids; 1 or 2
80328	3 or more
80329	Analgesics, non-opioid; 1 or 2
80330	3–5
80331	6 or more

Reimbursable CPT-4 Codes

CPT-4 Code	Description
80332	Antidepressants, serotonergic class; 1 or 2 3–5 6 or more
80333	
80334	
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2 3–5 6 or more
80336	
80337	
80338	Antidepressants, not otherwise specified
80339	Antiepileptics, not otherwise specified; 1–3 4–6 7 or more
80340	
80341	
80342	Antipsychotics, not otherwise specified; 1–3 4–6 7 or more
80343	
80344	
80345	Barbiturates
80346	Benzodiazepines; 1–12 13 or more
80347	
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1–3 4–6 7 or more
80351	
80352	
80353	Cocaine
80354	Fentanyl
80355	Gabapentin, non-blood
80356	Heroin metabolite

Reimbursable CPT-4 Codes

CPT-4 Code	Description
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	3 or 4
80364	5 or more
80365	Oxycodone
80366	Pregabalin
80367	Propoxyphene
80368	Sedative hypnotics
80369	Skeletal muscle relaxants; 1 or 2
80370	3 or more
80371	Stimulants, synthetic
80372	Tapentadol
80373	Tramadol
80374	Stereoisomer analysis; single drug class
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1–3
80376	4–6
80377	7 or more
81025	Pregnancy test (urine)
81220 II	CFTR (cystic fibrosis transmembrane conductance regulator) gene analysis; common variants (eg, ACMG/ACOG guidelines)

II Refer to the *Genetic Counseling and Screening* (gene coun) section in the Part 2 manual for applicable policy and billing information.

Reimbursable CPT-4 Codes

CPT-4 Code	Description
81508 §	Fetal congenital abnormalities screening (first trimester)
81511 §	Fetal congenital abnormalities screening (second trimester)
82731 ‡	Fetal fibronectin, cervicovaginal secretions, semi-quantitative
82950	Glucose; quantitative post glucose dose
82951	tolerance test (GTT), three specimens (includes glucose)
82952	tolerance test, each additional beyond three specimens
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)
83021	chromotography (eg, A2, S, C, and/or F)
84702 ***	Quantitative chorionic gonadotropin
84703 ***	Qualitative chorionic gonadotropin
85004	Blood count; automated differential WBC count
85007	blood smear, microscopic examination with manual differential WBC count
85009	manual differential WBC count, buffy coat
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count)
86592	Syphilis test; qualitative (e.g., VRDL, RPR, ART)
86689	HTLV or HIV antibody, confirmatory test
86701	HIV-1
86702	HIV-2
86703	Antibody, HIV-1 and HIV-2, single assay
86762	Antibody; rubella

‡ Refer to the *Pregnancy: Early Care and Diagnostic Services* (preg early) section in the appropriate Part 2 manual for applicable diagnosis and frequency billing restrictions.

§ Refer to the *Pathology: Molecular Pathology* (path molec) section in the Part 2 manual for applicable billing with an appropriate diagnosis code.

*** Refer to the *Pathology: Chemistry* section (path chem) in the Part 2 manual for specific billing information.

Reimbursable CPT-4 Codes

CPT-4 Code	Description
86850	Antibody screen, RBC, each serum technique
86900	ABO
86901	Rh (D)
87077	aerobic isolate, additional methods required for definitive identification, each isolate
87081	Culture, presumptive, pathogenic organisms, screening only
87086	Culture, bacterial; quantitative colony count, urine
87088	with isolation and presumptive identification of each isolate, urine
87147	Culture typing; immunologic method, other than immunofluorescence (eg, agglutination grouping), per antiserum
87184	Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents)
87186	microdilution or agar dilution
87340	Infectious agent detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87535	HIV-1, amplified probe technique, includes reverse transcription when performed
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87624 §	Human papillomavirus, high-risk types
87625 §	Human papillomavirus, types 16 and 18 only, includes type 45, if performed
87661	Trichomonas vaginalis, amplified probe technique
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87806	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies

§ Refer to the *Pathology: Molecular Pathology* (path molec) section in the Part 2 manual for applicable billing with an appropriate diagnosis code.

Reimbursable CPT-4 Codes

CPT-4 Code	Description
88141	Cytopathology, cervical or vaginal, requiring interpretation by physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision (Thinprep)
88147	Cytopathology smears, cervical or vaginal, screening by automated system under physician supervision
88148	screening by automated system under manual rescreening physician supervision
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88174	Cytopathology, cervical or vaginal, collected in preservation fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	and manual rescreening or review, under physician supervision
88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotype, with banding
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6 to 12 colonies, one karyotype, with banding
88300 §	Level I – Surgical pathology, gross examination only
88304 §	Level III – Surgical pathology, gross, and microscopic examination
88305 §	Level IV – Surgical pathology, gross, and microscopic examination
90384	Rhogam injection, full dose
90385	Rhogam injection, mini dose
90632 **	Hepatitis A vaccine, adult dosage, intramuscular use
90636 **	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, intramuscular use
90654	Influenza virus vaccine, split virus, preservative-free, for intradermal use

** Refer to the *Immunizations* (immune) section in the appropriate Part 2 manual for specific billing information.

§ Refer to the *Pathology: Molecular Pathology* (path molec) section in the Part 2 manual for applicable billing with an appropriate diagnosis code.

Reimbursable CPT-4 Codes

CPT-4 Code	Description
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90746	Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	each additional hour
96374	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	each additional sequential intravenous push of a new substance/drug
99000	Handling and/or conveyance of specimen
99201	Office visit – new patient (for confirmation of pregnancy; see the <i>Pregnancy: Early Care and Diagnostic Services</i> section in the appropriate Part 2 manual)
99211	Office visit – established patient (for confirmation of pregnancy; see the <i>Pregnancy: Early Care and Diagnostic Services</i> section in the appropriate Part 2 manual)
99281	Emergency department visit; self limited or minor
99282	low to moderate severity
99283	moderate severity
99284	high severity
99285	high severity with immediate threat to life or physiologic function

Brainteaser

1. What diagnosis code is used for confirmation of pregnancy?
_____.
2. When a patient's pregnancy test is negative what services can be billed?
_____ and _____ or _____.
3. Do we pay for an ultrasound to determine the gender of a baby?
Yes or *No*?

Answer Key: 1) N91.2 Amenorrhea, unspecified; 2) 81025 and 99201 or 99211; 3) No

Reimbursable HCPCS Codes

Please refer to the *Presumptive Eligibility* section (presum) in the Part 2 provider manual.

HCPCS Code	Description
A4649 †	Surgical supply; miscellaneous
G0431	Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0434	Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening
J1725	Injection, hydroxyprogesterone caproate, 1 mg
S0190 †	Mifepristone 200 mg (RU-486)
S0191 †	Misoprostol 200 mcg
S0197	Prenatal Vitamins, 30-day supply
S0199 †	Medical abortion
Z1030	Contraction stress test (non-oxytocin)
Z1032	Initial comprehensive pregnancy-related office visit
Z1034	Antepartum visit
Z6200 – Z6500 (excluding Z6208, Z6308 and Z6414)	CPSP services (CPSP providers only)
Z7500	Treatment room
Z7502	Use of emergency room

† Refer to the *Abortions* (abort) section in the appropriate Part 2 provider manual for specific billing information.

Non-Benefits

_____, _____ and _____ are not included in the scope of benefits for PE for Pregnant Women patients. If a patient needs a procedure that is not a PE for Pregnant Women benefit, she can apply for retroactive Medi-Cal benefits, which may cover those services if she is eligible.

HIPAA Code Conversion for Local Modifier ZS

Effective for dates of service on or after August 1, 2015, DHCS is discontinuing local modifier ZS. Modifier ZS designates both the professional (26) and technical (TC) components of a split-billable procedure on a claim or *Treatment Authorization Request* (TAR). When billing for both the professional and technical components, a modifier is neither required nor allowed. This change is to continue HIPAA compliance efforts and to align with the Centers for Medicare & Medicaid Services (CMS) guidelines.

Discontinuing local modifier ZS will affect claims and TARs for all split-billable procedures except for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and Positron Emission Tomography (PET) procedures. See the relevant sections of the Part 2 Medi-Cal Billing and Policy manual for details pertaining to the use of modifiers for MRI, MRA and PET procedures.

Answer Key: Inpatient services; delivery services; family planning services

Reporting Requirements

Eligibility

Providers must report eligibility to DHCS by completing a photocopy of the *Weekly PE Enrollment Summary Form* (MC 283) and faxing the form to (916) 440-5666, emailing it to PE@dhcs.ca.gov, or mailing to the following address:

DHCS
PE Support
P.O. Box 997417
Sacramento, CA 95899-7417

NOTE

The completed *Weekly PE Enrollment Summary* form must be sent within five working days from the date the first patient on the list became eligible for PE for Pregnant Women.

Enrollment

When completing the *Weekly PE Enrollment Summary* (MC 283), ensure that the following information is provided for each patient:

- PE for Pregnant Women enrollment date
- Temporary Medi-Cal ID number (from Proof of Eligibility card)
- Patient's name
- Date of birth, SSN (optional)

WEEKLY PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN ENROLLMENT SUMMARY

Provider Name				Week Ending
Provider Address	City	State	Zip Code	PE Provider Number
Provider Telephone Number ()	Contact Person			Provider NPI Number

INSTRUCTIONS: Patient enrollment into the PE for Pregnant Women program must be reported no later than five working days from the enrollment date of the first patient listed on the summary. Do not use this form to report multiple weeks or months of enrollments. For each patient enrolled in the PE for Pregnant Women program, complete the information below. The completed form must be sent to , the Department of Health Care Services, PE for Pregnant Women Support Unit by mail: MS 4607, P.O. Box 997417, Sacramento, CA 95899-7417, by fax: 1-916-440-5666 or 1-800-409-1498, or email: PE@dohcs.ca.gov. Do not send other PE for Pregnant Women forms. Please print legibly in black or blue ink only.

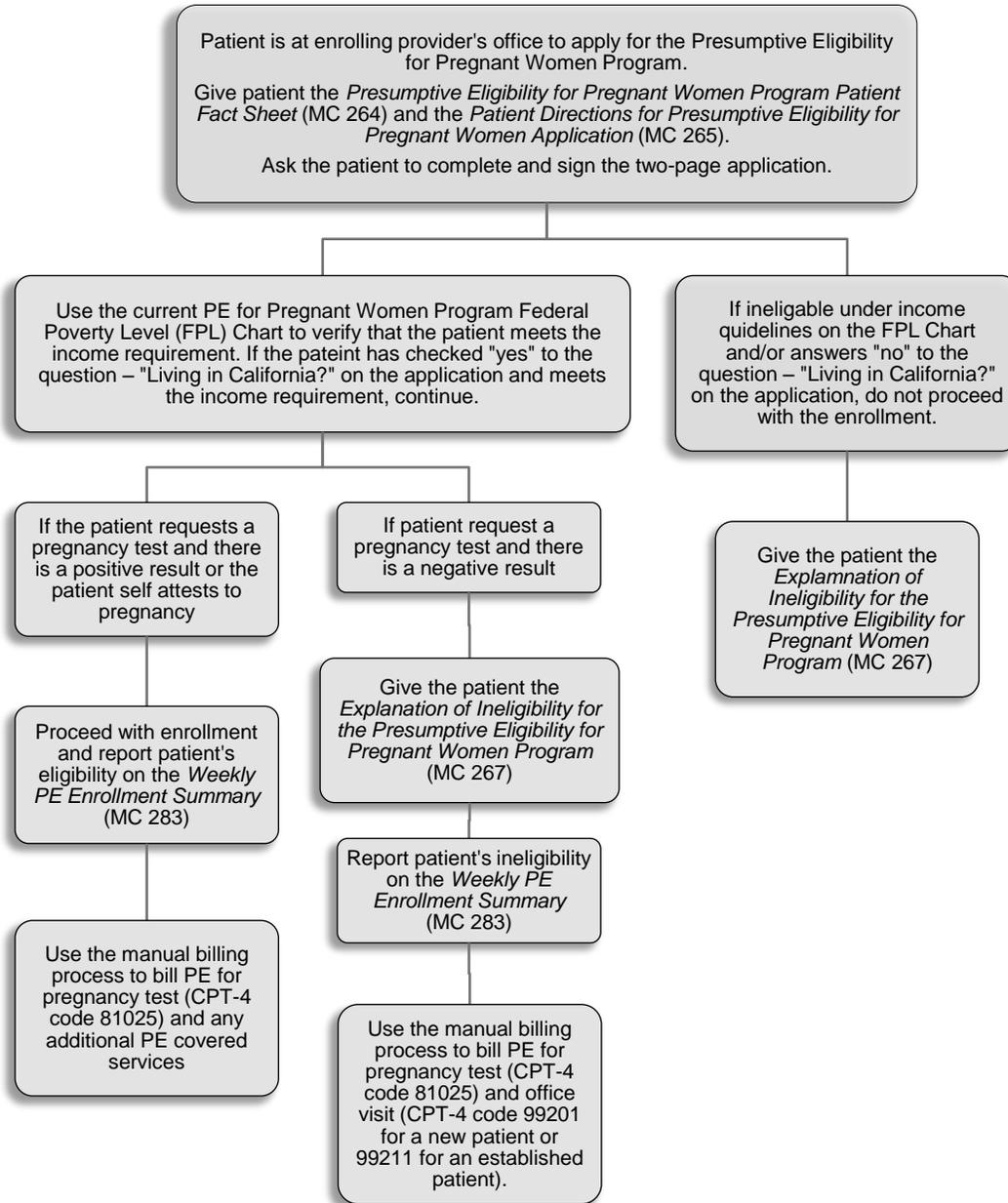
	PE Enrollment Date	Proof of Eligibility PE ID #*)	Patient's Name		Date of Birth	Social Security Number (Optional)	Test Results (EDC or NEG)
			Last	First			
	01/01/12	34-7G-ZA00101-2-50	Smith	Jane	01/01/76	123-45-6789	07/01/12
1	/ /				/ /		
2	/ /				/ /		
3	/ /				/ /		
4	/ /				/ /		
5	/ /				/ /		
6	/ /				/ /		
7	/ /				/ /		
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The MC 283 may be downloaded at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx>
 Visit the PE for Pregnant Women website at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx>

MC 283 (05/2012) Weekly Enrollment Summary

Sample: Weekly Presumptive Eligibility (PE) for Pregnant Women Enrollment Summary

Presumptive Eligibility Process Flowchart



Supplemental Information

Program Benefits Comparison	
Presumptive Eligibility Program	Family PACT Program
No charge	No charge
Eligibility self-declared – no proof	Eligibility self-declared – no proof
Income: 213 percent of Federal Poverty Guidelines (FPG) – family of two	Income: 200 percent of Federal Poverty Guidelines (FPG) – family of one
Paper enrollment – temporary Medi-Cal PE paper ID card	Electronic enrollment – plastic card
Two-month eligibility and extensions are available as long as the patient has a Medi-Cal application pending	12-month eligibility with annual renewal
No confidentiality for minors	Confidentiality
Pregnancy test upon request and visit	Pregnancy test and visit; as clinically needed
Sexually transmitted infection (STI) testing and treatment	STI testing and treatment
HIV testing	HIV testing; as clinically indicated when provided in conjunction with a family planning visit
PAP testing	PAP testing and treatment of cervical abnormalities
OB prenatal care	No OB care
Pregnancy termination benefits	No termination benefits
Psychosocial, health education and nutrition counseling (CPSP only)	Family planning counseling
No delivery, hospitalization or postpartum services	Family planning supplies
Hard copy pharmacy billing	Electronic pharmacy billing

Learning Activities

Learning Activity: Test Your Presumptive Eligibility IQ

1. PE for Pregnant Women will reimburse qualified providers for an office visit and a negative pregnancy test.
True False
2. The patient applying for PE for Pregnant Women does not have to show proof of California residency.
True False
3. A patient must show proof that she has already applied for Medi-Cal before she can be enrolled in PE for Pregnant Women.
True False
4. A patient is eligible for PE for Pregnant Women until Medi-Cal makes an eligibility determination.
True False
5. If the pregnant PE for Pregnant Women patient does not apply for Medi-Cal and her PE for Pregnant Women expires, she becomes a cash pay patient.
True False
6. All pregnancy-related medication is payable by PE for Pregnant Women.
True False
7. PE for Pregnant Women pays for inpatient, delivery, and family planning services.
True False
8. Providers may follow up on a denied claim that was billed with the PE for Pregnant Women – Proof of Eligibility ID number by using an Appeal only.
True False
9. CIF forms may not be used to follow up on a denied claim that was billed using the PE for Pregnant Women – Proof of Eligibility ID number.
True False
10. A patient may apply for PE for Pregnant Women as many times as she needs to during the same pregnancy.
True False
11. A provider may verify eligibility using the PE for Pregnant Women – Proof of Eligibility ID number in the POS network.
True False

Answer Key: 1) True; 2) True; 3) False; 4) True; 5) True; 6) True; 7) False; 8) True; 9) True; 10) False; 11) False

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

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

Medi-Cal Billing and Policy Provider Manual References

Part 2

Pregnancy Determination (preg determ)

Pregnancy: Early Care and Diagnostic Services (preg early)

Pregnancy Examples: CMS-1500 (preg ex cms)

Pregnancy: Global Billing (preg glo)

Pregnancy: Per-Visit Billing (preg per)

Pregnancy: Share of Cost (preg share)

Acronyms

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

NOTE

Interim codes Z1032, Z1034 and Z1038 are being converted to HIPAA-compliant codes. As they become available, code conversions and effective dates will appear in the Medi-Cal provider bulletins. Please refer to the *Special Appendix* section at the end of this module to learn more about the code conversion.

Description

This training module outlines the CPT-4 and HCPCS codes used to bill for services for providers who render obstetrical care.

Obstetrics Billing Guidelines

Refer to the *Pregnancy Determination* (preg determ) section in the appropriate Part 2 provider manual for the topics below.

Billing for Initial Pregnancy

Office Visit

Brainteasers: True or False

1. When a patient is first seen, an office visit code (CPT-4 codes 99201 – 99215) should be billed with ICD-10-CM diagnosis code N91.2 (amenorrhea, unspecified) to reflect the actual reason the patient was seen to confirm pregnancy.
True False
2. Evaluation and Management office visit codes 99201 – 99215 are reimbursable with a pregnancy-related diagnosis.
True False

Verification of Pregnancy

County welfare departments accept as verification of pregnancy 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.

Brainteaser: True or False

3. Pregnant patients applying for Medi-Cal must submit the written verification of pregnancy statement that provides the estimated date of delivery and sufficient information to verify the pregnancy diagnosis.
True False

Answer Key: 1) True; 2) False; 3) True

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

Pregnancy Related Office Visit (HCPCS Code Z1032)

HCPCS Code Z1032:

1. Is billed after the pregnancy has been confirmed and is considered to be the first prenatal visit.
2. Must be billed with a pregnancy associated diagnosis codes O09.0 – O48.1, O098.011 – O9A.519, Z34.00 – Z34.93.
3. Is billed separately in conjunction with per-visit or global care.
4. Is limited to once in six months per provider, unless care is transferred to another physician during the same pregnancy, or the provider certifies that pregnancy has recurred within a six-month period.
5. Must 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.

Co-management Pregnancy Policy (HCPCS Code Z1032)

6. Consultants who co-manage a pregnancy without _____ should not bill with HCPCS code Z1032 (initial pregnancy-related office visit). Providers must bill HCPCS code Z1034 (per-visit antepartum office visit).

NOTES

Answer Key: 6. complete transfer of care

Per-Visit Billing for Pregnancy

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

Policy

Providers who do not render total obstetrical care during the recipient's entire pregnancy or who render fewer than 13 antepartum visits must bill each visit or procedure separately. The initial pregnancy-related office visit (HCPCS code 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, Referrals for Specialty Care and Postpartum Visit Policy Clarification

Antepartum HCPCS Code Z1034

- Documentation for primary obstetrical providers must conform to current standards equivalent to those defined by the American Congress of Obstetricians and Gynecologists (ACOG) for antepartum visits.
- Documentation by consultants, including those who co-manage a pregnancy, should be consistent with CPT-4 guidelines for consultation services and document the appropriate history, physical examination and medical decision making.
- Services must be separately identifiable from the professional and/or technical components of any diagnostic study performed.

Referrals for Specialty Care (High-Risk)

- Medi-Cal allows consult codes (99241 – 99245) when the service is rendered to an obstetrics patient by a perinatologist or an OB/GYN. Code Z1032 or Z1034 is to be used for any antepartum visit.
- Include a pregnancy diagnosis code on the claim to ensure reimbursement.
- A nurse practitioner may see the patient, but the perinatologist must personally visit and evaluate every high-risk patient and sign off on the patient's chart.

Postpartum HCPCS Code Z1038

- The postpartum visit normally occurs four to six weeks after delivery and must conform to current standards equivalent to those defined by ACOG.
- An office visit seven to 14 days after delivery may be advisable after a cesarean delivery or to follow-up on a complicated gestation. This care is part of the delivery follow-up and is not separately reimbursable.
- More than one postpartum visit is reimbursable in six months if there is documentation of a postpartum complication in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim form or on an attachment.

Per-Visit Obstetrical Codes

HCP/CS/ CPT-4 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
59409; 59514	Vaginal delivery only; cesarean delivery only	1 in 6 months
59525	Subtotal or total hysterectomy after cesarean delivery	1 in 6 months
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

Brainteasers: Per-Visit

1. Reimbursement for antepartum visit (HCP/CS code Z1034) is limited to _____ visits in a nine-month period.
a) eight b) thirteen c) ten

Exception: More than 13 antepartum visits (HCP/CS code Z1034) are allowed in nine months if the provider documents a second pregnancy occurring within those nine months.

2. If providers bill one antepartum HCP/CS code Z1034, they _____ bill globally.
a) must b) cannot
3. If providers bill per-visit CPT-4 code 59409 or 59612 (vaginal delivery only) or 59514 or 59620 (cesarean delivery only), they must bill all antepartum visits separately.
True False
4. Postpartum visit HCP/CS code Z1038 may be billed by the primary maternity care provider or by the provider who saw the patient for only the postpartum office visit.
True False
5. Reimbursement for postpartum visit HCP/CS code Z1038 is limited to _____ in a six-month period.

Answer Key: 1) b; 2) b; 3) True; 4) True; 5) one visit

Per-Visit Billing Example: CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM													
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12													
<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>										1a. INSURED'S I.D. NUMBER 9000000A95001			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JANE				3. PATIENT'S BIRTH DATE 06 12 86 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY ANYTOWN		STATE CA		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER		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 _____			
ZIP CODE 958235555		TELEPHONE (Include Area Code) (916) 555-5555		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER				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 _____	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 01 08 15		15. OTHER DATE MM DD YY QUAL.	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				28. TOTAL CHARGE \$ 18900 29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				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 <i>John Doe</i> DATE 10/30/15		32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN CA 958765555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				33. BILLING PROVIDER INFO & PH # (916) 555-5555		34. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				35. BILLING PROVIDER INFO & PH # (916) 555-5555		36. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				37. BILLING PROVIDER INFO & PH # (916) 555-5555		38. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				39. BILLING PROVIDER INFO & PH # (916) 555-5555		40. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				41. BILLING PROVIDER INFO & PH # (916) 555-5555		42. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				43. BILLING PROVIDER INFO & PH # (916) 555-5555		44. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				45. BILLING PROVIDER INFO & PH # (916) 555-5555		46. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				47. BILLING PROVIDER INFO & PH # (916) 555-5555		48. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				49. BILLING PROVIDER INFO & PH # (916) 555-5555		50. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				51. BILLING PROVIDER INFO & PH # (916) 555-5555		52. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				53. BILLING PROVIDER INFO & PH # (916) 555-5555		54. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				55. BILLING PROVIDER INFO & PH # (916) 555-5555		56. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				57. BILLING PROVIDER INFO & PH # (916) 555-5555		58. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				59. BILLING PROVIDER INFO & PH # (916) 555-5555		60. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				61. BILLING PROVIDER INFO & PH # (916) 555-5555		62. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				63. BILLING PROVIDER INFO & PH # (916) 555-5555		64. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				65. BILLING PROVIDER INFO & PH # (916) 555-5555		66. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				67. BILLING PROVIDER INFO & PH # (916) 555-5555		68. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				69. BILLING PROVIDER INFO & PH # (916) 555-5555		70. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				71. BILLING PROVIDER INFO & PH # (916) 555-5555		72. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				73. BILLING PROVIDER INFO & PH # (916) 555-5555		74. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				75. BILLING PROVIDER INFO & PH # (916) 555-5555		76. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				77. BILLING PROVIDER INFO & PH # (916) 555-5555		78. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				79. BILLING PROVIDER INFO & PH # (916) 555-5555		80. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				81. BILLING PROVIDER INFO & PH # (916) 555-5555		82. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				83. BILLING PROVIDER INFO & PH # (916) 555-5555		84. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				85. BILLING PROVIDER INFO & PH # (916) 555-5555		86. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				87. BILLING PROVIDER INFO & PH # (916) 555-5555		88. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				89. BILLING PROVIDER INFO & PH # (916) 555-5555		90. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				91. BILLING PROVIDER INFO & PH # (916) 555-5555		92. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				93. BILLING PROVIDER INFO & PH # (916) 555-5555		94. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				95. BILLING PROVIDER INFO & PH # (916) 555-5555		96. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				97. BILLING PROVIDER INFO & PH # (916) 555-5555		98. BILLING PROVIDER INFO & PH # (916) 555-5555	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME				99. BILLING PROVIDER INFO & PH # (916) 555-5555		100. BILLING PROVIDER INFO & PH # (916) 555-5555	

Sample: Per-Visit Billing – Vaginal Delivery and Antepartum Office Visit

NOTE

When billing with Place of Service 21, you must indicate in the *Service Facility Location Information* field (Box 32) the name and address where the service took place. Use field 32a to indicate the NPI # that represents the facility in which the service was rendered.

Per-Visit Billing Example: Initial OB visit and Antepartum Office Visit

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTL. # 3b MED. REC. #		4 TYPE OF BILL 731	
8 PATIENT NAME DOE, JANE				9 PATIENT ADDRESS			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION TYPE	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE	
35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE CODE		38 OCCURRENCE DATE	
39 VALUE CODES		40 VALUE CODES		41 VALUE CODES		42 VALUE CODES	
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
1 INITIAL ANTEPARTUM VISIT		Z103299		100115		1	
2 ANTEPARTUM OFFICE VISIT		Z1034SA		100215		1	
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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		10	
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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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		10	
11		12		13		14	
15		16		17		18	
19		20		21		22	
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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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		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	
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79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
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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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	
07		08		09		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		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		00		01		02	
03		04		05		06	

Global Billing for Pregnancy

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

Global OB Billing Policy

Effective for dates of service on or after January 1, 2016, the requirement for global obstetrical (OB) billing has changed from a minimum of eight to 13 antepartum visits.

Global OB billing is only allowed if the provider renders at least 13 antepartum visits (HCPCS code Z1034). The initial comprehensive pregnancy-related office visit (HCPCS code Z1032) may not be counted as one of the 13 visits. 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.

The intent of global billing is to offer a convenient means of billing for providers. Global billing consists of antepartum, 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, hospital discharge and all applicable postoperative care.

Non-Reimbursable Global OB Services

- Antepartum visits (Z1034) reimbursed 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) that are related to the delivery, reimbursed to the same provider and within the 45-day follow-up period of the global OB delivery date

Global Obstetrical Codes

HCPCS/ CPT-4 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

* Refer to the CPT-4 codebook for complete procedure descriptions.

Global billing/ICD-10 Billing Guide

Providers who bill obstetrical services on a global basis will use the FROM date of service to determine the ICD code set used when billing. Claims with a FROM date of service prior to October 1, 2015, must use ICD-9-CM diagnosis codes. Claims with a FROM date of service on or after October 1, 2015, must use ICD-10-CM diagnosis codes.

Transfer of Care

Providers who accept a Medi-Cal transfer patient must bill each antepartum visit separately. Providers who accept a transfer-of-care patient are restricted to the number of visits reimbursed (up to one initial visit [HCPCS code Z1032] and a total of 13 antepartum visits [HCPCS code Z1034]) in nine months by all primary obstetrical providers.

Global Obstetrical Codes and Assistant Surgeons

The following global obstetrical codes are no longer reimbursable to assistant surgeons.

- 59400 (global antepartum care, vaginal delivery and postpartum care)
- 59510 (global antepartum care, cesarean delivery and postpartum care)
- 59610 (routine OB care vaginal delivery w/without episiotomy and/or forceps and postpartum care after previous cesarean delivery)
- 59618 (routine OB care cesarean delivery and postpartum care following attempted vaginal delivery after cesarean delivery)

Brainteasers: Global OB

1. The initial pregnancy-related visit HCPCS code Z1032 is included in the global fee and cannot be billed separately.
True False
2. If fewer than 13 visits are rendered, providers must bill services on a per-visit basis.
True False
3. Global OB claims must be billed on the _____ claim form using the _____ – _____ billing format.
4. If a provider plans to bill globally but does not perform the delivery, each antepartum visit (HCPCS code Z1034) must be billed separately. For any visits that exceed the six-month billing limit, providers should enter code _____ in the _____ field (Box _____) and state in the *Additional Claim Information* field (Box 19) the _____ the patient left their care.
5. To be reimbursed for global claims, providers must verify the recipient's eligibility for services during the _____.
6. Global claims are subject to the six-month billing limit, based on the delivery date.
True False

Answer Key: 1) False; 2) True; 3) CMS-1500, from, through; 4) "1"; EMG, 24C, date; 5) month of delivery; 6) True

CMS-1500 Global Billing Example

Documentation Requirements

- Date of Last Menstrual Period (LMP)
- Hospitalization dates
- Documentation of at least 13 antepartum visits in the *Additional Claim Information* field (Box 19)
- Pregnancy diagnosis
- "From-Through" billing format
- Global delivery procedure code
- Name, address of where the delivery took place and NPI # in Fields 32 and 32a

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 05 08 15				15. OTHER DATE QUAL. MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 02 12 16 TO 02 14 16				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 110215, 111615, 113015, 121415, 122815, 011116, 012516, 020116, 020816				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) CPT7/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPCSOT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 03 15 02 12 16 21				59400 AG				120000	1	NPI		
2										NPI		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 120000		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 <i>Jane Doe</i> DATE 03/30/16				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN, CA 958765555 a. 0123456789 b.				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555 a. 0123456789 b.				

PHYSICIAN OR SUPPLIER INFORMATION

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

Example: Partial CMS-1500 Claim Form

CMS-1500 Global Billing Example: Vaginal Delivery with Tubal Ligation – Same Date of Service

Documentation Requirements

- Date of LMP
- Hospitalization dates
- Documentation of at least 13 antepartum visits in the *Additional Claim Information* field (Box 19)
- Documentation of start/stop times for both procedures in the *Additional Claim Information* field (Box 19) or on an attachment
- Diagnosis codes to support pregnancy and tubal ligation services
- “From-Through” billing format
- Global delivery and tubal ligation procedure codes with appropriate modifiers
- Submission of the PM 330 sterilization *Consent Form*
- Name, address of where the delivery took place and NPI # in Fields 32 and 32a

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 08 15 QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 02 12 16 TO 02 14 16			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 070315, 080415, 090615, 100315 110215, 111615, 113015, 121415, 122815, 011116, 012516, 020116, 020816				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				22. RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0				23. PRIOR AUTHORIZATION NUMBER				24. A. DATE(S) OF SERVICE From To 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. #			
A. D1D1D1D B. D2D2D2D C. _____ D. _____				E. _____ F. _____ G. _____ H. _____				I. _____ J. _____			
1 07 03 15 02 12 16 21				59400 AG				120000 1 NPI			
2 02 12 16 02 12 16 21				58605 AG				40000 1 NPI			
3								NPI			
4								NPI			
5								NPI			
6								NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			
28. TOTAL CHARGE \$ 160000				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.) <i>Jane Doe</i> SIGNED Jane Doe DATE 03/30/16				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN, CA 958765555				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555			
a. 0123456789				b. _____				a. 0123456789 b. _____			

PHYSICIAN OR SUPPLIER INFORMATION

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

Example: Partial CMS-1500 Claim Form

CMS-1500 Global Billing Example: Cesarean Section with Tubal Ligation – Same Date of Service

Documentation Requirements

- Date of LMP
- Hospitalization dates
- Documentation of at least 13 antepartum visits in the *Additional Claim Information* field (Box 19)
- Diagnosis codes to support pregnancy and tubal ligation services
- “From-Through” billing format
- Global delivery and tubal ligation procedure codes with appropriate modifiers
- Submission of the PM 330 sterilization *Consent Form*
- Name, address of where the delivery took place and NPI # in Fields 32 and 32a

NOTE

See Part 2 – *Surgery: Billing with Modifiers* (surg bil mod): This illustrates the policy that allows code 58611 with modifier 51 to be reimbursed at 100 percent on the same date as the primary surgery with modifier AG.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 05 08 15				15. OTHER DATE QUAL: MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 02 12 16 TO 02 14 16				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 110215, 111615, 113015, 121415, 122815, 011116, 012516, 020116, 020816				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <u>D1D1D1D</u> B. <u>D2D2D2D</u> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. 0				22. RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER				24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE EMG C. 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				07 03 15 02 12 16 21 59510 AG				120000 1 NPI			
2				02 12 16 02 12 16 21 58611 51				40000 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 \$ 160000				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.) <i>Jane Doe</i> SIGNED DATE 03/30/16				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN, CA 958765555 a. 0123456789 b.				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555 a. 0123456789 b.			

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Example: Partial CMS-1500 Claim Form

Unique Billing Condition

Assistant Surgeon Billing for Delivery and Tubal Ligation – Same Date of Service

Assistant surgeons must bill CPT-4 code 59514 (cesarean delivery only) with modifier 80 and CPT-4 code 58611 with modifier 99. The *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form must indicate that modifier 99 was used to signify modifier 80 and modifier 51.

NOTE

Delivery services performed in an inpatient setting must be billed on a *CMS-1500* claim form using the physician's National Provider Identifier (NPI). The NPI is entered in Box 33a.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										
Line 2: 99 = 80 + 51										
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. _____		
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										
MM DD YY MM DD YY SERVICE CPT/HCPCS MODIFIER										
1	10	02	15			21		59514	80	
2	10	02	15			21		58611	99	
3										

Common Billing Practice for 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-4 code being billed.
- Frequency must meet the restrictions listed.
- Some claims must have documentation in the *Remarks* field (Box 80) of the *UB-04* claim form and the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form.

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.

Diagnosis, Frequency and Documentation Guidelines

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76801, 76805, 76811	<p>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</p> <p>O03.0 – O03.9 Spontaneous abortion</p> <p>O04.5 – O04.89 Complications following (induced) termination of pregnancy</p> <p>O09.511 – O09.513 Elderly primigravida</p> <p>O09.521 – O09.523 Elderly multigravida</p> <p>O10.011 – O16.9 Edema, proteinuria and hypertensive disorders</p> <p>O20.0 – O29.93 Other maternal disorders</p> <p>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</p> <p>O60.00 – O60.03 Preterm labor without delivery</p> <p>O98.011 – O98.919 Maternal infectious and parasitic diseases</p> <p>O99.011 – O99.89 Other maternal disease classifiable elsewhere</p> <p>O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</p> <p>Z33.2 Encounter for elective termination of pregnancy</p> <p>Z36 Encounter for antenatal screening of mother</p>	<p>Once in 180 days, same provider.</p> <p>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.</p>

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 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 <i>Remarks</i> field (Box 80/ <i>Additional Claim Information</i> field (Box 19) of the claim.
76813	Z36 Encounter for antenatal screening of mother	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. *

* The responsible party, the physician, is required to be certified, regardless of whether performing or merely supervising the ultrasound for nuchal translucency measurement.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76814	Z36 Encounter for antenatal screening of mother	<p>Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/<i>Additional Claim Information</i> field (Box 19) of the claim.</p> <p>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. *</p>
76815	<p>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</p> <p>O03.0 – O03.9 Spontaneous abortion</p> <p>O04.5 – O04.89 Complications following (induced) termination of pregnancy</p> <p>O09.511 – O09.513 Elderly primigravida</p> <p>O09.521 – O09.523 Elderly multigravida</p> <p>O10.011 – O16.9 Edema, proteinuria and hypertensive disorders</p> <p>O20.0 – O29.93 Other maternal disorders</p> <p>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</p> <p>O60.00 – O60.03 Preterm labor without delivery</p> <p>O98.011 – O98.919 Maternal infectious and parasitic diseases</p> <p>O99.011 – O99.89 Other maternal disease classifiable elsewhere</p> <p>O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</p> <p>Z33.2 Encounter for elective termination of pregnancy</p> <p>Z36 Encounter for antenatal screening of mother</p>	<p>Once in 180 days, same provider.</p> <p>Additional claims may be reimbursed if documentation justifies medical necessity.</p>

* The responsible party, the physician, is required to be certified, regardless of whether performing or merely supervising the ultrasound for nuchal translucency measurement.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	<p>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</p> <p>O03.0 – O03.9 Spontaneous abortion</p> <p>O04.5 – O04.89 Complications following (induced) termination of pregnancy</p> <p>O09.511 – O09.513 Elderly primigravida</p> <p>O09.521 – O09.523 Elderly multigravida</p> <p>O10.011 – O16.9 Edema, proteinuria and hypertensive disorders</p> <p>O20.0 – O29.93 Other maternal disorders</p> <p>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</p> <p>O60.00 – O60.03 Preterm labor without delivery</p> <p>O98.011 – O98.919 Maternal infectious and parasitic diseases</p> <p>O99.011 – O99.89 Other maternal disease classifiable elsewhere</p> <p>O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</p> <p>Z33.2 Encounter for elective termination of pregnancy</p> <p>Z36 Encounter for antenatal screening of mother</p>	<p>Once in 180 days (when billed without modifier 59), same provider.</p> <p>Additional claims may be reimbursed if documentation justifies medical necessity. Multiple gestation does not justify second and subsequent claims; use modifier 59.</p> <p>Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/<i>Additional Claim Information</i> field (Box 19) of claim.</p>

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76817	O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity.
76820	O36.5110 – O36.5999 Maternal care for known or suspected poor fetal growth O41.00X0 – O41.03X9 Oligohydramnios O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome	Once in 180 days, same provider. 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 <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76821	O36.0110 – O36.0999 Maternal care for rhesus isoimmunization O36.1110 – O36.1999 Care for other isoimmunization O36.20X0 – O36.23X9 Maternal care for hydrops fetalis O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome O98.511 – 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 <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).
76825, 76827	O24.011 – O24.919 Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	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 <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).
76826, 76828	O24.011 – O24.919 Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days, same provider. 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 <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).

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.

Ultrasound Billing Example: UB-04 Claim Form

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTL. # 3b MED. REC. #		4 TYPE OF BILL 731	
8 PATIENT NAME b DOE, JANE				9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR	
17 STATE		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACCT STATE		30		31 OCCURRENCE CODE		32 OCCURRENCE DATE	
33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH	
37		38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
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Obstetrical Ancillary Services

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

NOTE

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, 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 for recipients whose eligibility is restricted to pregnancy-only Medi-Cal.

2. Office visits for conditions not related to pregnancy must be billed using the appropriate office visit code (CPT-4 codes 99201 – 99215) and a _____-_____ related diagnosis.
3. Fetal stress and non-stress testing (CPT-4 code 59020 and 59025) is limited to _____-_____ pregnancies.

NOTE

CPT-4 code 59025 (fetal non-stress test) may be billed more than 10 times in nine months with any of the following ICD-10-CM diagnosis codes: O09.212 – O09.293, O09.892, O09.893, O24.011 – O24.919, O36.5120 – O36.5939, O36.8920 – O36.8999, O42.112, O42.113.

4. Supplies used during fetal stress or non-stress testing _____ separately reimbursable.
5. CPT-4 codes 59020 and 59025 may be split billed with modifier ____ or _____. When billing for both the professional and technical components, a modifier is not required nor allowed.

Answer Key: 1) include; 2) non-pregnancy; 3) high-risk; 4) are not; 5) 26, TC

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 OB services must make arrangements to collect or obligate the SOC for the month of delivery only.
- Arrangements must be made to collect or obligate the SOC for HCPCS code Z1032 (initial antepartum visit and any non-global OB services [e.g., sonogram or amniocentesis]).
- If 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 are reminded that, if they bill on a fee-for-service basis for obstetrical care, they must collect the SOC for each month in which services were rendered.

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 24 and 35 weeks gestation.

Fetal fibronectin testing is reimbursable when billed with the following:

- CPT-4 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 – HCPCS Code J1725

HCPCS code J1725 (injection, hydroxyprogesterone caproate 1 mg) is reimbursable with a gender restriction of female only in conjunction with ICD-10-CM diagnosis codes O09.211 – O09.219 (supervision of pregnancy with history of pre-term labor).

Injections are administered to prolong pregnancy for women with documented histories of spontaneous preterm births (less than 37 weeks gestation) and a current singleton pregnancy. Recommended dosage is one 250 mg injection every seven days between 16 and 36 weeks of gestation. Refer to the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for more information.

Obstetric Panel – CPT-4 Code 80055

The obstetric panel is restricted to once in nine months for the same provider. 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.

Noninvasive Prenatal Testing: Fetal Aneuploidy – CPT-4 Codes 81420, 81479 and 81507

The noninvasive prenatal test for fetal aneuploidy is reimbursable with CPT-4 codes 81420, 81479 or 81507. A *Treatment Authorization Request* (TAR) is required. Please refer to the *Pathology: Molecular Pathology* (path molec) section of the Part 2 provider manual for documentation requirements.

Internal Fetal Monitoring (IFM) During Labor

CPT-4 code 59050 (fetal monitoring during labor by consulting physician (that is, non-attending physician) with written report; supervision and interpretation) and 59051 (...interpretation only) are reimbursable only when the following billing requirements are met:

- The IFM is performed by a consultant (not the attending/delivering physician).
- The facility type must be inpatient hospital code “11” or “12” on the *UB-04* claim form or Place of Service code “21” on the *CMS-1500* claim form.
- Procedure is limited to use during labor within 48 hours before delivery in conjunction with diagnosis codes O35.0XX0 – O42.92, O61.0 – O63.9, O75.0 – O75.3, O76 – O77.9.
- Codes are reimbursable only once per pregnancy.
- The date of delivery is specified in the *Additional Claim Information* field (Box 19) or the *Remarks* field (Box 80) of the claim.

Tobacco Cessation Counseling for Pregnant and Postpartum Women

Under Medi-Cal, 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. 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).

Modifiers Commonly Used by OB Providers

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 surgeon
FP	Family planning services
SA	Nurse practitioner with physician service
SB	Certified nurse midwife service (when not billing as an independent provider)
TC	Technical component
TH *	Obstetrical treatment/services, prenatal or postpartum
U7	Physician assistant service For multiple modifiers billed for PA services, use modifier 99. Document on the claim form what is being used; e.g. 99 = U7 +ZL.

* As they become available, effective dates for these modifiers will appear in the Medi-Cal provider bulletins.

Special Appendix

HIPAA-Compliant Maternal Care Services Billing Code Conversions

The Department of Health Care Services (DHCS) will discontinue use of current Medi-Cal interim codes for maternal care services. These interim codes will be replaced by HIPAA-compliant CPT-4 codes and HCPCS code modifiers to comply with the provisions of HIPAA of 1996, Public Law 104-191, *Code of Federal Regulations*, Title 45, Part 162.1000.

Providers should monitor their monthly *Medi-Cal Update* bulletins for news about the specifics of these changes.

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
- Introduce list of Perinatal Services Coordinators (PSCs)

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

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

Provider Manual References

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/cpsp)

NOTE

For a list of CPSP Perinatal Services Coordinators (PSCs), click “CPSP Perinatal Services Coordinator Directory” under “Program Information.”

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook

NOTE

Interim codes Z1032, Z6200, Z6202, Z6204, Z6206, Z6210, Z6300, Z6302, Z6304, Z6308, Z6400, Z6402, Z6404, Z6408, Z6410, Z6412, Z6414 and Z6500 are being converted to HIPAA-compliant codes. Please reference the *Special Appendix* section at the end of this module to learn more about the code conversion. Effective dates for these changes will appear in monthly Medi-Cal provider bulletins.

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.

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/csp) for information about training for new CPSP providers and new staff of existing CPSP providers.

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/csp) for more information.

NOTES

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 administering 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

CPSP Providers May Employ or Contract Services *

CPSP providers may employ or contract with any or all of these practitioners for the purpose of providing CPSP services:

- General practice or family practice physicians, pediatricians and obstetricians
- Certified Nurse Midwives (CNMs)
- Certified Nurse Practitioners (CNP)
- Registered Nurses (RNs)
- Licensed Vocational Nurses (LVNs)
- Physician Assistants (PAs)
- Health Educators (HEs)
- Childbirth Educators (CEs)
- Registered Dietitians (RDs)
- Comprehensive Perinatal Health Workers (CPHWs)
- Social workers and Marriage and Family Therapists (MFTs)

* Refer to the *California Code of Regulations (CCR) 22, 51179.7* for specific educational requirements of the above CPSP practitioners

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 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 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
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

** 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.

*** 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.

Billing Example: Reimbursement Bonuses (Modifier ZL)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 08 15 15			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. _____ 17b. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0						22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____						23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From To MM DD YY 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 15		11		Z1032 ZL			18294	1		NPI	
2										NPI	
3										NPI	
4										NPI	

Sample: CMS-1500 claim form

Answer Key: 1) True; 2) Box 14, Box 80 Remarks; 3) True; 4) once

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		2		3a PAT. CNTL. #		4 TYPE OF BILL	
140 SECOND STREET				b. MED. REG. #		731	
ANYTOWN CA 958235555				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
6 PATIENT NAME a				9 PATIENT ADDRESS a			
b DOE, JANE				c			
10 BIRTHDATE		11 SEX		ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT		CONDITION CODES 22 23 24 25 26 27 28 29 ACCT STATE 30	
08241980		F					
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH			
38		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT	
42 REV. CD		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
1		INITIAL OFFICE VISIT		Z103299		100115	
2		COMBINED ASSESSMENTS		Z6500		101415	
3						1	
4						1	
5						18294	
6						13583	
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		001 PAGE OF		CREATION DATE		TOTALS 31877	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO		53 ASG. BEN.	
A O/P MEDI-CAL						54 PRIOR PAYMENTS	
B						55 EST. AMOUNT DUE	
C						31877	
56 INSURED'S NAME		59 PREL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A				90000000A95001		62 INSURANCE GROUP NO.	
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A							
B							
C							
68 DX		69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE	
D1D1D1D		A		B		C	
0		J		K		L	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 OPERATING NPI	
a		b		1234567890		QUAL	
c		d		LAST		FIRST	
e		f		LAST		FIRST	
78 OTHER NPI		79 OTHER NPI		QUAL		QUAL	
a		b		LAST		FIRST	
c		d		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
SUE SMITH, NP. NPI: 0123456789.							
LINE 1: LMP 010109. 99 = SA + ZL.							
LINE 2: PSYCHOSOCIAL ASSESSMENT 100115.							
HEALTH ASSESSMENT 101415.							
UB-04 CMS-1450		CMB APPROVAL PENDING		NUBC		THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF	
© 2005 NUBC				LIC9213257			

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

Billing Example: Combined Assessments (HCPCS Code Z6500)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NUTRITION, HEALTH EDUCATION AND PSYCHOSOCIAL ASSESSMENTS PROVIDED										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. D1D1D1D B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										FOR SUPPLIER INFORMATION	
1 10 01 15 11 Z1032 ZL 18294 1 NPI											
2 10 14 15 11 Z6500 13583 1 NPI											
3 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI											
4 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI											

Sample: CMS-1500 Claim Form

Answer Key: 1) three, Z1032, four-week period; 2) True; 3) six months, six-month; 4) True

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.

Breastfeeding-Related Services

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

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

5

TYPewriter ALIGNMENT
Elite Pica

CONFIDENTIAL PATIENT INFORMATION

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)

VERBAL CONTROL NO. _____

TYPE OF SERVICE REQUESTED: DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDI-CARE ELIGIBLE? YES NO

PROVIDER PHONE NO. **(916) 555-5555**

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

•

•

•

FOR STATE USE

33 PROVIDER: YOUR REQUEST IS:

1 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 REVIEW COMMENTS INDICATOR

I.D.# DATE

34 **67** 35 **100815** 44

COMMENTS/EXPLANATION

FOR PROVIDER USE

PROVIDER NAME AND ADDRESS

• **MARY BROWN**

• **1456 MAIN STREET**

• **ANYTOWN CA 95823555**

3. PROVIDER NUMBER **XYZ123456**

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.) **DOE, JANE**

MEDI-CAL IDENTIFICATION NO. **90000000A95001**

SEX **F** AGE **35** DATE OF BIRTH **052180**

STREET ADDRESS **1234 MAIN STREET**

CITY, STATE, ZIP CODE **ANYTOWN CA 98523**

PHONE NUMBER AREA **(916) 555-5555**

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

DIAGNOSIS DESCRIPTION: **DIABETES MELLITUS IN PREGNANCY** ICD-9-CM DIAGNOSIS CODE **D1D1D1D**

MEDICAL JUSTIFICATION:
35-YEAR-OLD GRAV IV, PARA III, EDC 10-2-15 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.

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36 1 2 3 4 5 6

LINE NO.	AUTHORIZED Y/M	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9 Y	32	FOLLOW-UP ANTEPARTUM NUTRITIONAL INTERVENTION	32	11 Z6204	12 32	13 \$ 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 MD 100615

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE **060715** 38 TO DATE **100215**

TAR CONTROL NUMBER

39 OFFICE **01** SEQUENCE NUMBER **23456789** P1 **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.

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 – 07 minutes equals 0 units, not billable
 - 08 – 22 minutes equals 1 unit
 - 23 – 37 minutes equals 2 units
 - 38 – 51 minutes equals 3 units, etc.
- Exceptions: Z6200, Z6300 and Z6402 are billed in 30-minute units.

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

CPSP Billing Codes

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

Service	HCPSCCode	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
	Z6202	Each subsequent 15 minutes (max. 1½ hours)	6
	Z6204	Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (max. 2 hours)	8
	Z6206	Group, per patient, each 15 minutes (max. of 3 hours)	12
	Z6208	Postpartum nutritional assessment, treatment and/or intervention, including development of care plan, individual, each 15 minutes (max. 1 hour)	4
	S0197	Prenatal vitamin-mineral supplement, 30 day supply. Restricted to 10 in 9 months.	10
Comprehensive Psychosocial Services	Z6300	Initial psychosocial assessment and development of care plan; first 30 minutes	1
	Z6302	Each subsequent 15 minutes (max. 1½ hours)	6
	Z6304	Follow-up antepartum psychosocial assessment, treatment, and/or intervention; individual, each 15 minutes (max. 3 hours)	12
	Z6306	Follow-up antepartum psychosocial assessment, treatment and/or intervention, group, per patient, each 15 minutes (max. 4 hours)	16
	Z6308	Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (max. 1½ hours)	6

Service	HPCSCCode	Description	Maximum Units of Service
Comprehensive Health Education Services	Z6400	Client orientation (health education) each 15 minutes (max. 2 hours)	8
	Z6402	Initial health education assessment and development of care plan, first 30 minutes	1
	Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes (max. 2 hours)	8
	Z6406	Follow-up antepartum health education assessment, treatment, and/or intervention, individual, each 15 minutes (max. 2 hours)	8
	Z6408	Follow-up antepartum health education assessment, treatment, and/or intervention, group, per patient, each 15 minutes (max. 2 hours)	8
	Z6410	Perinatal education, individual, each 15 minutes (max. 4 hours)	16
	Z6412	Perinatal education group per patient, each 15 minutes (max. 16 units per day) 72 units per pregnancy	16 per day
	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 <u>within</u> 4 weeks of initial visit (Z1032)												
1. Health Education – 30 min	Date:													
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 OB & CPSP Billing

FQHC/RHC/IHS OB & CPSP Billing	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	01	1												
Antepartum – 13 visits	Z1034	01	1	2	3	4	5	6	7	8	9	10	11	12	13
Postpartum	Z1038	01	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	01	1	30 minutes											
Additional Assess – 1.5 hrs	Z6202	01	1	2	3	4	5	6							
Follow-Up (F/U) Intervention/Reassessment – Individual 2 hrs	Z6204	01	1	2	3	4	5	6	7	8					
F/U Intervention – Group 3 hrs	Z6206	01	1	2	3	4	5	6	7	8	9	10	11	12	
NOTE: Contract providers bill one '01' code for group, using a patient who did not receive any other '01' services on a group session day.															
Postpartum – Individual 1 hr	Z6208	01	1	2	3	4									
Psychosocial															
Initial Assessment	Z6300	01	1	30 minutes											
Additional Init Assess 1.5 hrs	Z6302	01	1	2	3	4	5	6							
F/U Intervention/Reassessment – Individual 3 hrs	Z6304	01	1	2	3	4	5	6	7	8	9	10	11	12	
F/U Intervention – Group 4 hrs	Z6306	01	1	2	3	4	5	6	7	8	9	10	11	12	
			13	14	15	16									
NOTE: Contract providers bill one '01' code for group, using a patient who did not receive any other '01' services on a group session day.															
Postpartum – Individual 1.5 hrs	Z6308	01	1	2	3	4	5	6							
Health Education															
Client Orientation – Indiv. 2 hrs	Z6400	01	1	2	3	4	5	6	7	8					
Initial Assessment – Individual 30 min	Z6402	01	1	30 minutes											
Add'l Init Assessment – 2 hrs	Z6404	01	1	2	3	4	5	6	7	8					
F/U Intervention/Reassessment – Individual 2 hrs	Z6406	01	1	2	3	4	5	6	7	8					
F/U Ed Assess/Intervention – Group 2 hrs	Z6408	01	1	2	3	4	5	6	7	8					
Perinatal Education – Individual 4 hrs	Z6410	01	1	2	3	4	5	6	7	8	9	10	11	12	
			13	14	15	16									
Group Education – 18 hrs	Z6412	01	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	
NOTE: Contract providers bill one '01' code for group, using a patient who did not receive any other '01' services on a group session day.															
Postpartum – Individual 1 hr	Z6414	01	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.

Family PACT (Planning, Access, Care & Treatment) 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 as a comprehensive family planning services program. The Program is comprehensive because it includes contraceptive methods and family planning-related services, together with client-centered health education and counseling. The intent of the Program is to provide access to comprehensive family planning services to eligible California men and women in order to:

- Establish the timing, number and spacing of children
- Maintain optimal reproductive health

Module Objectives

- Review *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual updates
- Identify eligible Family PACT provider types
- Discuss client eligibility criteria
- Explain the importance of the *Health Access Programs Family PACT Program Client Eligibility Certification (CEC)* form and the *Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC)* form
- Review the issuance of the Health Access Programs (HAP) cards and activation options

References and Resource Information

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

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

Client Eligibility Certification and HAP Card Activation (client elig cert)

Client Eligibility Determination (client elig det)

Family PACT Program Overview (fam)

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)

Bulletins

Family PACT Update

Medi-Cal Update

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

Other References

Family PACT website (www.familypact.org)

Medi-Cal website (www.medi-cal.ca.gov)

Acronyms

A list of current acronyms is located in the *Appendix* section of this 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 family planning services to reduce the likelihood of unintended pregnancy and to allow clients to establish the number and spacing of their children.

There are two categories of services available in the program: family planning services and family planning-related services.

Family Planning Services

Family planning services through the Family PACT Program are designed to support contraceptive methods for women and men, as gender appropriate, by assisting individuals who have a medical necessity for family planning services. Family planning services are those relevant to the use of contraceptive methods and include specified reproductive health screening tests.

Family Planning-Related Services

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

The Department of Health Care Services, Office of Family Planning (OFP) reimburses testing, diagnosis and treatment of specified STIs during the initial family planning visit. STI services are also available at subsequent visits. Family planning consultation does not need to occur at these subsequent visits.

NOTES

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. Physicians, Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs) are eligible to apply for enrollment in the Family PACT Program if they:

- Are currently enrolled in Medi-Cal, in good standing and have a National Provider Identifier (NPI)
- Attend a legislatively required Provider Orientation
- Agree to abide by Program policies and administrative practices
- Provide the scope of comprehensive family planning services, either directly or by referral, consistent with Family PACT standards.

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

Orientation

For more information about upcoming Provider Orientation and additional requirements, please refer to the *Family PACT Policies, Procedures and Billing Instructions (PPBI) Manual, Family PACT Update* or *Medi-Cal Update*, the Family PACT website (www.familypact.org) or contact the Telephone Service Center (TSC) at 1-800-541-5555.

Client Enrollment

Providers use the Health Access Programs (HAP) system, an onsite client enrollment system for determining client eligibility, certifying clients as eligible and activating the client's HAP card. HAP reduces barriers to client participation in Family PACT so that services are available to eligible clients in a timely manner. Only enrolled Family PACT Program providers may determine client eligibility and enroll Family PACT clients.

Eligibility Determination Criteria

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

Criteria 1: California Resident

- The client must be a _____ of California (have a CA address).

Criteria 2: Family Size and Income

- The “basic family unit” consists of the _____, _____ and _____ 17 years of age or younger related by _____ or _____.
- Adults 18 years of age or older, other than spouses, residing together are considered a _____.
- This also applies to adults living with their parents, unless the parents claim the _____ as a _____.
- Client’s taxable family income must be at or below 200 percent of the _____.

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.

Criteria 3: Medical Necessity

- The client must have a medical necessity for _____ services.

Criteria 4: Barrier to Access and/or Other Health Coverage (OHC)

Clients with Barrier to Access

- Client has limited scope Medi-Cal that does not cover _____.
- Client needs to keep the appointment confidential from their _____, _____ or _____.

Clients with OHC

- OHC does not cover any family planning contraceptive _____.
- OHC requires an annual _____ that the client is unable to meet on the date of service.
- Client has a Medi-Cal unmet _____ on the date of service.

NOTE

If a barrier to access services exists, all clients must meet California residency, family size and income criteria requirements, and have a medical necessity for family planning services to be eligible and enrolled in the Family PACT Program, regardless of the client’s insurance status.

Answer Key: 1) resident; 2) applicant, spouse, minor children, blood, marriage, adoption; separate family; adult child; tax dependent; federal poverty level; 3) family planning; 4) family planning; spouse, partner, parents; methods, deductible, Share of Cost

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

Criteria 5: Clients with Medi-Cal Managed Care

For Medi-Cal managed care enrolled members 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.

Eligibility Assessment Guide Client Eligibility Determination Table

The following is from the Family PACT manual to assist providers in determining client eligibility.

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 (covers contraceptive methods), with no 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 health plan.	No	No activation – refer to plan
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

Family PACT Program Policy

Parental Consent

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.

Minors may apply for family planning services on the basis of their need, without parental consent, according to *California Family Code*, Section 6925, subdivision (a). *Welfare and Institutions Code* (W&I Code), Section 24003, subdivision (b). 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.

Barrier to Access

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. Not all clients seeking family planning services need this additional level of confidentiality or have this barrier to access their OHC. Providers are reminded to clarify accessing services for reasons of "confidentiality" with all clients prior to completing the CEC form in order for the client to make an informed decision.

Clients shall be informed of the regular confidentiality of services and be assured that their identity will not be disclosed without written consent, except as required by law or as may be necessary to provide emergency services to the client.

Recordkeeping and Signature Policy Update

Family PACT record retention policy for the CEC and the REC forms are as follows:

- Retention period is three years.
- Signatures can be captured electronically.
- Forms can be stored electronically rather than hard copy.

Family PACT Providers Required to Give Insurance Affordability Information

Family PACT providers must comply with W&I Code, Section 24005(u), which requires Family PACT providers or the enrolling entity to provide applicants and clients with information about applying to 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.

Client Eligibility Certification (CEC) Process

CEC Form

The *Health Access Programs Family PACT Program Client Eligibility Certification (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 Family PACT website (www.familypact.org) or requested from the Educational Materials Distribution Center by calling 1-800-848-7907. These are official State forms and must be reproduced without alteration. 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.

Federal Income Guidelines

The Federal Income Guidelines are updated and published annually by the federal government. Please ensure the most current version is used when determining program eligibility.

Family PACT Income Guidelines
200 Percent of the 2016 Federal Poverty Guidelines
Effective April 1, 2016

Number of Persons in Family	Monthly Income	Annual Income
1	\$1,980	\$23,760
2	\$2,670	\$32,040
3	\$3,360	\$40,320
4	\$4,050	\$48,600
5	\$4,740	\$56,880
6	\$5,430	\$65,160
7	\$6,122	\$73,460
8	\$6,815	\$81,780
For each additional person, add:	\$694	\$8,320

State of California
Health and Human Services Agency

Department of Health Care Services

**HEALTH ACCESS PROGRAMS
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION (CEC)**

Client HAP number

This form is the property of the State of California, Department of Health Care Services, Office of Family Planning, and cannot be changed or altered.

Please **print** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for Family PACT Program services.

- Providers must keep this original form in your medical record.
- **Code areas are for Provider use only.**
(See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)

Do you currently receive Medi-Cal benefits or services? Yes No

Do you have a Medi-Cal Benefits Identification Card (BIC)? Yes No

BIC number	Issue date
------------	------------

Do you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) Yes No

Have you had out of pocket expenses for family planning/reproductive health services covered by the Family PACT program in the 3 months immediately preceding enrollment in the Family PACT program? Yes No

Does your concern that your partner, spouse, or parent learn about your family planning appointment keep you from using your health care insurance? Yes No

How may we contact you if we need to talk to you about something?

--

Provider Use
Only CODE

First name	Middle name	Last name	Suffix (Jr., Sr.)
------------	-------------	-----------	-------------------

Is your current name the same as your name at birth? Yes No

If no, print your name at birth below.

First name at birth	Middle name at birth	Last name at birth	Suffix (Jr., Sr.)
Number of live births	County of residence	Provider Use Only CODE	9-digit ZIP code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Provider Use Only CODE	Mother's first name (optional)	Social security number	
Date of birth (mm/dd/yyyy)	Place of birth (county, if California)	State (if not California)	Country (if not USA)
	Provider Use Only CODE	Provider Use Only CODE	Provider Use Only CODE

Race/ethnicity

- 1 Asian 2 Black 3 Filipino 4 Hispanic
 5 Native American 6 Pacific Islander 7 White 0 Other

Primary Language

- 3 English 1 Armenian 2 Cantonese 4 Hmong 5 Khmer/Cambodian
 8 Spanish 6 Korean 7 Tagalog 9 Vietnamese 0 Other

Eligibility Determination: Please list all family members (self, spouse, and children) and all taxable income sources. If someone else claims you on their taxes, list everyone claimed and all related taxable income sources. Reportable income includes but is not limited to: income from employment, self-employment, social security (even if not taxable), passive income (dividends, interest, etc.), pensions and annuities, tips, commissions, spousal support received, and unemployment benefits.

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

Family size: _____ Total taxable family income \$ _____

I received information on how to apply for insurance affordability programs Yes No
 I understand that I can visit 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 the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Signature of witness
Date	Date

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.

FOR PROVIDER USE ONLY

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

Why: _____

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

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights. I also certify that the client has received the Notice of Privacy Practices.

Print name	Signature	Date
Deactivation: If client is deactivated (no longer eligible)	Date	Reason code (see Provider Manual)

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

Client Eligibility Certification Codes

CONFIDENTIALITY		COUNTY OF RESIDENCE / COUNTY OF BIRTH, IF CA (continued)	STATE OF BIRTH, IF NOT CALIFORNIA (continued)		STATE OF BIRTH, IF NOT CALIFORNIA (continued)		COUNTRY OF BIRTH, IF NOT USA (continued)		
Yes	Y								
No	N		Georgia	10	Tennessee	42	Guam	19	
COUNTY OF RESIDENCE / COUNTY OF BIRTH, IF CA		San Diego	37	Hawaii	11	Texas	43	Guatemala	20
		San Francisco	38	Idaho	12	Utah	44	Guyana	21
		San Joaquin	39	Illinois	13	Vermont	45	Honduras	22
		San Luis Obispo	40	Indiana	14	Virginia	46	India	23
Alameda	01	San Mateo	41	Iowa	15	Washington	47	Japan	24
Alpine	02	Santa Barbara	42	Kansas	16	West Virginia	48	North Korea	25
Amador	03	Santa Clara	43	Kentucky	17	Wisconsin	49	South Korea	26
Butte	04	Santa Cruz	44	Louisiana	18	Wyoming	50	Laos	27
Calaveras	05	Shasta	45	Maine	19	District of Columbia	51	Mexico	28
Colusa	06	Sierra	46	Maryland	20	Unknown	99	Nicaragua	29
Contra Costa	07	Siskiyou	47	Massachusetts	21	COUNTRY OF BIRTH, IF NOT USA	Panama	30	
Del Norte	08	Solano	48	Michigan	22		Paraguay	31	
El Dorado	09	Sonoma	49	Minnesota	23	Aleutian Islands	01	Philippines	33
Fresno	10	Stanislaus	50	Mississippi	24	Argentina	02	Puerto Rico	34
Glenn	11	Sutter	51	Missouri	25	Belize	03	Russia	35
Humboldt	12	Tehama	52	Montana	26	Bolivia	04	Samoa	36
Imperial	13	Trinity	53	Nebraska	27	Brazil	05	Spain	37
Inyo	14	Tulare	54	Nevada	28	Cambodia	06	Surinam	38
Kern	15	Tuolumne	55	New Hampshire	29	Canada	07	Thailand	39
Kings	16	Ventura	56	New Jersey	30	Chile	08	Uruguay	40
Lake	17	Yolo	57	New Mexico	31	China	09	Venezuela	41
Lassen	18	Yuba	58	New York	32	Columbia	10	Vietnam	42
Los Angeles	19	Unknown	99	North Carolina	33	Costa Rica	11	Virgin Islands	43
Madera	20	GENDER		North Dakota	34	Cuba	12	Other	99
Marin	21			Ohio	35	Ecuador	13		
Mariposa	22	Male	M	Oklahoma	36	El Salvador	14		
Mendocino	23	Female	F	Oregon	37	France	15		
Merced	24	STATE OF BIRTH, IF NOT CALIFORNIA		Pennsylvania	38	French Guiana	16		
Modoc	25			Rhode Island	39	Germany	17		
Mono	26			South Carolina	40	Great Britain	18		
Monterey	27			South Dakota	41				
Napa	28	Alabama	01	DEACTIVATION CODES					
Nevada	29	Alaska	02						
Orange	30	Arizona	03						
Placer	31	Arkansas	04						01 Not resident of California
Plumas	32	California	05						02 Over 200 percent of the federal poverty level
Riverside	33	Colorado	06						03 Sterilized, no longer contracepting
Sacramento	34	Connecticut	07						04 Health insurance coverage for family planning services
San Benito	35	Delaware	08						05 Full-scope Medi-Cal (does not have an unmet Share of Cost)
San Bernardino	36	Florida	09						06 Permanent deactivation of HAP card (lost/stolen)

Retroactive Eligibility Certification (REC)

Medi-Cal offers newly enrolled Family PACT clients retroactive eligibility in the event the client was seen for a Family PACT-covered family planning and/or reproductive health service during the three-month period prior to the month the client was initially certified for participation in the Family PACT Program.

Eligibility Criteria

- The client must meet all of the ten eligibility requirements listed on the first page of the *Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC)* (DHCS 4001) form to be reimbursed for family planning services.
- The client must complete the REC form.
- The client is responsible for submitting their claim within one year of receipt of services or within 90 days after certification for retroactive eligibility, whichever is longer.
- The client needs to provide receipts to show proof that they, or another person on their behalf, paid for their family planning or reproductive health services.

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

Mailing Address

Department of Health Care Services
Beneficiary Services Center
P.O. Box 138008
Sacramento, CA 95813-8008



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

**IF YOU ARE ELIGIBLE FOR FAMILY PACT, MEDICAL MAY REIMBURSE YOU FOR
FAMILY PLANNING AND REPRODUCTIVE HEALTH EXPENSES YOU PAID**

You may be able to be reimbursed for some expenses you paid. The California Department of Health Care Services (DHCS) will assist you in getting your money back if all criteria below are met:

1. You received a Family PACT-covered family planning and reproductive health service during the 3-month period prior to the month you were initially certified for participation in the Family PACT program.
2. You paid for your family planning service, or another person paid for your family planning service on your behalf. You **must** provide proof that the family planning service was paid for by you or another person and provide an itemized list of services covered by the payment.
3. This form (DHCS 4001) must be certified by a Family PACT provider for you to be eligible for retroactive reimbursement.
4. You do not seek reimbursement for co-payments or excess Share of Cost charges. Reimbursement for valid claims will not exceed the Family PACT rate for the covered service at the time the service was rendered.
5. The medical provider was in California.
6. You are required to provide documentation of medical necessity if prior authorization is required for the service rendered.
7. You were eligible to receive that specific family planning service.
8. The family planning service was a benefit under the Family PACT program.
9. You give the Beneficiary Service Center permission to contact you and/or your Family PACT provider directly.
10. You authorize your medical providers to release necessary records to verify this claim.

Important dates and time frames:

- You must submit your claim within one year of the date of the service. A Claim not submitted within one year of the date of a service will be denied. Only that portion of the claim that is within the allowable timeframe, if any, will be considered for reimbursement.

To file a claim for reimbursement or for more information call:

Beneficiary Service Center - Family PACT, (916) 403-2007 TDD: (916) 635-6491

****REMEMBER TO KEEP ALL RECEIPTS FOR THE FAMILY PLANNING
AND REPRODUCTIVE HEALTH CARE YOU RECEIVED****

The Beneficiary Service Center will review your claim and send you a letter describing the status of your claim. If you disagree with any action taken, you may ask for a state hearing. The letter will tell you how to ask for a state hearing.

Your Rights:

You have the right to request a state hearing to review a Beneficiary Service Center decision or action regarding your request for a Beneficiary Reimbursement. You must request a state hearing within 90 days of the date on the Notice of Action that informs you of the decision or action that was mailed to you by the Beneficiary Service Center. Please follow the instructions provided in the Notice of Action to request a state hearing or call the California Department of Social Services' State Hearings Division at 800-952-5253. For TDD service, call 1-800-952-8349. Written requests must be mailed to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-99
Sacramento, CA 94244-2430

Privacy Statement (Civil Code § 1798 et seq.)

Civil Code, § 1798.17, and the Federal Privacy Act, 5USC 552a, subdivision (e)(3), require this notice be provided when collecting personal or confidential information from individuals.

Affirming Eligibility at Each Visit

A provider or designee must affirm and verify client eligibility at each visit. Client's total taxable family income, family size and health insurance status must be reaffirmed at each visit verbally, and confirmed through AEVS or the POS device.

Ineligible Clients – Reapplication

If a client who was previously determined ineligible returns to a Family PACT provider, a 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.

HAP Card Deactivation

If a client has been determined no longer eligible for Family PACT services, providers are required to deactivate the client's Family PACT HAP card. Providers should select the "deactivation" option on the AEVS, POS device or Internet and indicate the reason for deactivation using the appropriate deactivation code and refrain from billing Family PACT for services.

Deactivation Codes	
01	Not a resident of California
02	Over 200% of the federal poverty level
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)

Reasons for Deactivation

Pregnancy (Deactivation 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 the diagnosis of pregnancy was determined. The HAP card may be retained in the client's file for future use.

Permanent Sterilization (Deactivation 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.

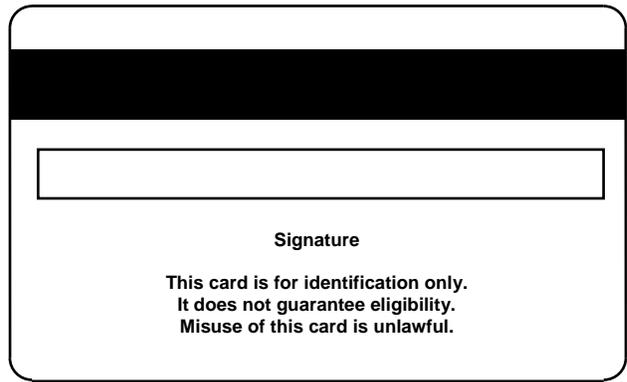
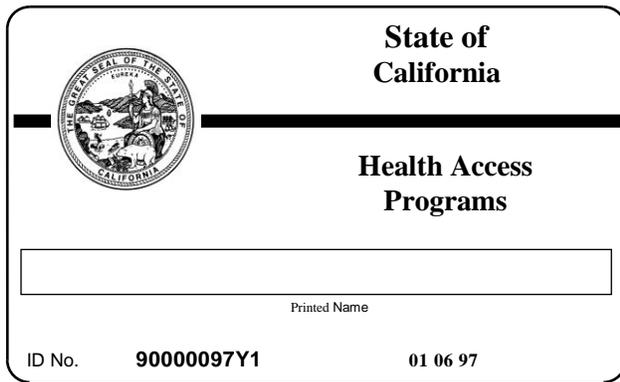
NOTE

Do not deactivate the client’s HAP card until the end of the designated post-operative period, or earlier, if the clinician determines the client is no longer at risk for pregnancy or causing pregnancy.

Clients with Benefits Identification Cards

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 recipient has met any required Share-of-Cost (SOC). If the client has met their SOC and has no barrier to access, the client should not be enrolled into Family PACT.

HAP Card



HAP Identification Card (Initial)

HAP Card Terms and Conditions

- The HAP card must be activated the day the client signs the _____.
- Eligibility extends for _____ days and must be recertified _____.
- The HAP card is good anywhere in California as long as the provider is a _____.
- HAP card activation must occur _____ at the service site represented by the enrolled Family PACT provider number to whom the cards were distributed. HAP cards must not be shared among _____ or other _____.

NOTES

Answer Key: *Client Eligibility Certification* form; 365, annually; certified Family PACT provider; only, provider sites, providers

Replacement Cards

 <p>State of California</p> <p>Health Access Programs</p> <p>_____</p> <p>Printed Name</p> <p>_____</p> <p>(Existing ID No.) 01 06 97</p>	<p>_____</p> <p>Signature</p> <p>This card is for identification only. It does not guarantee eligibility. Misuse of this card is unlawful.</p>
--	--

Family PACT providers can order new and replacement HAP cards by calling the TSC at 1-800-541-5555. Additional resources can be found on the “My HAP Card” page of the Family PACT website at (www.familypact.org).

1. Replacement cards are issued to clients who have lost his/her pre-numbered HAP card.
True False
2. A client may have more than one HAP card activated at any time.
True False
3. HAP cards that have been lost or stolen from the provider’s supply must be reported to the TSC at 1-800-541-5555.
True False
4. Providers must write the client’s existing HAP card ID number on the replacement card.
True False

Answer Key: 1) True; 2) False; 3) True; 4) True

HAP Card Activation Options

The HAP card must be activated immediately upon certification of eligibility. Failure to activate the card will result in denial of payments to providers, laboratories and pharmacies. Providers who neglect to activate a card in a timely manner are responsible for covered services rendered or ordered. Clients must not be charged for Family PACT services after certification is complete.

There are three types of eligibility transaction methods to activate a HAP card:

- Automated Eligibility Verification System (AEVS)
- Point of Service (POS) Network
- Internet (www.medi-cal.ca.gov)

Providers are not to use the Internet Transaction application to check for client eligibility. Providers should use the POS device or AEVS to verify Family PACT client eligibility.

Eligibility Transactions

Providers can perform the following eligibility transactions:

- Activate
- Inquire
- Update
- Re-certify
- Deactivate

Eligibility Confirmation

All Family PACT eligible clients have an aid code of 8H. When providers confirm eligibility, they receive a message that the client is Family PACT eligible with aid code 8H, unless the client has been deactivated and is no longer eligible for the program.

NOTES

How Well Do You Know Family PACT Eligibility?

Eligibility Brainteasers

1. Eligibility must be confirmed at each visit via?
 - a. AEVS
 - b. POS
 - c. Any of the above (also verbally)
2. Clients must be recertified?
 - 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 changes
 - d. All of the above
4. Providers can 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 decertified.
 - a. True
 - b. False

Answer Key: 1) C; 2) B; 3) D; 4) A; 5) C; 6) A; 7) A; 8) A

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

Introduction

Purpose

The purpose of this module is to provide participants with an overview of Family Planning, Access, Care and Treatment (Family PACT) as a comprehensive family planning clinical services program. The Program is comprehensive because it includes family planning and family planning-related services together with client-centered health education and counseling. The intent of the Program is to provide access to comprehensive family planning services to eligible California men and women in order to:

- Establish the timing, number and spacing of children
- Maintain optimal reproductive health

Module Objectives

- Identify Family PACT-covered contraceptive methods
- Review ICD-10-CM diagnosis codes for contraceptive methods
- Identify family planning-related services
- Explain Family PACT complications services, *Treatment Authorization Request* (TAR) requirements and claim documentation requirements
- Discuss evaluation and management/education and counseling services
- Review sterilization policy and the *PM 330* consent form
- Detail claim form documentation requirements for dispensing drugs and supplies
- Review case studies and claim examples
- Identify common billing errors and denials

Reference and Resource Information

The following reference materials provide Family PACT program billing information:

References

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

Family PACT Update bulletin

Medi-Cal Update bulletin

Family PACT website (www.familypact.org)

Medi-Cal website (www.medi-cal.ca.gov)

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

Acronyms

A list of current acronyms is located in the *Appendix* section of this 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 family planning services to reduce the likelihood of unintended pregnancy and to allow clients to establish the number and spacing of their children.

There are two categories of services available in the program: family planning services and family planning-related services.

Federal Regulation and Program Services

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

Family Planning Services

Family planning services through the Family PACT Program are designed to support contraceptive methods for women and men, as gender appropriate, by assisting individuals who have a medical necessity for family planning services. Family planning services are those relevant to the use of contraceptive methods and include specified reproductive health screening tests.

Family Planning-Related Services

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

The Department of Health Care Services (DHCS) Office of Family Planning (OFP) reimburses testing, diagnosis and treatment of specified STIs during the initial family planning visit. STI services are also available at subsequent visits. Family planning consultation does not need to occur at these subsequent visits.

Family Planning Services

Covered Contraceptives

- Oral Contraceptives
- Transdermal Patch
- Contraceptive Implants
- Intrauterine Contraceptives
- Cervical Barrier Methods
- Male and Female Condoms
- Lactation Amenorrhea Method
- Oral Emergency Contraceptives
- Vaginal Ring
- Contraceptive Injection
- Diaphragm
- Spermicides
- Fertility Awareness Methods
- Male/Female Sterilization

Availability of Covered Services

All Family PACT-covered family planning methods shall be made available to clients by the practitioner, including all FDA-approved contraceptive methods, fertility awareness methods, sterilization procedures and limited fertility services.

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

NOTE

If the practitioner lacks the skills to provide specialized contraceptive procedures or sterilization, or there is insufficient volume to ensure and maintain a high skill level, clients shall be referred to another qualified practitioner for these methods/procedures.

ICD-10-CM Diagnosis Codes for Contraceptive Methods

Contraceptive Counseling

ICD-10-CM	National Code Description	Additional Information
Z30.012	Encounter for prescription of emergency contraception	Counseling and advice limited to females
Z30.09	Encounter for other general counseling and advice on contraception	Counseling and advice No contraceptive method initiated during visit
Z31.61	Procreative counseling and advice using NFP	Natural family planning (NFP) to become pregnant 2 visits, per 12 month period, per client, per provider

Contraceptive Methods

ICD-10-CM	National Code Description	Additional Information
Z30.011	Encounter for initial prescription of contraceptive pills	Initiation of oral contraceptives (OC)
Z30.013	Encounter for initial prescription of injectable contraceptive	Initiate DMPA injection
Z30.018	Encounter for initial prescription of other contraceptives	Initiate use of contraceptive patch, vaginal ring or contraceptive implant
Z30.019	Encounter for initial prescription of contraceptives, unspecified	Initiate use of female condoms, diaphragms, cervical cap and/or spermicide
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy	Natural family planning to avoid pregnancy
Z30.2	Encounter for sterilization	Sterilization procedure, male/female

Contraceptive Methods (Continued)

ICD-10-CM	National Code Description	Additional Information
Z30.40	Encounter for surveillance of contraceptives, unspecified	Follow-up visit for diaphragms, female and male condoms, cervical cap and/or spermicide management
Z30.41	Encounter for surveillance of contraceptive pills	Follow-up visit OCs
Z30.42	Encounter for surveillance of injectable contraceptive	Follow-up visit for DMPA injection
Z30.430	Encounter for insertion of intrauterine contraceptive device	Insertion visit for intrauterine contraceptive (IUC)
Z30.431	Encounter for routine checking of intrauterine contraceptive device	Follow-up visit for IUC
Z30.432	Encounter for removal of intrauterine contraceptive device	Removal of IUC
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device	Removal and reinsertion of IUC
Z30.49	Encounter for surveillance of other contraceptives	Follow-up visit for patch or vaginal ring management
Z30.8	Encounter for other contraceptive management	Follow-up visit for subdermal contraceptive implant
Z30.9	Encounter for contraceptive management, unspecified	Initiate use of male condoms and/or spermicides
Z98.51	Tubal ligation status	Routine post-op management and surveillance
Z98.52	Vasectomy status	Routine post-op management and surveillance

Reproductive Health Screening Tests

These services may be provided as clinically indicated. These services are not reimbursable for Z30.012, Z30.09 and Z31.61. For male and female clients:

CPT-4 Code	Description	Reflex Testing (based on a positive screening test result)		Restrictions
86592	VDRL, RPR	86593	Syphilis test, non-treponemal antibody; quantitative	
		86780	TP-confirmatory test; if positive, 86593 is required	
86701	HIV-I	86689 HIV confirmation test OR 86701 and 86702 differentiation assay AND 87535 HIV amplified probe technique (if differentiation assay results are negative or indeterminate)		86689 Limited to HIV antibody
86702	HIV-II			
86703	HIV-I and HIV-II single result			
87491	NAAT – Chlamydia	None		Refer to the CT and GC screening guidelines **
87591	NAAT – Gonorrhea	None		

* These screening tests have a frequency limit of one test, per recipient, per month. For more information regarding the Laboratory Services Reservation System (LSRS), refer to the *Laboratory Services* section in the *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual.

** CT and GC screening tests for females 25 years and older and males of all ages require an additional ICD-10-CM diagnosis code. Females 25 years of age and under require an additional ICD-10-CM diagnosis code. For additional information, refer to the *Benefits: Family Planning* section in the PPBI manual.

NOTES

Family Planning-Related Services

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

CMS-1500 and UB-04 Claim Form Requirements

An ICD-10-CM diagnosis code for the family planning-related condition being treated is required on the claim form. This code must be billed with the ICD-10-CM diagnosis code that identifies the contraceptive method for which the client is being seen.

Sexually Transmitted Infections (STIs)

Chlamydia	Pelvic inflammatory disease (PID)
Gonorrhea	Trichomoniasis
Genital Herpes	Genital Warts
Vulvovaginitis	Syphilis

Urinary Tract Infection (UTI)

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

Acute cystitis without hematuria	Painful micturition, unspecified
Acute cystitis with hematuria	Frequency of micturition
Dysuria	Lower abdominal pain, unspecified
Gross hematuria	

Cervical Cancer Screening

Cervical cancer screenings are covered when provided as part of, or as a follow-up to, a family planning visit. Cervical screening is not a stand-alone service. CPT-4 cervical screening codes are restricted to women 21 to 65 years of age, regardless of sexual history. Services may be provided to women younger than 21 years or over the age of 65 who have, or do not have, a cervix under certain conditions. For additional information refer to the *Benefits: Family Planning – Related Services* section in the Family PACT PPBI manual.

Cervical Cytology Screening Tests

88142	88143	88147	88148
88164	88165	88167	88174
88175			

Cervical Abnormalities and Preinvasive Cervical Lesion Services

Services and supplies are reimbursable when performed on an outpatient basis for the diagnosis and treatment of cervical abnormalities found on Pap smear or physical exam and preinvasive cervical lesions for females 15 years of age or older. Additional age and frequency restrictions apply to some procedures.

Abnormal result, cytologic smear of cervix	CIN 3 (Biopsy)
ASC-H Pap	HGSIL Pap
ASC-US Pap	Leukoplakia, cervix
Cervical high-risk HPV DNA test positive	LGSIL Pap
CIN 1 (Biopsy)	Other Abnormal cytological findings
CIN 2 (Biopsy)	Unspecified abnormal cytological findings

Complication Services

Services are available for the management of complications that arise from the use of a contraceptive method, STI, UTI or cervical abnormalities. Only those complications that can be reasonably managed on an outpatient basis are reimbursable.

Management of a complication resulting from a contraceptive method, STI, UTI or cervical abnormalities may require an additional ICD-10-CM diagnosis code to identify the complication. The complication ICD-10-CM diagnosis code must be billed on the claim form with the diagnosis code that identifies the contraceptive method for which the client is being seen.

ICD-10-CM Diagnosis Codes

Contraceptive Complications: Example

ICD-10-CM	Interim Description	National Code Description	Code Must be Billed with:
I26.99	Pulmonary embolism with combined hormonal method	Other pulmonary embolism without acute cor pulmonale	Contraceptive method in which the complication arose
I82.401	DVT with combined hormonal method	Acute embolism and thrombosis of unspecified deep veins of right lower extremity	Contraceptive method in which the complication arose
T81.4XXA	Female sterilization; operative site infection (< 30 days post-op)	Initial encounter, infection following a procedure	Contraceptive method in which the complication arose

Evaluation and Management

Office Visits

Visits billed with CPT-4 codes for Evaluation & Management (E&M) services must be performed by a clinician, although the computation of the E&M level of the visit may also include services provided by non-clinician counselors. Selection of the appropriate E&M code level is determined by:

- The content of the client's history
- The number of elements of the physical examination and the complexity of medical decision making
- If greater than 50 percent of the visit time was spent in counseling by the interval of face-to-face client interaction provided by both the clinician and counselor

When time is the criteria for selection of the E&M code, the amount of face-to-face time is cumulative of all staff who counsels the client, and the total time must be documented in the client's medical record.

CPT-4 Codes – E&M Office Visits

CPT-4 Code	Client Reimbursement
99201	New females/males
99202	New females/males
99203	New females/males
99204	New females; males for complications only
99211	Established females/males
99212	Established females/males
99213	Established females/males
99214	Established females; males for complications only

E&M Frequency Restrictions

Unless stated otherwise in the Family PACT PPBI manual, standard Medi-Cal policy for billing E&M CPT-4 codes and modifiers applies.

E&M/CPT-4 Codes – Same Date of Service

CPT-4 codes for surgical procedures include performance of history and physical examination, performance of the procedure, postoperative care, including preoperative and postoperative counseling. However, if a “significant, separately identifiable E&M service is provided by the same clinician on the same day of the procedure,” then an E&M claim for the evaluation of the separate condition may be billed using modifier 25.

The following CPT-4 procedure codes will accommodate an E&M code with modifiers 25 when a significant, separately identifiable E&M service is provided by the same clinician on the same date of the procedure.

Allowable CPT-4 Codes with E&M Codes

11976	11981	54050	54056	54100
56501	56605	57061	57452	57454
57455	57456	57460	57511	58100
58110	58300	58301		

NOTE

CPT-4 codes will require an appropriate modifier. Please refer to the *Modifiers: Approved List* in the appropriate Part 2 provider manual.

Registered Nurses and E&M Codes

Registered nurses (RNs) can administer injectable contraceptives or dispense hormonal contraceptives (OCs, patch, vaginal ring, injectable contraceptive and emergency contraceptive pills) pursuant to the California Business and Professions code, Chapter 6, Section 2725. If performed by an RN, CPT-4 codes 99201, 99211 or 99212 must be billed with modifier TD.

Education and Counseling

Office Visits

Both HCPCS and CPT-4 codes are used to bill for health education and counseling (E&C) office visits. These codes are used when the purpose of the visit is to provide family planning reproductive health education and counseling. Health education and counseling may be provided by either clinicians or non-clinician counselors. In order to be reimbursed by the program, education and counseling services must be conducted at the site of the clinical service delivery.

Medical record documentation must reflect the scope of education and counseling services provided to clients according to Family PACT standards, including, but not limited to, individual client assessment, topics discussed and name and title of counselor. Documentation must support services billed for reimbursement. The total time must be documented in the client's medical record.

Clients may be oriented to the Family PACT Program by a licensed clinician or by a supervised, non-licensed counselor either in a group session of two or more clients or in an individual session.

Education & Counseling (E&C) Codes

HCPCS Code	HCPCS Description
S9445	Individual orientation to Family PACT, only once by the same provider for the same client.
S9446	Family planning group education (including orientation to Family PACT), only once by the same provider for the same client.
99401U6	Preventative medicine counseling and/or risk factor reduction intervention, individual, approximately 15 minutes
99402U6	Preventative medicine counseling and/or risk factor reduction intervention, individual, approximately 30 minutes
99403U6	Preventative medicine counseling and/or risk factor reduction intervention, individual, approximately 45 minutes

NOTE

For CPT-4 codes, use modifier U6 to indicate Family PACT E&C services. HCPCS codes S9445 or S9446 may be billed alone, with an E&M visit code 99201 – 99204, 99211 – 99213 or with a higher level E&C code 99401U6, 99402U6 or 99403U6, one time per client, by the same provider.

CPT-4 E&C code office visits (99401U6 – 99403U6) are limited to two visits, per client, per 30 days, per provider. Codes may be billed with Family PACT laboratory, surgical, medication and supply codes. These codes may be used to report counseling issues, including lifestyle and relationship issues, risk reduction interventions, method use and adherence, infertility, preconception counseling, pregnancy options and sexually transmitted infection (STI) prevention. Medical record documentation must support services claimed for reimbursement.

Family PACT Sterilization

Sterilization Consent Form (PM 330)

Claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 00851, 00921, 00952, 55250, 58565, 58600, 58615, 58670, 58671, 99144, 99145 or HCPCS code A4264) must adhere to all Medi-Cal policies regarding the PM 330 indicated in the *Sterilization* (ster) section of the appropriate Part 2 Medi-Cal provider manual.

Consent Policy

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

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

Coverage Requirements

- The individual is at least 21 years of age at the time of written consent.

NOTE

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

- The individual is not mentally incompetent. A mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state or local court of competent jurisdiction for any purposes that include the ability to consent to sterilization.
- The individual is able to understand the content and nature of the informed consent process. A patient who is mentally ill or mentally retarded may sign the consent form if the physician determines that the individual is capable of understanding the nature or significance of the sterilizing procedure.
- The individual is not institutionalized. An institutionalized individual is a person who is:
 - Involuntarily confined or detained in a correctional or rehabilitative facility, including a mental hospital or other facility for care and treatment of mental illness; or
 - Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- At least 30 days, but no more than 180 days, have passed between the date of written and signed consent and date of sterilization.
- Submission of the PM 330 sterilization consent with claim form for reimbursement.

PM 330 Completion Tips

- Name of procedure must be exactly the same in all four places on the PM 330.
Fields: 2, 6, 13 and 20

Abbreviations for procedures are accepted and must be consistent throughout the form. The full name of the procedure must be written out and asterisked (*) at the bottom of the consent form.

- Cross out the paragraph that does not apply. Fields: 21 or 22:
 - (21) Paragraph one. Do not cross off paragraph one if the minimum waiting period of 30 days has been met.
 - (22) Paragraph two. Do not cross off paragraph two if the minimum waiting period of 30 days has not been met.
- Client's name must appear exactly the same in all four places on the PM 330. If a middle initial is used, it must be consistent throughout the consent form.
Fields: 4, 7, 12 and 18
- To avoid "Physician's signature not legible" denials, type the name of the physician under the signature line and also include their professional title, such as "M.D."
Field: 27
- Top right section of the PM 330 is the location where the patient was counseled.
Fields: 12–17
- Lower right quarter of the PM 330 must be signed and dated on or after the day of the surgery, not before. Field: 28

NOTE

If the physician whose name appears on the PM 330 is not available on the date of surgery, enter, for example, "Dr. Joe Smith, M.D., and Associates" when filling in the physician's name. This addition allows a different doctor's name to be accepted if the physician is not available. However, the client must be notified of the change in physician prior to the procedure.

Sterilization Consent Form Ordering

A sterilization *Consent Form* (PM 330) can be downloaded (in English and Spanish) from the Forms page of the Medi-Cal website or ordered by calling the Telephone Service Center (TSC) at 1-800-541-5555. Providers must supply their National Provider Identifier (NPI) number when ordering the form(s).

The following information also may be requested:

- Date of request
- Name of document (sterilization *Consent Form* [PM 330])
- Registered provider name associated with the NPI
- "Ship to" site address (service address) – P.O. Box addresses are not accepted
- Quantity of forms requested
- Contact person and telephone number

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

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

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

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

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

Entiendo que se me va a esterilizar mediante un método conocido como: 2

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

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

Declaro tener al menos 21 años de edad y que nací en 3 / /

4 / /

Apellido

Nombre

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por 5

utilizando un método conocido como 6

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

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

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

He recibido copia de este formulario. 7 Fecha: 8 / /

Firma de la persona a ser esterilizada

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en

idioma 9 y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

10 Fecha: 11 / /

Firma del intérprete

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que 12 (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como 13 (Nombre del procedimiento).

También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

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

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

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

14 / / Fecha: 15 / /

Firma de quien recibe el consentimiento

16 / /

Nombre del lugar donde el paciente recibió la información

17 / / / /

Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco antes de operar a 18 (Nombre de la persona a ser esterilizada) en 19 / / (Fecha de esterilización), le explique la naturaleza del método de esterilización conocido como 20 (Nombre del procedimiento).

también le expliqué que este método es final e irreversible y le informé de los malestares, riesgos y beneficios asociados con este procedimiento.

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

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

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

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

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

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

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

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

27 / / / / Fecha: 28 / / / /

Firma del Doctor a cargo de la cirugía

Contraceptive Drugs and Devices and Drugs for Family Planning- Related Services

HCPCS Code	National Code Description	Additional Information
J3490U5	Unclassified drugs	NDC required on claim Use modifier U5 to indicate ulipristal acetate as an emergency contraceptive pill There is a combined restriction of 6 packs per year on J3490U5 and J3490U6
J3490U6	Unclassified drugs	NDC required on claim Use modifier U6 to indicate Levonorgestrel as an emergency contraceptive pill There is a combined restriction of 6 packs per year on J3490U5 and J3490U6
J3490U8	Unclassified drugs	NDC required on claim Use modifier U8 to indicate medroxyprogesterone acetate for contraception
J7300	Copper IUC	NDC required on claim
J7301	Levonorgestrel IUC, 13.5 mg	NDC required on claim
J7302	Levonorgestrel IUC, 52 mg	NDC required on claim
J7303	Contraceptive supply, vaginal ring	NDC required on claim
J7304	Contraceptive supply, patch	NDC required on claim
J7307	Etonogestrel contraceptive implant	NDC required on claim
S4993	Oral contraceptives	NDC required on claim
S5000/S5001	Prescription drug, brand name/Prescription drug, generic	NDC required on claim

Drugs: Onsite Dispensing Billing Instructions

The maximum reimbursement rates for many of the items dispensed onsite are set by the Medi-Cal program and are contained in the Medi-Cal rates table. However, when a Medi-Cal maximum reimbursement rate is not specified, Family PACT sets the reimbursement rates for the drugs and contraceptive supplies. The price guide is in the Family PACT PPBI manual under *Drugs: Onsite Dispensing Price Guide* (drug onsite) section.

Drugs: Onsite Dispensing Price Guide

The *Drugs: Onsite Dispensing Price Guide* section contains the following information for calculating the Family PACT reimbursement rates for each HCPCS codes A4267, A4268, A4269 (U1-U4), S5199 and S5000 or S5001 dispensed onsite.

- Billing unit definitions
- Family PACT rate per unit
- Maximum units per claim
- Clinic dispensing fees
- Upper payment limit (drug cost + clinic dispensing fee)
- Fill frequency limit (minimum interval between refills)

Contraceptive Supplies

HCPCS Code	National Code Description	Additional Information
A4267	Condom, male, each	Up to 36 condoms per 27 days
A4268	Condom, female, each	Up to 6 condoms per 27 days
A4269U1	Spermicide	Use modifier U1 to indicate gel, jelly, foam, cream as a contraceptive spermicide
A4269U2	Spermicide	Use modifier U2 to indicate suppository as a contraceptive spermicide
A4269U3	Spermicide	Use modifier U3 to indicate vaginal film as a contraceptive spermicide
A4269U4	Spermicide	Use modifier U4 to indicate contraceptive sponge as a contraceptive spermicide
S5199	Personal care item, NOS each	
	Diaphragm, cervical cap, basal body thermometer	Pharmacy dispensing only

NOTE

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

Treatment and Dispensing Guidelines for Clinicians

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

Family Planning-Related Conditions Drug Regimens (Example)

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

Claim Form Documentation

Claim form documentation for S5000 and S5001 drug and/or contraceptive supplies dispensed onsite must be entered in the *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form or the *Remarks* field (Box 80) on the *UB-04* claim form, or an attachment. Please refer to the *Drugs: Onsite Dispensing Billing Instructions* (drug) section of the Family PACT PPBI manual for examples. Documentation must include the following.

- Name of drug/supply
- Size and/or strength, if applicable
- Number of units
- Clinic dispensing fee, if applicable
- Total cost

Coding Case Studies

Outpatient Coding Questions to Determine

1. Is the client new or established?
2. What procedures were performed?
 - Office surgical procedures
 - Supplies for covered procedures (UA/UB)
 - Drugs or devices administered or dispensed on-site
 - Office lab tests or imaging studies
3. What visit type and level of E&M or E&C code was performed?
 - E&M level, time or history, physical, medical decision making
4. What modifiers, if any, are required?
5. What is the ICD-10-CM diagnosis code for each CPT-4 or HCPCS code (+ E&M or E&C)?

Case Study 1: Start OCs and UTI Diagnosis

- Client has an initial family planning office visit, including history/physical and counseling on all contraceptive methods
- Pregnancy test performed in house, due to late period
- Dipstick urine test performed for symptoms of a UTI
- Blood specimen is drawn in office and sent to outside lab due to history of diabetes and a high BMI
- Client is given a prescription for OCs and an antibiotic for the UTI
- Clinician dispenses condoms and foam for quick start

Case Study 1: Answer

	CPT-4/HCPCS Code	ICD-10-CM Code
Procedure	99000 (blood draw)	
Supplies	A4267 (condoms) A4269U1 (foam)	
Drugs	None	
Lab	81025 (pregnancy test) 81002 (UA dipstick)	
E&M	99204	D1D1D1D D2D2D2D
Modifier	As appropriate	

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

CMS-1500 Case Study 1 Claim Example

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Specimen sent to an unaffiliated lab. L5: Condoms @ .28 X 20 = \$5.60 + CDF 56 = \$6.16 L6: 2 foam @ .20 X 40gm = \$8.00 + CDF 80 = \$8.80				20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				22. RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0				23. PRIOR AUTHORIZATION NUMBER				24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #					
1	10	01	15		11		99204			8000	1		NPI
2	10	01	15		11		99000			1000	1		NPI
3	10	01	15		11		81002			800	1		NPI
4	10	01	15		11		81025			1000	1		NPI
5	10	01	15		11		A4267			616	20		NPI
6	10	01	15		11		A4269 U1			880	40		NPI
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
								\$ 12296		\$			

PHYSICIAN OR SUPPLIER INFORMATION

Case Study 2: IUC Removal with Reinsertion

- Mary has had an IUC for ten years.
- She has no plans to bear children and wants a new IUC.
- The nurse practitioner asks a few questions about any problems with the IUC. Mary signs a consent form.
- The nurse practitioner removes the old IUC and inserts a new one during same visit.

Case Study 2 Answer:

	CPT-4/HCPCS Code	ICD-10-CM Code
Procedure	58301 (IUC removal) 58300 (IUC insertion)	D1D1D1D
Supplies	58301 (IUC removal supplies) 58300 (IUC insertion supplies)	
Drugs	J7300 (ParaGard)	
Lab	None	
E&M	None	
Modifier	58301 AG 58300 51 58301 UA 58300 UA	

No E&M services are reported for the brief discussion with the client prior to the removal and reinsertion procedures.

Common Billing Denials – RAD Codes

RAD Code	Description	Prevention Tips
0169	This service is not payable when billed with this diagnosis	<ul style="list-style-type: none"> • Verify primary diagnosis code is valid for procedure code being billed • Review the covered services in the Family PACT PPBI manual • Call the TSC at 1-800-541-5555
9511	Date of service is outside of the Family PACT (Planning, Access, Care and Treatment) eligibility period.	<ul style="list-style-type: none"> • Activate HAP card at the time the client is certified • Confirm eligibility at every visit. Ensure the HAP card is activated or recertified before providing services. Recertify clients on or before the client's recertification/deactivation date.
9515	The procedure code is not a benefit of the Family PACT Program.	<ul style="list-style-type: none"> • Review the covered services in the Family PACT PPBI manual • Procedure code is missing, incomplete or invalid for the Family PACT Program • Call the TSC at 1-800-541-5555 to verify the procedure code and diagnosis code are benefits of the Family PACT Program
9516	Secondary diagnosis code is missing or invalid for the procedure code.	<ul style="list-style-type: none"> • Verify diagnosis code is valid for procedure code being billed • Review the covered services in the Family PACT PPBI manual • Call the TSC at 1-800-541-5555
9517	Diagnosis codes are only valid for Family PACT clients.	<ul style="list-style-type: none"> • Primary diagnosis is missing, incomplete or invalid for Family PACT • For services before December 30, 2013, otherwise verify the diagnosis is valid
9518	The referring provider must be a Family PACT-certified provider.	<ul style="list-style-type: none"> • The referring provider must be an enrolled certified Family PACT provider when the billing provider is not an enrolled Family PACT provider • If the referring provider is part of a group, the group NPI must be entered in the <i>Name of Referring Provider</i> or <i>Other Source</i> field on the claim
0155	The referring provider's state license number or Medi-Cal provider number/NPI is missing or is invalid	<ul style="list-style-type: none"> • Verify provider number/NPI is correct • Verify provider number/NPI is in the correct field on claim • Verify provider's status on the Provider Master File • Call the TSC at 1-800-541-5555
9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.	<ul style="list-style-type: none"> • Verify the NDC/UPN is valid

Acronyms

AEVS	Automated Eligibility Verification System
AGOG	American Congress of Obstetricians and Gynecologists
BIC	Benefits Identification Card
CE	Childbirth Educator
CEC	Client Eligibility Certification
CHDP	Child Health and Disability Prevention
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
COS	Category of Service
CPHW	Comprehensive Perinatal Health Worker
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
DOS	Date of Service
E&C	Education & Counseling
E&M	Evaluation and Management
EDD	Expected Date of Delivery
FAM	Fertility Awareness Method
FDA	Food and Drug Administration
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FIG	Federal Income Guidelines
FPG	Federal Poverty Guidelines
FPL	Federal Poverty Limit
FQHC	Federally Qualified Health Centers
HAP	Health Access Program
HCPCS	Healthcare Procedure Coding System
HE	Health Educator
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPV	Human Papilloma Virus
ICP	Individualized Care Plan
IHS	Indian Health Services

IUC	Intrauterine Contraceptive
LAM	Lactational Amenorrhea Method
LMP	Last Menstrual Period
LVN	Licensed Vocational Nurse
MFT	Marriage Family Therapist
NDC	National Drug Code
NFP	Natural Family Planning
NMP	Non-Physician Medical Practitioner
NP	Nurse Practitioner
NPI	National Provider Identifier
OB	Obstetrics
OC	Oral Contraceptives
OHC	Other Health Coverage
PA	Physician Assistant
PACT	Planning, Access, Care and Treatment
PE	Presumptive Eligibility
PID	Pelvic Inflammatory Disease
POS	Point of Service
PPBI	Policies, Procedures and Billing Instructions
PSC	Perinatal Services Coordinator
QP	Qualified Provider
RAD	Remittance Advice Details
RD	Registered Dietician
REC	Retroactive Eligibility Certification
RHC	Rural Health Clinics
RN	Registered Nurse
SOC	Share of Cost
SSN	Social Security Number
STI	Sexually Transmitted Infection
TAR	Treatment Authorization Request
TCN	TAR Control Number
TSC	Telephone Service Center
UTI	Urinary Tract Infection
W&I Code	Welfare and Institutions Code