Provider Enrollment and Responsibilities

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This section outlines the requirements of enrollment and responsibilities as a Family Planning, Access, Care and Treatment (Family PACT) Program provider, including, but not limited to, administrative responsibilities, referring clients to Medi-Cal providers and other programs, compliance reviews, and record keeping. The statutes and regulations noted in this section are binding for all Family PACT providers, their designated agents, all public and private agencies and/or individuals that are engaged in providing or securing Family PACT services for, or on behalf of, eligible Family PACT clients. Providers should carefully review the full text of California's Welfare and Institutions Code (W&I Code), Section 24005.

Eligible Providers

Per W&I Code, Section 24005(b) and (c), only licensed medical personnel with family planning skills, competency and knowledge, may provide the full range of services covered by the program. Medi-Cal enrolled providers, as determined by the Department of Health Care Services (DHCS) shall be eligible to provide family planning services under the program when the services are within their scope of practice and licensure. Eligible providers shall provide the full scope of family planning, education, counseling and medical services specified by Family PACT, either directly or by referral, consistent with the standards of care issued by the Department per W&I Code, Section 24005(c). For more information about the Family PACT Program Standards, refer to the *Program Standards* section in this manual. Family PACT providers are required to offer and provide Long Acting Reversible Contraception onsite. See *Long Acting Reversible Contraception (LARC)* in this section for additional information.

Clinical providers electing to participate in the Family PACT Program must be enrolled Medi-Cal providers in good standing prior to submitting a Family PACT application. A Family PACT application submitted by a provider in which the service location and/or the participating providers identified on the application for enrollment are not enrolled in Medi-Cal or not in good standing with Medi-Cal shall be denied.

Eligible Provider Types

Solo providers, group providers, Primary Care Clinics (PCCs), Affiliate Primary Care Clinics (APCCs), Federally Qualified Health Centers (FQHCs), Tribal FQHCs, community clinics, intermittent clinics, mobile clinics, Rural Health Centers (RHCs), IHS-MOA 638 clinics, certain specialty clinics, and outpatient hospitals are eligible to apply for enrollment in the Family PACT Program if they currently have a National Provider Identifier (NPI) and are enrolled in Medi-Cal in good standing. See *Primary Care and Affiliate Primary Care Clinics* in this section for additional information.

Intermittent clinics, as defined by Health and Safety (H&S) Code, Section 1206(h) and mobile clinics, as defined by H&S Code, Sections 1765.120, 1765.150 and 1765.155, must apply for enrollment in the Family PACT Program. Intermittent clinics and mobile clinics may apply using their own NPI or their organizational NPI and must be enrolled in Medi-Cal in good standing.

Ineligible Providers

Per W&I Code, Section 24005(g), providers and participating practitioners who, in the last 10 years, have been convicted of any felony or misdemeanor that involves fraud or abuse in any government program, or have been found liable for fraud or abuse in any civil proceeding, or entered into a settlement in lieu of conviction for fraud or abuse in any government program will not be eligible to enroll in the Family PACT program.

Per W&I Code, Section 24005(h), providers and participating practitioners will not be eligible to enroll in the Family PACT Program if they are under investigation by the department or any local, state, or federal government law enforcement agency for fraud, abuse or has an open department audit.

Enrollment

A provider's enrollment is location specific. A (physical) service location is certified for enrollment in the Family PACT Program when all the Family PACT provider enrollment requirements set forth in this section have been met. A Family PACT site may only be enrolled under one provider's NPI, and no other organizational NPI may enroll at the same service location. All Family PACT services shall be rendered by, or at, an enrolled service location(s) only.

Provider Groups

The California Code of Regulation (CCR), Title 22, Chapter 3, Article 1, Section 51000.16, defines a “Provider Group” as two or more rendering providers. When enrolling as a group provider, failure to properly report at least two (2) rendering providers at the time of application may result in the denial of the application. Rendering providers are individual providers who render healthcare services, or provide goods, supplies, or merchandise, as a member of a provider group and use the group provider number to bill the Family PACT Program.

Primary Care and Affiliate Primary Care Clinics

Pursuant to Health and Safety Code (HSC) 1222, an applicant for licensure as a Primary Care Clinic (PCC), as defined in subdivision (a) of H&S Code, Section 1204 may submit an application for review of the clinic’s qualifications for participation in the Family PACT Program simultaneously with the clinic’s application for enrollment and certification as a provider in the Medi-Cal Program.

An Affiliate Primary Care Clinic (APCC) enrollment in the Family PACT Program is dictated by W&I Code, Section 24005(t) (1) and (2).

Within 30 calendar days of receiving a complete application for enrollment into the Family PACT Program from an APCC licensed under H&S Code, Section 1218.1, the department will do one of the following:

- Approve the APCC’s Family PACT application, provided the applicant meets the Family PACT provider enrollment requirements set forth in this section; or
- If the APCC is enrolled in Medi-Cal in good standing, notify the applicant in writing of any discrepancies identified in the Family PACT enrollment application. The applicant shall then have 30 calendar days from the date of the written notice to correct any identified discrepancies. Upon receipt of all requested corrections, the department shall approve the application within 30 calendar days. The APCC’s Family PACT enrollment effective date will then be made retroactive to the date the department received the Family PACT enrollment application; or
- If the APCC is not enrolled in Medi-Cal at the time the provider’s Family PACT enrollment application is submitted, DHCS shall not proceed with the actions until it receives confirmation that the APCC is enrolled in Medi-Cal. After DHCS receives confirmation of Medi-Cal enrollment, and the APCC’s
- Family PACT application is approved, the APCC’s Family PACT enrollment date will be made retroactive to the date the APCC was enrolled in Medi-Cal

All APCCs are subject to the provider orientation requirements set forth in this section.

Non-Physician Medical Practitioners

Non-Physician Medical Practitioners (NMPs) employed by a Medi-Cal provider who will be delivering Family PACT services must be identified on the *Application to Participate in the Family PACT Program* (DHCS 4468) and complete a *Family PACT Program Practitioner Participation Agreement* (DHCS 4470). NMPs eligible to participate in the Family PACT Program include Certified Nurse Practitioners (CNPs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs).

Definitions for NMPs are located in the *Non-Physician Medical Practitioners (NMP)* section in the appropriate Part 2 Medi-Cal provider manual. Unless otherwise stated, the Family PACT Program defers to Medi-Cal policies, billing instructions and reimbursement for NMPs who deliver Family PACT services.

NMPs are authorized to deliver the full scope of Family PACT family planning and family planning-related services, with the exception of male and female sterilization, within their scope of practice and to the extent permitted by applicable professional licensing statutes and regulations as set forth in the physician/practitioner interface document.

Providers Not Required to Enroll

Anesthesiologists, laboratories, pharmacies and radiologists are not required to enroll in the Family PACT Program, but must be enrolled in Medi-Cal. Anesthesiologists, laboratories, pharmacies and radiologists cannot enroll or recertify clients in the Family PACT Program.

Ordering, Referring, or Prescribing (ORP) Providers

W&I Code, Section 14043.1(b) and (o) require the enrollment of ORP providers as participating providers in the Medi-Cal program. W&I Code, Section 14043.15(b)(3) provides that the NPI of the ORP provider must be listed on all claims for reimbursement.

There are three basic requirements for ORP providers:

- The ORP provider must be enrolled in Medi-Cal as a billing provider, rendering provider or as an ORP only (non-billing) provider
- The ORP provider's enrolled NPI (Type 1) must be for an individual, not an organizational NPI
- The ORP provider must be eligible to order, refer and/or prescribe in accordance with law and the health care practitioner's practice act

If an ORP provider identified on a Family PACT claim is not enrolled in Medi-Cal, the claim for reimbursement of the goods or services they provided in filling a client's order, referral or prescription will be denied.

Additional information on ORP providers is available on the DHCS website.

Long-Acting Reversible Contraception (LARC)

Each site enrolling into the Family PACT Program must identify, at a minimum, one practitioner trained to provide LARC services onsite. LARCs include the copper and hormonal intrauterine devices (IUDs) and contraceptive implant. Per W&I Code 24005(k), enrolled providers who insert IUDs or contraceptive implants shall have received prior clinical training specific to these procedures. The trained practitioner(s) must be indicated on the application for enrollment. Each practitioner identified on the application for enrollment as trained to provide LARC services must list their specialty i.e., OB/Gynecology, Women's Health Nurse Practitioner (NP), or provide proof of training or a signed affidavit.

Applying for Enrollment

Per W&I Code, Section 24005(e), DHCS may screen applicants at the initial application and at any reapplication pursuant to the requirements developed by DHCS to determine provider suitability for the program.

Provider applicants interested in applying for enrollment into the Family PACT Program shall follow the application instructions listed on the Family PACT and DHCS websites. The *Family PACT Program Provider Agreement* (DHCS 4469) and the *Family PACT Program Practitioner Participation Agreement* (DHCS 4470) will be provided to applicants during the application process and must be completed, signed, and submitted to the program within 10 business days of the date they were provided.

Each practitioner, Medical Doctor (MD NMP's serving Family PACT clients shall agree to comply with *Family PACT Program Standards* by signing the DHCS 4470. The DHCS 4470 is not required to be completed by an APCC, nonprofit community clinic or PCC, or Indian Health Services, Memorandum of Agreement (IHS-MOA) 638, Clinics.

Enrollment Forms and Agreements

Enrollment forms and agreements shall be:

- Signed under penalty of perjury under the laws of the State of California. Background checks and data searches are performed to verify the information provided on the enrollment forms
- Completed by the provider applicant only
- Any enrollment forms received by a third party (for example: consultants, attorneys, or enrollment brokers) will not be accepted. Additionally, third parties (for example: consultants, attorneys, or enrollment brokers) must not be the contact person listed on the application

Providers must maintain legible copies of all initial and updated provider enrollment applications, initial and updated provider and practitioner agreements, and all related required training documents at the provider site. A site certifier's in-person orientation certificate of attendance must be displayed at all times.

Additional Documentation

Copies of the following supporting documentation must be submitted during the application process:

- All clinic policies and procedures for Family PACT client eligibility and enrollment (for example: policies and procedures and/or staff training plan for enrolling clients, record retention of CEC forms, security plan for Health Access Programs (HAP) cards, client appointment process, etc.)
- All clinic policies and procedures for referrals and follow-ups for all services provided at the location (i.e., policies and procedures and/or staff training plan for referring clients for services covered by Family PACT, but not offered by the provider, clinician visit/back office documentation procedures, documentation procedures for the education and counseling provided, and the patient outcome/treatment plan, etc.)
- Clinic organizational chart (for example: staff list and roles for each, etc.
- Proof or attestation of LARC training for each practitioner identified on the application as being LARC trained, if not an OB/Gynecology or Women's Health NP (for example: training log)
- Site certifier's Family PACT training certificates and in-person orientation certificate (for example: training log, staff list, etc.)
- Any additional documentation requested by DHCS

Application Deficiencies

Applicants are allowed 60 calendar days from the notification date to resubmit a corrected application when the application is returned deficient.

If a Family PACT provider applicant and/or new provider location fails to resubmit the corrected application to the DHCS' Office of Family Planning (OFP) or fails to remediate the deficiencies within 60 calendar days, the application will be denied.

Applicants denied for failure to resubmit or remediate deficiencies in a timely manner may reapply at any time.

Additional Provider Locations

To enroll additional provider locations under the organizational NPI, each additional provider location must be enrolled in Medi-Cal in good standing. Provider applicants applying to enroll additional locations shall follow the application instructions listed on the Family PACT and DHCS websites.

Provider Orientation and Trainings

Medi-Cal enrolled providers attempting to enroll or recertify into the Family PACT Program must complete the legislatively mandated Provider Orientation per W&I Code, Section 24005(k). The In-Person Provider Orientation provides an overview on comprehensive family planning, program benefits and services, client eligibility, provider responsibilities and compliance.

Site Certifiers, rendering, and NMP providers administering the Family PACT Program must complete all required trainings and Provider Orientation prior to submitting an enrollment application

Required Trainings

All required trainings are posted on the Family PACT Provider Learning Management System (LMS) website. The trainings in LMS are based on the primary functional role of a provider's staff. The Site Certifier, Clinician(s), and Administrator(s) have specific trainings to complete as part of the Family PACT provider enrollment process. For more information and the complete list of the required trainings visit the Trainings web page on the OFP Registration website.

Site Certifier

Each service location must designate one eligible representative, who works at the service location, to be the location's site certifier. A Medical Director, MD, CNP, or CNM who is enrolled in Medi-Cal is eligible to certify the site. The designated site certifier must be identified on the application for enrollment and is responsible for overseeing the family planning services rendered at the identified service location to be enrolled.

A Medical Director, MD, CNP or CNM will not be eligible to certify the service location if they are under investigation by any local, state, or federal government law enforcement agency, including DHCS, for fraud or abuse; have an open department audit; or have previous sanctions. This includes any previous disciplinary action, probation, and/or limits on practice by the Medical Board of California. PAs are approved by the Physician Assistants Board of California to perform direct patient care services under the supervision of a licensed physician. PAs are employed by Medi-Cal providers but are never independent Medi-Cal providers and are therefore ineligible to certify a site.

Site certifiers are responsible to ensure that all practitioners and personnel providing services on behalf of the Family PACT Program, complete and track required trainings approved by OFP on an annual basis (i.e., Front Office, Back Office, etc.). Required online trainings are available via the Family PACT LMS at: OFP Registration website. Prior to registering for the Provider Orientation, the site certifier must complete all online trainings listed in the designated Learning Track in the LMS.

Enrolled service locations electing a new site certifier are required to have the site certifier:

- Submit a DHCS 4470 to DHCS (APCC, nonprofit community clinic or PCC, and IHS-MOA 638 Clinics are exempt from DHCS 4470 requirement)
- Complete all required online trainings
- Attend a Provider Orientation within 60 calendar days of hire, or change to this role if already an established employee and
- Provide any additional documentation as requested by DHCS

Enrollment Confirmation

Once all provider enrollment requirements set forth in this section have been met and the Family PACT application is approved, the Family PACT enrollment effective date will be retroactive to the date DHCS' OFP received the Family PACT application.

Providers will receive written confirmation of enrollment, including the Family PACT enrollment effective date.

Recertification for Continued Participation

Family PACT providers must recertify their enrollment as a Family PACT provider every five (5) years or as directed by DHCS.

The recertification process includes reapplication for enrollment in the Family PACT Program, which requires that:

- A complete application package be submitted to DHCS OFP within 60 calendar days of the notification by DHCS. Refer to Applying for Enrollment outlined in this section for a description of a complete application package. If corrections are needed, 60 calendar days are allowed from the notification date to resubmit a corrected application
- The information on the application package must match the information on file with DHCS PED
- A site certifier should complete an In-Person Provider Orientation and all required trainings to certify the service location within 90 calendar days of the notification of recertification by DHCS

Failure to submit a complete application package within 60 calendar days of receiving written notification by DHCS, remediate a deficient application package within 60 calendar days, or complete all required training within 90 calendar days will result in the provider being disenrolled from the Family PACT Program.

Reporting a Change of Information

Providers shall report to both DHCS' Provider Enrollment Division (PED) and DHCS' OFP within 35 calendar days of any addition or change in information previously submitted in the application package. Failure to notify DHCS' PED (Medi-Cal) and DHCS' OFP (Family PACT) of any changes to previously submitted information may result in disenrollment from the Family PACT Program.

A provider must submit a new application to DHCS' OFP within 35 calendar days when reporting the following changes to a Medi-Cal record and the new information in the application must already be on file on file with DHCS' PED:

- Service, mailing and/or pay-to addresses
- National Provider Identifier (NPI)
- Taxpay Identification Number (TIN)
- Legal name or business name

These changes do not require a provider to attend a Provider Orientation to certify the service location unless the service location is designating a new site certifier. For more information related to Site Certifier requirements, refer to Site Certifier in this section.

If the changes are to provider type or ownership, a provider must reapply for enrollment in the Family PACT Program within 35 days of the action taken, i.e., an individual provider changes their provider type from a solo provider to a group provider. The new information in the application must already be on file with DHCS' PED. A site certifier must complete all required trainings to certify the service location.

Program Integrity and Compliance

The Family PACT Standards define the scope, type, and quality of care required under the Family PACT Program, and the terms and conditions under which the providers will be reimbursed.

Family PACT providers shall establish policies and procedures to comply with the Family PACT Standards and administrative policies contained in this manual, including applicable regulations and laws and program policies and administrative practices. The Department may conduct or arrange for compliance reviews and/or audits to be conducted to ensure compliance with Family PACT Standards, regulations and laws and program policies and administrative practices. In addition, desk reviews or provider self-audits may be performed and/or requested by DHCS. Follow-up compliance reviews, audits or site reviews may occur as deemed necessary. Failure to comply with Family PACT Standards, regulations and laws and program policies and administrative practices will result in suspension and/or disenrollment from the Family PACT Program.

Compliance reviews shall cover a period of time as determined by DHCS, and include but are not limited to, a review of medical records, staff employment files, detailed job descriptions, appropriate licensing and certification for all personnel, business related contracts and documents outlining budgets and fiscal integrity. If a compliance review results in a corrective action plan (CAP) or temporary suspension, the provider must agree to comply with all aspects of the program's directed CAP or suspension before the provider is reinstated. The site certifier shall use the results of the compliance review to identify the areas that shall be the subject of ongoing monitoring and periodic self-audits.

Self-monitoring is required and shall include documentation of completed trainings signed by staff; ensuring client files are reviewed and re-certified annually, ensuring all Family PACT forms are accurately completed, medical record documentation meets the Family PACT Program Standards; and a HAP card log for new cards issued, de- activated, and re-activated be maintained for at least three (3) years.

Additional Screening Requirements for Enrolling and Maintaining Enrollment

DHCS reserves the right to limit the enrollment of new providers in designated service areas, if DHCS, at its sole discretion, determines that the service area is adequately covered. Provider enrollment screening to determine provider suitability into the program is necessary to safeguard the fiscal and programmatic integrity of the Family PACT Program.

Per W&I Code, Section 24005(f), DHCS may conduct a background check for the purpose of verifying the accuracy of the information provided on the application package. The background check may include, but may is not limited to, the following: one (1) on-site inspection before, during, or after enrollment, for the purpose of determining whether enrollment or continued enrollment is warranted; two (2) review of business records and three (3) data searches.

DHCS may prohibit a provider from enrolling in the Family PACT Program for up to three (3) years if its enrollment application is denied as the result of a provider submitting false or misleading information (or omitted information from) on or with its application in order to gain enrollment in the Family PACT Program.

Provider Disenrollment

Providers, including all of the provider's site locations, are subject to disenrollment for failure to adhere to program standards, policies and administrative practices. DHCS shall immediately disenroll the provider from the Family PACT Program when:

- Documents mailed to a provider's mailing address, pay-to address or business address, are returned by the United States Postal Service as not deliverable
- A provider has not submitted a claim for reimbursement to the Family PACT Program, for a period of one (1) year
- The provider, any individual who, or any entity that has a license, certificate or other approval to provide healthcare, which is revoked or suspended by a federal, California or another state's licensing, certification or other approval authority, has otherwise lost that license, certificate or approval while a disciplinary hearing on that license, certificate or approval or has surrendered that license, certificate, or approval while a disciplinary hearing on the license, certificate, or approval was pending
- The provider's license is currently revoked under a different name, NPI, or business identity, and the applicable reenrollment bar period has not expired

- The provider submits claims for services performed at, or items furnished from, a location that it knew or should reasonably have known did not comply with Family PACT enrollment requirements
- A provider receives recertification for continued participation notification and fails to respond to the Department within the designated timeframes
- Pursuant to W&I Code, Section 24005(h), if it is discovered that a provider is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse or has an open department audit

Disenrollment from the Family PACT Program by DHCS is not subject to an administrative appeal. Disenrolled providers may reapply to become a Family PACT provider. Approval will be considered on a case-by-case basis. Disenrollment from the Family PACT Program may affect eligibility to participate in other programs and/or result in additional sanctions or penalties.

DHCS' OFP shall make referrals to the Medi-Cal Program for those providers who are suspected of fraud, waste, and abuse. If a provider is suspended from the Medi-Cal Program, enrollment in the Family PACT Program is terminated effective the date of the Medi-Cal suspension and Family PACT services are no longer reimbursable. Providers and provider staff who are disenrolled from the Family PACT Program for fraud, waste, and abuse may not reapply for a minimum period of three (3) years from the date of disenrollment.

Provider Suspension

DHCS has the discretion to suspend and/or take corrective action against a provider in lieu of disenrollment. DHCS may terminate or constitute grounds for issuing a reprimand; place the provider on probationary status; or suspend the provider from participation in the Family PACT Program, in accordance with the regulations contained in W&I Code Section 14123 and CCR, Title 22, Chapter 3, Article 6, Section 51452(a).

Voluntary Disenrollment

Providers may terminate their participation in the Family PACT Program at any time by following the instructions listed on the Family PACT website.

Health Access Programs Cards

HAP cards are to be provided to the client after activation and activated cards shall not be stored at the provider's location. Upon disenrollment, unused HAP cards must be returned. For more information, refer to the *Health Access Programs* (*HAP) Cards* section in this manual.

Reinstatement

If a provider was determined ineligible to participate in the Medi-Cal program, and is reinstated, the provider's Family PACT status is not automatically reinstated. The provider must reapply to become a Family PACT provider. Approval as an enrolled Family PACT provider will be considered on a case-by-case basis.

Provider Responsibilities

Nondiscrimination and Language Assistance

Medi-Cal providers may not discriminate against beneficiaries and must provide language assistance services, as described below.

Nondiscrimination

Medi-Cal providers must allow full and equal access to the benefits of the Medi-Cal program and may not discriminate on the basis of:

- Race*
- Color*
- Sex*
- Age*
- National origin*
- Ancestry
- Ethnic group identification
- Religion
- Disability*
- Mental disability
- Physical disability
- Medical condition
- Genetic information
- Marital status
- Gender
- Gender identity
- Sexual orientation

Language Assistance Under Federal Law

Under the regulations implementing Section 1557, of the Patient Protection and Affordable Care Act (ACA), Medi-Cal providers must take reasonable steps to ensure limited English proficient (LEP) individuals have meaningful access to the health program or activity they provide. Language assistance services must be accurate, timely, provided free of charge and protect the privacy and independence of the LEP individual. These language assistance services may include interpretation (oral language assistance) and written translation of content in paper or electronic form per the Code of Federal Regulations (45 CFR Sec. 92.101).

Language Assistance Under State Law for Managed Care Plans

In addition to federal requirements, under W&I Code Section 14029.91, a managed care plan contracted with DHCS to provide Medi-Cal services must provide language assistance services to LEP beneficiaries who are mandatorily enrolled in managed care as follows:

- Oral interpretation services must be provided in any language on a 24-hour basis at key points of contact
- Translation services must be provided to the language groups identified by DHCS (See DHCS All Plan Letter [APL 20-015, 17-011] and any subsequent APLs)

A managed care plan must notify beneficiaries of the availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to health care programs or activities to LEP beneficiaries. (W&I Code Sections 14029.91, 14727).

Requirement Resources

For more information about the application and requirements of W&I Code 14029.91 and the rule implementing Section 1557 of the ACA, providers should contact their representative professional organizations. Visit the HHS Section 1557 web page for find more information on Section 1557 of the ACA.

Contact Information for Claims of Discrimination

In the event that a Family PACT client makes a claim that a health care provider has failed to provide covered Family PACT services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, the health care provider must refer the Family PACT client to its representative designated to coordinate compliance with nondiscrimination requirements, or to handle grievances generally, and to DHCS' Office of Civil Rights (OCR) by phone, in writing or electronically.

By phone: Call (916) 440-7370. If clients cannot speak or hear well, call 711 (Telecommunications Relay Service).

In writing: fill out a complaint form or send a letter to:

Department of Health Care Services
Office of Civil Rights, MS 0009
P.O. Box 997413, Sacramento, CA 95899- 7413
Email: CivilRights@dhcs.ca.gov

Complaint forms are available on the DHCS website (www.dhcs.ca.gov).

The health care provider must also refer the Family PACT client to the U.S. Department of Health and Human Services, OCR by phone, in writing or electronical.

By phone: call (800) 368-1019. If clients cannot speak or hear well, call TTY/TDD at (800) 537-7697.

In writing: fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington D.C., 20201-0004

Complaint forms are available on the HHS website

Electronically: Visit the OCR Complaint Portal on the HHS website.

Access to Care

The Family PACT provider is responsible for client access to Family PACT Program services in accordance with the requirements of the Family PACT Standards. Enrolled Family PACT providers agree to make available to eligible clients the scope of comprehensive family planning and family planning-related services, consistent with the Family PACT Standards, either directly or by referral. Clients must only be referred to enrolled Family PACT providers or Medi-Cal providers.

Collaboration Encouraged

Enrolled Family PACT providers have the responsibility to ensure client access to services and are encouraged to collaborate with other providers, such as laboratory, pharmacy and primary care providers. Ensuring that other providers participating in client care have information about the Family PACT Program will facilitate clients' access and care.

Family PACT Referrals

Medi-Cal providers who are not enrolled in the Family PACT Program may render Family PACT services only when the client is referred by an enrolled Family PACT provider. Family PACT providers may refer clients to Medi-Cal laboratory, pharmacy, radiology and anesthesiology providers for covered services. Referrals may be made to Medi-Cal consulting clinicians when a covered procedure is outside the technical skill of the Family PACT provider or when there is insufficient volume to ensure and maintain a high skill level of the Family PACT provider.

Referring Providers

The referring Family PACT provider is responsible for informing all rendering providers (including clinicians, laboratories, anesthesiologists, radiologists and facilities) of Family PACT Program policies and scope of services, so that clients do not receive services that are not program benefits and are not charged for services. A Medi-Cal provider who is not enrolled in the Family PACT Program must know the following information to bill for services:

- Client name
- HAP ID number
- Family planning ICD-10-CM diagnosis code and any additional ICD-10-CM diagnosis code(s) needed and reimbursed by Family PACT and
- Referring enrolled Family PACT provider’s name and NPI

Client Records Transfer

Family PACT clients must not be charged for exchange or transfer of medical record information.

Primary Care and Local Resource Referral

Family PACT Standards include a provision that providers shall make referrals to appropriate resources for needed medical, psychosocial and more intensive counseling services that are not covered by this Program, including primary care not offered in enrolled provider practices. Information about other sources of funding for these services and options for a sliding-fee-scale is particularly helpful for clients who have no other health care or mental health care coverage.

Other Programs by Referral

Family PACT providers may refer clients to other programs, such as Every Woman Counts (EWC), Breast and Cervical Cancer Treatment Program (BCCTP) and Presumptive Eligibility for Pregnant Women (PE4PW).

Every Woman Counts

Clients who meet the EWC eligibility requirements, with a finding such as a positive mammogram, breast nodule or bloody nipple discharge, and require diagnostic testing to evaluate the possibility of breast cancer diagnosis may be referred to EWC at 1-800-511-2300. For eligibility requirements, refer to the *Every Woman Counts* section in the appropriate Part 2 Medi-Cal manual. After a cancer diagnosis is confirmed, either the Family PACT provider or the EWC primary care provider may enroll the client into BCCTP for treatment.

Breast and Cervical Cancer Treatment Program

Family PACT providers have the opportunity to enroll clients directly into BCCTP for services beyond the scope of Family PACT. The BCCTP provides Medi-Cal benefits for the treatment of breast and cervical cancer. Family PACT providers may enroll clients with a breast or cervical cancer diagnosis (including CIN 2 and CIN 3) into BCCTP with an internet-based application available on the Transactions web page of the Medi-Cal website (*www.medi- cal.ca.gov*). Clients must meet the Family PACT income guidelines in order to be referred to, or enrolled in, BCCTP. For more information about BCCTP, call 1-800-824-0088. To find out how to participate as a referring provider, call the Telephone Service Center (TSC) at 1-800- 541-5555.

Presumptive Eligibility for Pregnant Women

PE4PW is a Medi-Cal program designed to provide immediate, temporary coverage for prenatal care to low-income, pregnant women pending a formal Medi-Cal application. Any woman who thinks she is pregnant and whose family income is below a determined amount is eligible for PE. However, this care must be through a participating provider to determine eligibility for this program. For more information, and to find out how to become a PE4PW provider, refer to the *Presumptive Eligibility for Pregnant Women Provider Enrollment Instructions* section in the appropriate Part 2 Medi-Cal manual.

Recordkeeping

Medical Record Documentation

In accordance with W&I Code, Section 24005(p), each provider of health care services rendered to any program beneficiary shall keep and maintain records of each service rendered, the beneficiary to whom the service was rendered, the date and any additional information that the department may by regulation require. The clinical rationale for providing, ordering or deferring services for client assessment, diagnosis, treatment and follow-up is required. Documentation must reflect the scope of education and counseling services, including individual client assessment. All medical record entries must be legible and the clinician must be clearly identifiable.

Recordkeeping

The Family PACT Program defers to Medi-Cal regulations for keeping and maintaining medical records. For a summary of Medi-Cal regulations, refer to the *Provider Regulations* section in the Part 1 Medi-Cal manual. The Family PACT Program has additional guidelines for recordkeeping that include, but are not limited to:

- *Client Eligibility Certification Form* (CEC) form (DHCS 4461)
- *Sterilization Consent Form* (PM 330)
- Signature requirement for drugs and devices
- A log of devices and implants

Client Eligibility Certification (CEC) Form

The provider must maintain the Client Eligibility Certification (CEC) form in the medical record for each applicant/client, including those found ineligible, for at least three (3) years. The CEC form may be maintained electronically, in compliance with all aspects of H&S Code, Section 123149.

Signature for Drugs or Devices Billed to Family PACT

W&I Code, Section 14043.341 requires providers 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. Providers who dispense a drug, device or supplies requiring a written order or prescription to be covered under the program, and providers who obtain a specimen for performance of a clinical laboratory test or examination, must maintain the following items in their files to qualify for Family PACT reimbursement:

- Signature of the person receiving the drug or device, or from whom a specimen was obtained
- Client’s printed name
- Date signed
- Prescription number or item description for drugs or devices
- Relationship of the client to the person receiving a prescription, if the client is not picking up the medication

As an alternative, a provider obtaining a specimen for a clinical laboratory test or examination may satisfy this requirement by doing both of the following:

- Keep the requisition document provided to the clinical laboratory on file, and
- Obtain the signature and printed name of the client on the requisition document

Several exceptions apply to the signature requirement. A provider does not need to obtain a signature and related information when:

- A biological specimen is obtained for the purpose of anatomical pathology examinations performed during inpatient or outpatient surgery, if a notation of the performance of the anatomical pathology examination appears in the medical record
- Dispensing a complimentary sample of a dangerous drug, provided no charge is made to the patient and an appropriate record is entered in the client's chart

- Dispensing a drug or device occurs on a periodic basis within an established provider/patient relationship. The signature shall only be required with the initial dispensing or furnishing of the drug, so long as an appropriate record of each dispensing or furnishing is entered in the patient's chart
- Obtaining a biological specimen is required in order that a test or examination occurs on a periodic basis within an established provider/patient relationship. The signature shall only be required upon obtaining the biological specimen necessary for the initial test or examination, so long as an appropriate record of each test or examination is entered in the patient's chart
- The provider is a licensed pharmacy or clinical laboratory, owned and operated by a non-profit health care service plan with at least 3,500,000 enrollees, or is owned and operated by a non-profit hospital corporation that has a mutually exclusive contract with a non-profit health care service plan with at least 3,500,000 enrollees

The provider is a licensed provider who practices within a physician organization that meets either of the requirements set forth in paragraph two (2) of subdivision (g) of H&S Code, Section 1375.4; that is, a risk-bearing organization such as a professional medical corporation, medical partnership, medical foundation or other lawfully organized group of physicians that deliver, furnish, arrange for or provide health care services.

Providers who bill Family PACT but do not comply with the requirements and do not qualify for an exception, will be subject to civil money penalties.

Signature Requirement for Medication Delivery

In accordance with W&I Code, Section 14043.341, providers must obtain either a handwritten or electronic signature for prescription medications sent to a client. Providers may obtain the signature of a client or the recipient either before the medication is sent, or upon receipt when delivered to the client.

Signature Prior to Delivery

Providers have two options to obtain a client's signature when the client is not in person, such as during a telehealth visit.

- Recorded oral signature: Providers must ensure that they are able to collect an audio or video recording that can be stored in the provider's case record and retrieved upon request. Providers may use either of the following two options for audio or video-recorded signatures

  - Recording only the signature portion of the telehealth visit. When recording only the signature portion of the visit, providers must record the portion of the visit where the client acknowledges and confirms the medications they will be receiving and provides their understanding that the oral signature holds the same weight as a written signature; or
  - Recording the entire visit with the oral signature included

- Electronic signature: Providers may obtain an electronic signature. Consistent with the *Uniform Electronic Transactions Act, California Civil Code* Section 1633.2, an "electronic signature" is an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record. An electronic signature includes a "digital signature" defined in subdivision (d) of Section 16.5 of the Government Code to mean an electronic identifier, created by a computer, intended by the party using it to have the same force and effect as a manual signature. Regardless of the type of electronic signature collected, providers must ensure that they are able to store and/or easily access documentation of the electronic signature in the client's medical record

Signature upon Receipt of Delivery

Providers may obtain a client's handwritten or electric signature upon receipt of delivery if the delivery service offers physical or electronic return receipts, such as those offered through the United States Postal Service. Providers must retain documentation of the signature in the client's medical record.

Log of Intrauterine Contraceptive Devices and Contraceptive Implants

For at least three (3) years from the date of insertion, providers should keep a written log or electronic record of all intrauterine contraceptive devices (IUC) and contraceptive implants provided, including the following:

- Client's name
- Medical record and HAP card numbers
- Date of insertion
- Type of IUC or implant
- Lot number of the device or product

All IUCs and implants inserted through the Family PACT Program must be FDA-approved devices, labeled for use in the United States, and obtained from FDA-approved distributors. Providers must maintain invoices for insertion kits billed to Family PACT for at least three (3) years from the date of the invoice (W&I Code, section 24005 [7][p]).

Electronic Claims Submission and Recordkeeping

Providers or their agents who electronically submit claims via Point of Service (POS) network or Computer Media Claims (CMC) must retain sufficient data to meet all recordkeeping requirements, including every document, record and/or printed representation of information on which the provider relies to submit a claim.

Accuracy and Correction of Claims or Payments

Family PACT providers are responsible for all claims submitted regardless of who completes the claim on behalf of the provider. Family PACT providers are responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Family PACT provider agrees to seek correction of any claim errors through the appropriate processes as designated by the DHCS or its fiscal intermediary. For more information, refer to Part I Medi-Cal manual and your signed Form DHCS 6153, Medi-Cal Telecommunications Provider and Biller Application/Agreement.

Non-Medi-Cal Clinics

As defined in the California Code of Regulations (CCR), Title 22, Section 51115(b), community clinics, free clinics, county operated organized outpatient clinics, Rural Health Clinics (RHC) and other clinics that are not enrolled in the Medi-Cal Program as an “organized outpatient clinic with surgical facilities” may not bill Family PACT for emergency, examining and treatment rooms. This includes HCPCS codes Z7500, Z7506, Z7508, Z7510 and Z7512, as defined by CCR, Title 22, Section 51509.1. A Family PACT provider must have the appropriate provider type on file with Medi-Cal PED to bill for facility use.

Legend

Symbols used in the document above are explained in the following table

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the above categories marked with an asterisk. Discrimination on the basis of the other categories is prohibited by Government Code section 11135.