

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) Program. Family PACT is California's innovative approach to providing comprehensive family planning to low-income women and men.

Module Objectives

- Identify Family PACT categories of services
- Review Family PACT-approved contraceptive methods
- Provide list of family planning and family planning-related ICD-10-CM diagnosis codes
- Detail the requirements for Family PACT complications services and *Treatment Authorization Requests (TARs)*
- Clarify Family PACT-excluded services
- Discuss evaluation and management/education and counseling services
- Review sterilization policy and the sterilization *Consent Form (PM 330)*
- Detail claim documentation requirements for dispensing drugs and supplies
- Feature a case study and claim example

Acronyms

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

Family PACT Overview

The Family PACT Program is designed to assist individuals who have a medical necessity for family planning services. The overall goal of the Family PACT Program is to ensure that low-income women and men have access to health information, counseling and family planning services to reduce the likelihood of unintended pregnancy and to allow clients to establish the number and spacing of their children, as well as maintain optimal reproductive health.

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

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 PACT Categories of Services

There are two categories of services available in the Family PACT Program:

- Family planning services
- Family planning-related services

Family Planning Services

Family planning services are those relevant to the use of contraceptive methods and include specified reproductive health screening tests. These include the U.S. Food and Drug Administration (FDA) approved contraceptive methods, emergency contraceptives, office visits and interventions for the management of complications that arise from the use of covered contraceptive methods.

Family Planning-Related Services

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

The 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, regardless of the initial purpose of the visit.

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

Family Planning Services

Covered Benefits

- Oral Contraceptives
- Transdermal Patch
- Contraceptive Implant
- 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 for Family PACT Clients

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

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

NOTE

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

ICD-10-CM Codes for Contraceptive Counseling

ICD-10-CM	National Code Description	Additional Information
Z30.012	Encounter for prescription of emergency contraception	No contraceptive method initiated during visit or currently used by client
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy	
Z30.09	Encounter for other general counseling and advice on contraception	No contraceptive method initiated during visit or currently used by client
Z31.61	Procreative counseling and advice using natural family planning (NFP)	NFP to become pregnant

NOTES

ICD-10-CM Codes for Contraceptive Methods

ICD-10-CM	National Code Description
Z30.011	Encounter for initial prescription of contraceptive pills
Z30.013	Encounter for initial prescription of injectable contraceptive
Z30.015	Encounter for initial prescription of vaginal ring hormonal contraceptive
Z30.016	Encounter for initial prescription of transdermal patch hormonal contraceptive device
Z30.017	Encounter for initial prescription of implantable subdermal contraceptive
Z30.018	Encounter for initial prescription of other contraceptives Encounter for initial prescription of barrier contraceptives Encounter for initial prescription of diaphragm
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
Z30.2	Encounter for sterilization
Z30.41	Encounter for surveillance of contraceptive pills
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.432	Encounter for removal of intrauterine contraceptive device
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z30.44	Encounter for surveillance of vaginal ring hormonal contraceptive device
Z30.45	Encounter for surveillance of transdermal patch hormonal contraceptive device
Z30.46	Encounter for surveillance of implantable subdermal contraceptive (checking, reinsertion or removal)
Z30.49	Encounter for surveillance of other contraceptives Encounter for surveillance of barrier contraceptives Encounter for surveillance of diaphragm
Z98.51	Tubal ligation status
Z98.52	Vasectomy status

Reproductive Health Screening Tests

Reproductive Health Screening Tests may be provided as clinically indicated. These services are not reimbursable for ICD-10-CM diagnosis codes Z30.012, Z30.09 and Z31.61. Screening tests listed below are for male and female clients:

CPT 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-1 antibody	86689 HIV confirmatory test (for example, Western Blot) OR 86701 and 86702 differentiation assay AND 87535 HIV – NAAT (if differentiation assay results are negative or indeterminate)		86689 Limited to HIV antibody
86702*	HIV-2 antibody			
86703*	HIV-1 and HIV-2 antibodies, single result			
87389*	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result			
87806*	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies			
87491**	NAAT – Chlamydia	None		Refer to the Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (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 (lab) section in the Family PACT Policies, Procedures and Billing Instructions (PPBI) manual.*

** These screening tests have a frequency limit of three (3) tests per recipient, per day. CT and GC screening tests for females 25 years of age and older and males of all ages require an additional ICD-10-CM code. Females under 25 years of age may require an additional ICD-10-CM diagnosis code. For additional information, refer to the *Benefits: Family Planning (ben fam) section in the PPBI manual.*

Family Planning-Related Services

Family planning-related services include the diagnosis and treatment of specified STIs when provided pursuant or coincident to a family planning visit for the management of a family planning method. In addition, the Family PACT Program covers 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.

Claim Form Billing Requirements

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

Sexually Transmitted Infections (STIs)

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

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

Urinary Tract Infection (UTI) (Females Only)

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

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

Cervical Cancer Screening

Cervical cancer screenings are covered when clinically indicated and provided as part of a family planning visit. It is not a stand-alone service. These tests are billed with the appropriate family planning ICD-10-CM code and do not require an additional diagnosis code. Follow-up visits and services related to abnormal results from screening can be found under the "Management of Cervical Abnormalities and Preinvasive Cervical Lesions" heading in the *Benefits: Family Planning-Related Services* (ben fam rel) section in the PPBI manual.

The CPT cervical screening codes listed below 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 if the woman meets one or more conditions.

Cervical Screening CPT Codes

CPT Codes		
88142	88148	88167
88143	88164	88174
88147	88165	88175

CPT Code 87624 Co-testing for Cervical Cancer Screening

Effective for dates of service on or after December 1, 2018, CPT code 87624 (infectious agent detection by nucleic acid [DNA or RNA]; Human Papillomavirus [HPV], high-risk types [eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68]) is reimbursable for female clients aged 21 years and older with modifier 33. Use of modifier 33 indicates the service was provided in accordance with a U.S. Preventive Services Task Force (USPSTF) recommendation. The service must be billed with the ICD-10-CM diagnosis code that identifies the contraceptive method for which the client is being seen. Additional ICD-10-CM diagnosis code Z11.51 (encounter for screening human papillomavirus [HPV]) is required.

The USPSTF recommends screening for cervical cancer every three years with cervical cytology alone in women 21 to 29 years of age. For women 30 to 65 years of age, USPSTF recommends screening every three years with cervical cytology alone, every five years with high-risk human papillomavirus (hrHPV) testing alone or every five years with hrHPV testing in combination with cytology (co-testing).

NOTE

For screening results of negative cytology with positive HPV test, the American Society of Colposcopy and Cervical Pathology's (ASCCP) *2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors* recommends repeat co-testing at one year. If the one-year repeat co-test is HPV negative and cytology is also negative, repeated co-testing in three years is recommended. The follow-up co-testing screening encounters are reimbursable with the additional ICD-10-CM code R87.810 (cervical high risk human papillomavirus [HPV] DNA test positive) or R87.820 (cervical low risk human papillomavirus [HPV] DNA test positive).

Cervical Abnormalities and Pre-invasive Cervical Lesion Services

Services and supplies are reimbursable when provided as part of, or as a follow-up to, a family planning visit on an outpatient basis for the diagnosis and treatment of cervical abnormalities found on Pap smear or physical exam, and pre-invasive cervical lesions. An ICD-10-CM code for the cervical abnormality being treated and the ICD-10-CM code that identifies the contraceptive method for which the client is being seen are both required and must be included on the claim form. Age and frequency restrictions apply to some procedures.

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

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

NOTES

Complication Services

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

Management of a complication resulting from a contraceptive method or treatment of a family planning-related service requires an ICD-10-CM diagnosis code for the complication and must be billed with the diagnosis code that identifies the contraceptive method for which the client is being seen.

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

Example: Contraceptive Complication Services

ICD-10-CM	National Code Description	Code Must be Billed with:
I26.99	Other pulmonary embolism without acute cor pulmonale	Contraceptive method in which the complication arose. For additional information, refer to the <i>Benefits: Family Planning</i> (ben fam) section of the PPBI manual.
N92.0	Excessive and frequent menstruation with regular cycle	
T81.4XXA	Initial encounter, infection following a procedure	

NOTES

Treatment Authorization Request (TAR)

A TAR is required for services needed to evaluate and manage a complication, including office visits, procedures, facility use, and laboratory, pharmacy and radiology services.

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

TAR Requirements

Outpatient Complication Services

A TAR is required for outpatient services for the following:

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

NOTE

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

Inpatient Complication Services

A TAR is required for inpatient services for the following:

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

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

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

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

NOTES

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

CMS-1500 Claim Form TAR Documentation

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					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) ICD Ind. 0					22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. D1D1D1D	B. D2D2D2D	C. _____	D. _____	23. PRIOR AUTHORIZATION NUMBER 12345678909		
E. _____	F. _____	G. _____	H. _____			
I. _____	J. _____	K. _____	L. _____			
24. A. DATE(S) OF SERVICE From To MM DD YY 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. EPICR Family Plan
					I. ID. QUAL.	J. RENDERING PROVIDER ID. #

Partial Sample: CMS-1500 Claim Form Prior Authorization Number field (Box 23)

UB-04 Claim Form TAR Documentation

63 TREATMENT AUTHORIZATION CODES 12345678909		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 ICD-9-CM D1D1D1D D2D2D2D		67 ICD-9-CM B C D E F G H		68	
69 ADMIT DX		70 PATIENT REASON DX		71 ICD-9-CM a b c	
				72 ICD-9-CM a b c	

Partial Sample: UB-04 Claim Form Treatment Authorization Codes field (Box 63)

NOTES

Family PACT Transgender Services

Effective for dates of service on or after August 1, 2017, modifier KX (requirements specified in the medical policy have been met) may be used to facilitate claims processing in instances when the patient's gender conflicts with the billed procedure code. The patient's medical record must support medical necessity for the procedure.

Providers may already override a gender conflict with an approved TAR when the gender on the claim conflicts with the billed procedure code. However, utilizing the KX modifier is an alternative method without requiring an approved TAR.

NOTE

The use of modifier KX will not override other policy requirements for an approved TAR.

Family PACT Excluded Services

Family PACT has a limited scope of benefits and is not a primary care program. If a non-covered service is recommended for a Family PACT client, the client must be informed of the medical necessity of the service and that it is not reimbursed by the program. The provider should inform the client that the services can be rendered, but it may be an out-of-pocket expense.

Family PACT does not cover the following services:

- Prenatal, perinatal care, or any services for pregnant clients other than the diagnosis of pregnancy and required counseling about options
- Infertility diagnosis and treatment, except fertility awareness
- HIV or hepatitis treatment
- Hepatitis B immunization and Hepatitis B laboratory testing
- Screening mammograms
- Services beyond the scope of Family PACT
- Abortion services, or services ancillary to abortions with the exception of contraceptive supplies, devices or IUCs provided immediately following an abortion. Office visits during the 21-day postoperative period are not reimbursable.

NOTES

Evaluation and Management

Office Visits

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

E&M services must be performed by a clinician, 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.

Or, if more than 50 percent of the visit time was spent in counseling, then:

- the time 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.

NOTES

CPT Codes –Office Visits

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

New Patients

CPT Code	Client Reimbursement
99201	New patient, females/males
99202	New patient, females/males
99203	New patient, females/males
99204	New patient, females; males for complications only

Established Patients

CPT Code	Client Reimbursement
99211	Established patient, females/males
99212	Established patient, females/males
99213	Established patient, females/males
99214	Established patient, females; males for complications only

NOTES

E&M and CPT Codes on the Same Date of Service

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

Allowable CPT Procedure Codes

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

NOTE

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

E&M Codes – Registered Nurses

Registered nurses (RNs) can administer 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 2725.2. If performed by an RN, who has completed the required training, E&M CPT codes 99201, 99211 or 99212 must be billed with modifier TD.

Education and Counseling

Office Visits

Both HCPCS and CPT codes are used to bill for health education and counseling (E&C) office visits. Health education and counseling may be provided by either clinicians or non-clinician counselors. To be reimbursed by the program, 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.

NOTES

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

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. Providers may select only one of the following codes:

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.

The provider shall take into consideration the cumulative time spent counseling the client by all staff when selecting a preventive medicine service counseling code for billing. For example, a medical assistant spends 15 minutes counseling about all methods of contraception, and a nurse practitioner spends 10 minutes counseling about the details of the method the client selects. This 25-minute office visit is coded as 99402U6. Only one of these codes (99401U6, 99402U6 or 99403U6) may be billed on date of service.

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

Family PACT Sterilization

Sterilization Consent Form (PM 330)

Claims submitted by Family PACT providers for elective sterilizations (CPT 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 sterilization *Consent Form* (PM 330) outlined in the *Sterilization* (ster) section of the 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.
- The individual is able to understand the content and nature of the informed consent process.
- The individual is not institutionalized.
- 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 statement of the person obtaining consent.
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

IMPORTANT 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

The 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 NPI number when ordering the form(s).

State of California -- Health and Human Services Agency

**CONSENT FORM
PM 330**

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from 1 (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a 2 (Name of procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 3 / / Mo Day Yr

I,	Last												
	[Grid for last name]												
First												M. I.	
[Grid for first name]													

hereby 5 consent of my own free will to be sterilized by 6 (Doctor's name) by a method called 6 (Name of procedure). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services.
- Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form. 7 Signature of individual to be sterilized Date: 8 / / Mo Day Yr

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 9 language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

10 Signature of Interpreter Date: 11 / / Mo Day Yr

PM 330 (1/99)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 12 signed the consent form, I explained 13 (Name of individual to be sterilized) to him/her the nature of the sterilization operation 13 (Name of procedure) the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

14 Signature of person obtaining consent Date: 15 / / Mo Day Yr
16 Name of Facility where patient was counseled
17 Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 18 (Name of individual to be sterilized) on 19 / / Mo Day Yr (Date of Sterilization), I explained to him/her the nature of the

sterilization operation 20 (Name of procedure) the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of Alternative Final Paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

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

22 (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box below and fill in information requested.)

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

26 B Emergency abdominal surgery; describe circumstances: _____

27 Signature of Physician performing surgery Date: 28 / / Mo Day Yr

Sample: Sterilization Consent Form - PM 330 (English Version)

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

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

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

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

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

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas 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) (Nombre del país)

Declaro tener al menos 21 años de edad y que nací en (3) (Nombre del país)

Mes	Día	Año
Apelido		
Nombre		

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por (5) (Nombre del Doctor)

utilizando un método conocido como (6) (Nombre del procedimiento)

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

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

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

He recibido copia de este formulario.

(7) (Firma) Fecha: (8) / / (Mes Día Año)
 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) (Nombre del idioma) y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

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

■ 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 informo 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) (Firma) Fecha: (15) / / (Mes Día Año)
 Firma de quien recibe el consentimiento

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

(17) (Dirección)
 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), 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) / / (Mes Día Año) (Debe ser 30 días a partir de la firma de la persona).

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

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

Contraceptive Drugs and Devices

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
J7296	Levonorgestrel IUC, (kyleena), 19.5 mg	
J7297	Levonorgestrel IUC, (liletta) 52 mg 3 yr	NDC required on claim
J7298	Levonorgestrel IUC, (mirena) 52 mg 5 yr	NDC required on claim
J7300	Copper IUC	NDC required on claim
J7301	Levonorgestrel IUC, (skyla) 13.5 mg	NDC required on claim
J7303	Contraceptive supply, vaginal ring	NDC required on claim
J7304	Contraceptive supply, patch	NDC required on claim
S4993	Oral contraceptives	NDC required on claim
S5000/S5001	Prescription drug, brand name/Prescription drug, generic	NDC required on claim

Onsite Dispensing Billing Instructions

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

Onsite Dispensing Price Guide

The *Drugs: Onsite Dispensing Price Guide* (drug onsite) section contains 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)

NOTES

Family PACT Contraceptive Supplies

HCPCS Code	National Code Description	Additional Information
A4261	Cervical cap	Limited to 2 cervical caps per year
A4266	Diaphragm	Limited to 1 diaphragm per year
A4267*	Condom, male, each	Up to 36 units per 27 days
A4268*	Condom, female, each	Up to 6 units per 27 days
A4269U1*	Spermicide: Gel, jelly, cream or foam	Limited to three refills in any 75-day period
A4269U2*	Spermicide: Suppository	Limited to three refills in any 75-day period
A4269U3*	Spermicide: Vaginal film	Limited to three refills in any 75-day period
A4269U4*	Spermicide: Contraceptive sponge	Limited to three refills in any 75-day period
S5000	Prescription drug, generic	Miscellaneous drugs
S5001	Prescription drug, brand name	Miscellaneous drugs
S5199*	Personal care item, NOS each	Lubricant Limited to three refills in any 75-day period
	Basal Body Thermometer (each)	Pharmacy dispensed only (1 per year)

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

Treatment and Dispensing Guidelines for Clinicians

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

Family Planning-Related Conditions Drug Regimens

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		

* CDC Sexually Transmitted Diseases Treatment Guidelines 2015, MMWR 2015:64.

Sample: Treatment and Dispensing Guidelines for Clinicians

NOTES

Claim Form Documentation

Claim form documentation for contraceptive supplies and miscellaneous drugs dispensed onsite must be entered in the *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form or the *Remarks* field (Box 80) on the *UB-04* claim form, or an attachment. Refer to the *Drugs: Onsite Dispensing Billing Instructions* (drug) section of the PPBI manual for examples. Below is a claim example for contraceptive supplies dispensed onsite (20 male condoms at \$0.28 each and foam [40 gm] at \$0.20).

Documentation must include:

- Name of drug/supply (e.g., male condoms at \$0.28 [20 condoms] and foam at \$0.20 [40 gm])
- Size and/or strength, if applicable
- Number of units (e.g., 20 condoms; 40 gm foam)
- Clinic dispensing fee, if applicable (e.g., 10% total cost; each contraceptive item)
- Total cost (e.g., Line 1: male condoms \$5.60 plus 10% = \$6.16; Line 2: foam \$8.00 plus 10% = \$8.80. Total contraceptive supplies dispensed in-house charges for date of service is \$14.96)

<p>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p> <p>L1: Male condoms @ .28 x 20 = \$5.60 + CDF 10% .56 = \$6.16 L2: Foam @ .20 x 40 gm + \$8.00 + CDF 10% .80 = \$8.80</p>
--

Partial Sample: CMS-1500 Claim Form Additional Claim Information field (Box 19)

NOTE

There is a \$14.99 claim limit for all contraceptive supplies dispensed on a single date of service. For additional information and the Family PACT rate per unit, refer to the *Drugs: Onsite Dispensing Price Guide* (drug onsite) section of the PPBI manual. For claim supplies for contraceptive supplies and miscellaneous drugs, refer to the *Claim Completion: CMS-1500* (claim cms) section and *Claim Completion: UB-04* (claim ub) section in the PPBI manual.

NOTES

Family PACT Case Study

Amanda is a new Family PACT client enrolled on October 1, 2018 and comes in for family planning services. She thinks her period is late and is also experiencing UTI symptoms. Amanda has an initial family planning and office visit, including counseling on all contraceptive methods at Dr. John Davis' Family Planning office.

What services were available to be performed for Amanda at her visit?

- Office visit
- Education and counseling
- Oral contraceptives
- Urine dip-stick test

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

Do you need Amanda's consent to perform the pregnancy test? Yes. Amanda gives her verbal consent. The pregnancy test is negative.

Amanda has a dipstick urine test performed for symptoms of a UTI, and it is confirmed that she has a UTI. Amanda is given a prescription for oral contraceptives and an antibiotic for the UTI. The provider dispenses condoms (20 condoms at \$0.28 each [HCPCS code A4267]) and foam (40 gm at \$0.20 [HCPCS code A4269U1]) for quick start.

Is the provider eligible for the clinic dispensing fee (CDF)? Yes. The CDF is 10 percent of the total amount of contraceptive supplies dispensed onsite. There is a \$14.99 claim limit for all contraceptive supplies dispensed on a single date of service.

NOTE

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

	CPT/HCPCS Code	ICD-10-CM Code
Contraceptive Supplies	A4267 (condoms) A4269U1 (foam)	
Drugs	None	
Lab	81025 (pregnancy test) 81002 (UA dipstick)	
Evaluation & Management	99203U6	D1D1D1D D2D2D2D
Modifier	U6 is required to indicate individual family planning counseling was provided during the office visit	
Education & Counseling	S9445 (Individual orientation to Family PACT, only once by the same provider for the same client)	

Amanda's Case Study Claim Form

Complete the partial CMS-1500 claim form below based on Amanda's case study information.

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)				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. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				ICD Ind. _____				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1																					
2																					
3																					
4																					
5																					
6																					
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use					
				<input type="checkbox"/> <input type="checkbox"/>						<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$							

PHYSICIAN OR SUPPLIER INFORMATION

NOTES

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

Amanda's Case Study: Answer Key

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. _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
17b. NPI								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) L4: Condoms @ .28 X 20 = \$5.60 + CDF 56 = \$6.16 L5: 2 foam @ .20 X 40gm = \$8.00 + CDF 80 = \$8.80								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								
A. <u>D1D1D1D</u>		B. <u>D2D2D2D</u>		C. _____		D. _____		E. _____		F. _____						
E. _____		F. _____		G. _____		H. _____		I. _____		J. _____						
I. _____		J. _____		K. _____		L. _____										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #			
1 10 01 18			11		99203 U6				8000	1		NPI				
2 10 01 18			11		81002				800	1		NPI				
3 10 01 18			11		81025				1000	1		NPI				
4 10 01 18			11		A4267				616	20		NPI				
5 10 01 18			11		A4269 U1				880	40		NPI				
6 10 01 18			11		S9445				4500	1		NPI				
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
				<input type="checkbox"/>					<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 15796		\$			

PHYSICIAN OR SUPPLIER INFORMATION

Partial Sample: CMS-1500 Family PACT Office Visit

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)