Benefits: Clinical Services Overview

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This section is an overview of the clinical services available to clients in the Family **(Planning, Access, Care and Treatment) Family** PACT ~~**(Planning, Access, Care and Treatment)**~~ Program. Family PACT services are designed to support contraceptive methods for women and men, as gender appropriate, by assisting individuals who have a medical necessity for family planning services.

Secondarily, Family PACT includes assistance with family planning-related services to achieve and maintain optimal reproductive health.

There are two categories of services available in the program: Family planning services and family planning-related services for specified reproductive health conditions.

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 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. Some services have restrictions associated with gender and age. Refer to the *Benefits: Family Planning* section in this manual for a complete listing of services and associated restrictions.

ICD-10-CM Diagnosis Codes

An ICD-10-CM diagnosis code related to the items in the preceding paragraph is required for billing. ICD-10-CM codes that relate to family planning services are listed in the *Benefits: Family Planning* section of this manual.

Laboratory

Family planning services include laboratory tests specific to each contraceptive method. These tests may be indicated on a case-by-case basis to determine whether a client can safely use a particular contraceptive method and are not intended to be routinely ordered for all clients. Certain restrictions may apply and are noted. In accordance with program standards, tests performed when "medically indicated in the context of provision of contraceptive services or required by an outpatient facility" require justification for ordering to be documented in the client's medical record. For more information, refer to the *Benefits: Family Planning* section in this manual.

Laboratory tests performed in a provider's office or clinical laboratory for Family PACT clients are billed using standard CPT® codes and modifiers. For more information, refer to the *Modifiers: Approved List* and *Pathology: Billing and Modifiers* sections in the appropriate Part 2 Medi-Cal manual.

While the definition of certain CPT codes includes testing for multiple pathogens, only the laboratory tests to detect the specific pathogens listed in this manual are considered Family PACT benefits.

For a comprehensive listing of reimbursable laboratory tests, descriptions and restrictions, refer to the *Laboratory Services* section in this manual.

Providers must have the appropriate Clinical Laboratory Improvement Amendment (CLIA) certification on file with the Department of Health Care Services Provider Enrollment Division for the tests performed in the office. For more information, refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section in the appropriate Part 2 Medi-Cal manual.

Family Planning-Related Services

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

Family planning-related services for male and female clients are pre-selected by the program. Refer to the *Benefits: Family Planning-Related Services* section in this manual for a complete listing of services and associated restrictions.

ICD-10-CM Codes for Family Planning-Related Services

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

For more information, refer to the *Benefits: Family Planning-Related Services* and *Drugs: Onsite Dispensing Billing Instructions* sections in this manual.

Laboratory Tests, Procedures and Drugs

Family planning-related services include tests for UTIs in women and specified STI diagnostic laboratory tests. Pre-selected office and outpatient procedures to treat specific STIs and cervical abnormalities are also covered. Prescription drugs are reimbursed when they are an appropriate treatment regimen and are listed in the *Family PACT Pharmacy Formulary* on the Medi-Cal Rx website (*https://medi-calrx.dhcs.ca.gov*) and the *Clinic Formulary* section in this manual. For a listing of covered services, refer to the *Benefits: Family Planning-Related Services* and *Drugs: Onsite Dispensing Billing Instructions* sections in this manual.

Complications

Complications may arise as a result of the use of a contraceptive method as well as from the treatment of a family planning-related condition. Management of complications requires a *Treatment Authorization Request* (TAR).

Complication Restrictions for Family Planning Services

Services are available for management of complications that arise from the use of a particular contraceptive method. Only those complications that can be reasonably managed on an outpatient basis are reimbursable.

ICD-10-CM Codes for Complications of Family Planning Services

When a procedure, laboratory test or drug is for the management of a complication resulting from the use of a particular contraceptive method, an ICD-10-CM code for the complication is required on the claim. This code must be billed with the diagnosis code that identifies the contraceptive method for which the client is being seen. For more information, see the *Benefits*: *Family Planning* section in this manual.

Complications for Family Planning-Related Services

Complications that may arise from the treatment of an STI or UTI include severe skin ulcerations/infections and allergic reactions to drugs or topical applications prescribed. Complications from procedures to treat cervical abnormalities and pre-invasive lesions include hemorrhage and pelvic infection secondary to surgical intervention.

Complication Restrictions for Family Planning-Related Services

Services for management of complications from the treatment of family planning-related services are pre-selected and identified in this manual. Only those complications that can be reasonably managed on an outpatient basis are reimbursable. Services are limited to the appropriate gender.

ICD-10-CM Codes for Complications of Family Planning Related Services

When a procedure, lab test or prescription drug is for the management of a complication from the treatment of a family planning-related service, an ICD-10-CM diagnosis code is required on the claim form. This code must be billed with the diagnosis code that identifies the contraceptive method for which the client is being seen. For additional information, see the *Benefits*: *Family Planning-Related Services* and *Drugs: Onsite Dispensing Billing Instructions* sections in this manual.

Treatment Authorization Request (TAR)

A TAR is required for complication services for both enrolled Family PACT providers and Medi-Cal providers who deliver services upon referral from an enrolled Family PACT provider. TAR requirements apply to medical, anesthesia, laboratory, pharmacy, radiology and hospital providers. Authorization requirements for pharmacy providers submitting pharmacy claims are found in the *Family PACT Formulary* on the Medi-Cal Rx website (*https://medi-calrx.dhcs.ca.gov*). Authorization requirements for services billed on non-pharmacy claims are in the *Treatment Authorization Request (TAR)* section in this manual. For information about completing a TAR, refer to the *TAR Completion* section in the Part 2 Medi-Cal manual.

Comparable Services for Males and Females

Family PACT clinical services are comparable for both male and female clients, except for appropriate gender differences, which are noted. Services shall be provided to eligible clients in accordance with the *Program Standards* section in this manual.

Transgender and Gender Diverse Services

In all sections of this manual, regardless of the gender stated, the benefit or policy applies to individuals of all gender identities as long as the procedure/benefit is medically necessary and meets all other requirements.

Gender Override

For instructions on overriding gender differences for procedures, refer to the *Transgender and Gender Diverse Services* section in the appropriate Part 2 Medi-Cal manual.

Telehealth

~~**Policy related to telehealth is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. To use the telehealth modality and applicable billing codes for covered Family PACT services, providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 Medi-Cal manual.**~~ **Family PACT providers must ensure that the covered Family PACT service or benefit being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s) associated with the Family PACT covered service or benefit, as well as any other requirements described in this manual. In addition,** Family PACT services rendered by the use of ~~**the**~~ **a** telehealth modality must follow ICD-10-CM diagnosis code billing policy as noted in this ~~**section**~~**manual**.

All healthcare practitioners rendering Family PACT covered benefits or services under this policy must comply with all applicable state and federal laws.

Telehealth Definitions

For purposes of the telehealth policy outlined in this manual, the following definitions shall apply:

Telehealth

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Asynchronous Store and Forward

"Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site. Consultations via asynchronous electronic transmission initiated directly by patients, including through mobile phone applications, are not covered under this policy.

E-Consults

"E-consults" fall under the auspice of store and forward. E-consults are asynchronous health record consultation services that provide an assessment and management service in which the patient's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient's health care needs without patient face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers.

E-Visits

"E-visits" are communications between a patient and their provider through an online patient portal.

Synchronous Interaction

"Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

Distant Site

"Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site, for purposes of telehealth under Family PACT, must be the enrolled Family PACT service site.

Originating Site

"Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for Family PACT covered services provided through telehealth, the type of setting where services are provided for the client or by the health care provider is not limited. The type of setting may include, but is not limited to, an enrolled Family PACT site such as a FQHC, medical office, community clinic, or the client's home.

Establishing New Patients via Telehealth

Family PACT providers may establish a relationship with new patients via synchronous video telehealth visits.

Family PACT providers may also establish a relationship with new patients via audio-only synchronous interaction only if one or more of the following applies:

- The visit is related to the provision of family planning services in accordance with California Family Code Section 6925, subd. (a), Welfare and Institutions Code (W&I Code), Section 24003, subd. (b), or medical care related to the diagnosis, treatment and/or prevention of sexually transmitted infections (STIs) according to California Family Code Section 6926, et seq. obtained by a patient at or above the minimum age specified for consenting to these services.
- The patient requests an audio-only modality.
- The patient attests they do not have access to video

Consent for Services Provided via Telehealth

Family PACT providers must inform the client prior to the initial delivery of telehealth services about the use of telehealth, and obtain verbal or written consent from the

client for the use of telehealth as an acceptable mode of delivering health care services.

If a provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services and includes the required information, as explained below, then this is sufficient for documentation of client consent, and should be kept in the client's medical record. Providers must also document when a client consents to receive services via audio-only prior to initial delivery of services. The consent shall be documented in the client's medical record and be available to DHCS upon request.

Providers are required to share additional information with clients regarding:

- Right to in-person services
- Voluntary nature of consent
- Limitations/risks of receiving services via telehealth, if applicable
- Availability of translation services

Consent requirements may be found in Business and Professions Code, Section 2290.5 [b]. Model patient consent language may be found on the DHCS website.

Family PACT providers who bill using the *CMS-1500 Health Insurance Claim Form* are required to report the most applicable Place of Service (POS) code on the claim.

Reimbursable Telehealth Services

Family PACT covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Family PACT coverage and reimbursement policies, including any *Treatment Authorization Request* (TAR) requirements, may be provided via a telehealth modality, as outlined in this section, only if all of the following are satisfied:

- The provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth.
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Family PACT covered service or benefit, as well as any extended guidelines as described in this section and the *Medicine: Telehealth* section in the appropriate Part 2 Medi-Cal manual.
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a client's right to his or her medical information.

Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of three ways:

- For services or benefits provided via synchronous, interactive audio and visual telecommunications systems, the health care provider bills with modifier 95.

- **For services or benefits provided via asynchronous store and forward telecommunications systems, the health care provider bills with modifier GQ.**
- **For services or benefits provided via synchronous telephone or other real-time interactive audio-only telecommunications systems, the health care provider bills with modifier 93.**

Payment Parity

The amount paid by DHCS and Medi-Cal managed care plans for a service rendered via telehealth is the same as the amount paid for the applicable service when rendered in-person.

Examples of Services Not Appropriate for Telehealth

Family PACT covered benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to, benefits or services that are performed in an operating room or while the patient is under anesthesia, require direct visualization or instrumentation of bodily structures, involve sampling of tissue or insertion/removal of medical devices, and/or otherwise require the in-person presence of the client for any reason.

Billing Requirements

Refer to the *Medicine: Telehealth* section, *Billing Requirements* subsection, in the appropriate Part 2 Medi-Cal manual for billing requirements for specific telehealth services, including the use of modifiers.

Medical Justification

Medical record documentation must reflect the clinical rationale for providing, ordering or deferring services rendered to clients according to the *Program Standards* section, including, but not limited to, client assessment, diagnosis, treatment and follow-up. Medical record documentation must include justification to support claims for reimbursement. For more information, refer to the *Program Standards* section in this manual.

Excluded Services

Procedures, lab tests, drugs and/or contraceptive supplies used for purposes other than family planning or family planning-related services, as defined by the Family PACT Program, are not reimbursable by the program. Family PACT has a limited scope of benefits and is not a primary care program.

Drugs and/or supplies ordered by a provider who is not enrolled in the Family PACT Program, without a referral by an enrolled Family PACT provider, are not reimbursable. For more information, refer to “Family PACT Referrals” in the ‹‹*Provider Enrollment and Responsibilities* section in this manual.

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 services can be rendered, but it may be an out-of-pocket expense.

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.