



MEDI-CAL UPDATE

Part 2

Billing and Policy

www.medi-cal.ca.gov

Pharmacy

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Billing Tips for Medi-Cal Universal Claim Form Transition Period

Beginning April 23, 2007 through June 24, 2007, Medi-Cal will accept both versions of the professional claim form, either the *HCFA 1500* or the *CMS-1500*. During this period, providers are encouraged to migrate their business processes away from the *HCFA 1500*, depleting their form stock, in preparation for exclusive use of the *CMS-1500*.

Providers may choose to fully transition to the new *CMS-1500* claim form at any time during this two-month window before the use of the *CMS-1500* is mandatory. Beginning June 25, 2007, Medi-Cal will only accept the *CMS-1500*.

Separate billing instructions apply, as Medi-Cal is announcing a National Provider Identifier (NPI) dual-use period that starts during the claim form transition period. (For more information on the NPI implementation date, refer to the Medi-Cal Web site [www.medi-cal.ca.gov] and future *Medi-Cal Updates*.)

Providers billing on the new *CMS-1500* claim form must continue to use their Medi-Cal provider number until instructed otherwise. Beginning May 23, 2007, the NPI, if available, should be reported along with the Medi-Cal provider number, but is not necessary for proper adjudication.

For providers who choose to use the new claim form during the transition period, below are instructions on how to fill out the new form during the April 23 to June 24 time frame.

Providers may also continue to use the *HCFA 1500* claim form during the transition period and bill as they do currently. To clarify, providers using the *HCFA 1500* must use their Medi-Cal provider number. Only the new *CMS-1500* supports provision of both identifiers.

Box 17

14. DATE OF CURRENT: MM DD YY	ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY	16.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	18.
		17b. NPI	
19. RESERVED FOR LOCAL USE			20.

If a referring provider is necessary, providers should list the referring provider's name in Box 17 and enter the referring provider's Medi-Cal provider number or state license number in Box 17A. Providers can enter the referring provider's NPI in Box 17B.

When the referring provider is a Non-physician Medical Practitioner (NMP) working under the supervision of a physician, enter the name of the NMP in Box 17. Beginning April 23, 2007 and until instructed otherwise, enter the NMP's Medi-Cal provider number or state license number in Box 17A. Providers will be instructed at a later date when they can enter the referring provider's NPI in Box 17B.

Please see **Billing Tips**, page 2

Billing Tips (continued)

Boxes 24I and 24J

BILLING PROVIDER	F.	G.	H.	I.	J.
	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
				NPI	
				NPI	

Box 24I is not required by Medi-Cal. Box 24J is only necessary if the individual rendering provider number is different from the billing provider number. If the provider numbers are different, then enter the rendering provider’s Medi-Cal number in the shaded area of Box 24J. Do not enter a physician license number in Box 24J. Providers can enter the rendering provider’s NPI in the unshaded area of Box 24J.

Box 32

32. SERVICE FACILITY LOCATION INFORMATION		3
a. NPI	b.	a

In Box 32, enter the service facility’s name; address (without a comma between the city and state) and a nine-digit ZIP code (without a hyphen); and telephone number. This information is not required when clinical laboratories bill for their own services.

Providers can enter the facility’s NPI in Box 32A. In Box 32B, enter the Medi-Cal provider number of the facility where the services were rendered if the Place of Service on the claim is other than Office (11), Home (12), Ambulance (Land) (41), Ambulance (Air or Water) (42), Residential Substance Abuse Treatment Facility (55), End Stage Renal Disease Treatment Facility (65), Independent Laboratory (81) or Other (99). This information is required for all other Place of Service codes.

Box 33

33. BILLING PROVIDER INFO & PH # ()		
a. NPI	b.	

APPROVED OMB 0938-0000 FORM CMS-1500 (09/05)

In Box 33, enter the billing provider’s name; address (without a comma between the city and state) and nine-digit ZIP code (without a hyphen); and telephone number.

Providers can enter the billing provider’s NPI in Box 33A. In Box 33B, enter the billing provider’s individual or group Medi-Cal provider number.

Fresno Medi-Cal Field Office to Close

The Fresno Medi-Cal Field Office (FMCFO), located at 3374 East Shields Avenue, Suite C-4 in Fresno, California, will close no earlier than November 2007.

The closure is part of a statewide effort to streamline Medi-Cal field office operations and to increase consistency in *Treatment Authorization Request* (TAR) decisions on behalf of Medi-Cal recipients.

Note: The closure of other Medi-Cal field offices is not being considered, and the Medical Case Management (MCM) program will not be closing.

The majority of TAR services currently handled by the Fresno Field Office staff will be redirected to other Medi-Cal field offices. Hospital onsite review of TARs at area hospitals will continue, as will local MCM activities.

Provider notification regarding specific details on the redirection of the various TAR types adjudicated by the FMCFO to other Medi-Cal field offices will be provided in future *Medi-Cal Updates* as information becomes available. The California Department of Health Services (CDHS) does not anticipate any negative impact to providers or recipients as a result of the closure of the FMCFO, as all TAR and MCM services will continue.

Orthotic and Prosthetic Code Modifier Exceptions Update

Effective March 1, 2007, the California Department of Health Services (CDHS) has updated the list of Orthotic and Prosthetic appliance codes that do not require billing with an RT (right side) or LT (left side) modifier:

A6501 – A6503, A6509 – A6511, A6513, A6544, L0100, L0110, L0120 – L0220, L0450 – L0488, L0490 – L0492, L0621 – L0640, L0700 – L0710, L0810 – L0861, L0960 – L0999, L1000 – L1652, L1690, L1700 – L1730, L2580, L2627 – L2628, L2640, L3212 – L3214, L3650, L3652, L3660, L3675, L4000, L4205, L4210, L7510, L7520, L8000, L8002, L8015, L8310, L8499, L8500 – L8510, S1040.

These codes may be billed without modifiers.

This information is reflected on manual replacement page [ortho 2](#) (Part 2).

Update on Generic Albuterol Inhalers Containing Chlorofluorocarbons (CFCs)

In 1987, environmental concerns led to an international agreement, called the “Montreal Protocol on Substances that Deplete the Ozone Layer,” that provided for the phase-out of chlorofluorocarbons (CFCs), which have been shown to damage the earth’s protective ozone layer. Inhalers were temporarily exempt from the CFC ban until ozone-friendly alternatives became available.

The Federal Drug Administration (FDA) issued a final regulation on March 31, 2005 that requires the phase-out of all CFC Albuterol metered-dose inhalers by December 31, 2008, due to the availability of hydrofluoroalkane (HFA) alternatives. Many manufacturers have already discontinued their production of CFC-containing Albuterol inhalers, and production of CFC-containing inhalers will stop by July 1, 2007. This reduction in manufacturing has contributed to the shortage of CFC-containing generic Albuterol inhalers in the marketplace as supplies are exhausted.

Medi-Cal Fee-For-Service (FFS) has decided to remove the CFC-containing Albuterol inhalers from the Contract Drugs List (CDL), since the environmental friendly alternative Levalbuterol Tartrate HFA is available on the CDL. This change will promote the FFS patients’ transition from the CFC inhalers to the HFA inhalers prior to the 2008 deadline.

California Children's Services Service Code Groupings Updates

Effective January 1, 2007, updates were made to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03 and 07.

HCPCS codes X7582, X7588 and X7634 and CPT-4 code 90634 have been end-dated for dates of service on or after January 1, 2007.

In addition, HCPCS codes J9001, J9045 and J9310 and CPT-4 codes 20600, 20605, 20610, 20650, 20670, 20680, 20690, 20692 – 20694, 90384 – 90386, 90399, 90649, 90660, 90680, 90710, 90714 – 90715, 90734, 90740 and 90747 have been added for dates of service on or after January 1, 2007.

Reminder: SCG 02 includes all the codes in SCG 01 plus additional codes applicable only to SCG 02; SCG 03 includes all the codes in SCG 01 and SCG 02 plus additional codes applicable only to SCG 03; and SCG 07 includes all the codes in SCG 01 plus additional codes applicable only to SCG 07. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement pages cal child ser 1, 3, 11 and 18 (Part 2).

New Wheelchair Manual Section

Wheelchair and wheelchair accessory information that used to be in the *Durable Medical Equipment: Bill for DME* section has been transferred into a new provider manual section: *Durable Medical Equipment: Wheelchairs and Wheelchair Accessories*. This new section is to facilitate manual updating only. Wheelchair policy has not changed.

Changes are reflected on manual pages dura 1, 2, 4, 6 and 7 (Part 2), dura bil dme 1, 2 and 4 (Part 2), new manual pages dura bil wheel 1 thru 10 (Part 2), dura ex 4, 12 and 13 (Part 2) and tar field 10 (Part 2).



Family PACT Clinic Dispensed Drugs and Contraceptive Drugs and Supplies Update

Pursuant to *Welfare and Institutions Code* (W&I Code), Section 14132.01, as amended by AB 77, of the Statutes of 2005, the Family PACT (Planning, Access, Care and Treatment) program is implementing fees for onsite dispensing of drugs and supplies.

Effective February 16, 2007, Clinic Dispensing Fees (CDF) for the Family PACT program are implemented for the following HCPCS Level III interim codes. These codes may be used by all Family PACT providers.

HCPCS Code	Description
X7706	(oral contraceptives)
X7716	(azithromycin 250mg tablets)
X7722	(emergency contraception)
X7728	(contraceptive patch)
X7730	(contraceptive vaginal ring)

*Please see **Family PACT**, page 5*

Family PACT (continued)

For the codes listed above, the CDF is defined as the difference between the drug acquisition cost and the rate listed in the Medi-Cal Basic Rate table. The amount listed in the Medi-Cal Basic Rate table shall represent the Family PACT Fixed Claim Rate, which includes the CDF. This Fixed Claim Rate is multiplied by the number of units dispensed and the total is entered in the appropriate box on the claim form. This calculation method is not a change from current policy. However, the recognition of inclusion of the CDF as part of this Fixed Claim Rate is the published policy change.

Providers who choose not to claim a dispensing fee shall continue to claim only the actual acquisition cost of the drug. Reimbursement shall be the lesser of the amount billed or the Medi-Cal limit.

There is no CDF for antibiotic or contraceptive injections, intrauterine contraceptives or contraceptive implants. Policies regarding claims submission for these items remain unchanged.

HCPCS Code X7706 (Oral Contraceptives) Updated Dispensing Limits

Refills are permitted after 14 days for each cycle dispensed (for example: 1 pack refill after 14 days; 3 packs refill after 42 days; and 13 packs refill after 182 days). The existing policy of a maximum quantity of 13 cycles dispensed per client, per provider remains. This policy change allows for the option of continuous use regimen.

Family PACT Formulary Additions

Effective for dates of service on or after February 16, 2007, the following drugs and contraceptive supplies are added to the Family PACT formulary for clinic and pharmacy dispensing:

- Ciprofloxacin XR 500 mg
- Miconazole 4 percent vaginal cream
- Clindamycin vaginal ovules 100 mg
- Nonoxynol-9 contraceptive sponge

HCPCS Codes Z7610 and X1500

Effective for dates of service on or after May 1, 2007, the following Family PACT policy updates apply to HCPCS codes Z7610 (miscellaneous drugs for non-surgical procedures) and X1500 (contraceptive supplies). The California Department of Health Services (CDHS), Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) Branch, has developed a Family PACT Fixed Rate and quantity limit for each medication billed using code Z7610 and a Family PACT Fixed Rate and unit definition for each item billed with code X1500. This information follows in the Family PACT Price Guide.

Z7610

This code may only be used by community clinics, hospital outpatient departments, emergency rooms and surgical clinics.

Code Z7610 includes estradiol, most oral antibiotics, anti-virals and anti-fungals contained in the Family PACT formulary for clinic dispensing. Drugs billed with code Z7610 have no individual rates listed in the Medi-Cal Basic Rate table.

The overall rates in the Family PACT Price Guide are generally comparable to the net cost of the drug or supply to the Medi-Cal program. The methodology used to determine Family PACT Fixed Rates is available upon written request to the MCAH/OFP. Quantity limits for each drug are based on regimens previously defined in the Family PACT Program “2006 Provisional Clinical Services Benefits Grid,” published in the June 2006 *Medi-Cal Update*.

Please see Family PACT, page 6

Family PACT (continued)

CDFs for Z7610 apply once per drug, per claim. CDFs for medications billed with code Z7610 are defined as follows:

- Level A: pharmacist pre-packaged containers of tablets or capsules (flat rate); \$3.00 per drug
- Level B: manufacturer pre-packaged tubes or other containers (flat rate); \$2.00 per drug

For each Z7610 claim, providers must enter the following in the *Remarks* field (Box 84) on the *UB-92 Claim Form*:

- Name of the drug
- Dosage size
- Number of units dispensed multiplied by the FAMILY PACT Fixed Rate (the subtotal)
- CDF (if claimed)

Providers must then calculate a total and enter it in the *Total Charges* field (Box 47) for the appropriate line.

The following table provides examples for completing a claim form for clinic dispensed drugs.

<i>Remarks field (Box 84) of the UB-92 Claim Form</i>				Box 46	Box 47
Drug Name	Dosage size	Number of units dispensed multiplied by fixed claim rate (subtotal)	Plus CDF	Total Charges	“Service Units”
Acyclovir	200 mg capsule	50 capsules X \$0.15/capsule = \$7.50	\$ 3.00	\$ 10.50	1
Butoconazole	2% SR cream/tube	1 tube X \$29.33/tube = \$29.33	2.00	31.33	1
Doxycycline	100 mg tablets	28 tablets X \$0.14 = \$3.92	3.00		
Probenecid	500 mg tablets	2 tablets X \$0.71 = \$1.42	3.00	11.34	1

Every Z7610 claim must have an acceptable secondary diagnosis code entered on the *UB-92 Claim Form* for reimbursement. Only one secondary diagnosis code can be processed per claim form.

When the same secondary diagnosis code applies to more than one Z7610 drug claimed, more than one regimen may be listed in the *Remarks* field (Box 84) of the claim form. If a combination of drug regimens is claimed under a single secondary diagnosis code, it should be entered as one (service) unit. If two or more drugs are dispensed with different secondary diagnoses, then a separate claim form must be submitted for each secondary diagnosis and its corresponding drug(s). If the *Remarks* area is left blank, the claim will be denied.

X1500

Contraceptive supplies that may be billed by all Family PACT providers with code X1500 include the following: male or female condoms, spermicides, lubricants, diaphragms, cervical caps and basal temperature thermometers. These supplies are dispensed alone or in combination and are currently subject only to a maximum Medi-Cal basic rate, which is currently \$14.99.

The overall rates are generally comparable to the net cost of the drug or supply to the Medi-Cal program. The methodology used to determine Family PACT Fixed Rates is available upon written request from the OFP.

Please see Family PACT, page 7

Family PACT (continued)

The CDF for contraceptive supplies claimed under code X1500 is defined as follows:

- Level C: Contraceptive Supplies, ten percent of contraceptive supply claim (rounded to the nearest cent)

The combined total of all supplies plus CDF cannot exceed the Medi-Cal basic rate for code X1500.

To avoid denials on claims, providers billing for code X1500 must enter the following in the *Reserved for Local Use* field (Box 19)/*Remarks* field (Box 84) of the claim form: the quantity of condoms, film, suppositories, contraceptive sponges, diaphragms, cervical caps or grams of spermicide/lubricant dispensed.

Multiply the number of each product by the fixed claim rate for each product and add a dispensing fee equal to ten percent of the sum for individual products to calculate the total amount claimed for code X1500. The total is entered in the *Charges* field (Box 24F)/*Total Charges* field (Box 47) of the claim form and shall not exceed the Medi-Cal limit.

The following table provides examples for completing a claim form for clinic dispensed drugs.

Remarks field (Box 84) of the UB-92 Claim Form Reserved for Local Use field (Box 19) of the HCFA 1500 claim form				Box 47/ Box 24F	Box 46/ Box 24G
Supply Name	Unit	Number of units dispensed multiplied by fixed claim rate (subtotal)	Plus 10% CDF	Claim total	“Units” on claim
Male condoms	1 condom	35 condoms X \$0.28/condom = \$9.80	\$ 0.98	\$ 10.78	1
Spermicidal foam	1.4 oz. can	1 can (40 grams) X \$0.21/gram = \$8.40	0.84	9.24	1

The following tables, “Family PACT Price Guide,” are the dispensing guidelines for covered drugs, dosage size/billing unit, maximum billing units per claim, the Family PACT rate per unit, the maximum drug cost, the clinic dispensing fee, the upper payment limit and the fill frequency (days). The Family PACT Price Guide will be updated periodically and will be posted on the Family PACT Web site at www.familypact.org.

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Acyclovir	200 mg caps	50	\$ 0.15	\$ 7.50	\$ 3.00	\$ 10.50	30
Acyclovir	400 mg tabs	30	0.23	6.90	3.00	9.90	30
Acyclovir	400 mg tabs	60	0.23	13.80	3.00	16.80	30
Acyclovir	800 mg tabs	10	0.47	4.70	3.00	7.70	30
Azithromycin	1 g packet	1	17.18	17.18	2.00	19.18	7
Azithromycin	1 g packet	2	17.18	34.36	2.00	36.36	7
Azithromycin	500 mg tabs	4	10.64	42.56	3.00	45.56	7
Butoconazole	2% tube	1	29.33	29.33	2.00	31.33	30
Cefpodoxime	200 mg tabs	2	3.83	7.66	3.00	10.66	7
Cephalexin	250 mg caps	40	0.18	7.20	3.00	10.20	7
Cephalexin	500 mg caps	20	0.36	7.20	3.00	10.20	7
Ciprofloxacin	250 mg tabs	2	0.38	0.76	3.00	3.76	7
Ciprofloxacin	250 mg tabs	6	0.38	2.28	3.00	5.28	7
Ciprofloxacin	500 mg tabs	6	0.45	2.70	3.00	5.70	7

Please see **Family PACT**, page 8

Family PACT (continued)

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Ciprofloxacin	500 mg tabs	1	0.45	0.45	3.00	3.45	7
Ciprofloxacin XR	500 mg tabs	3	5.82	17.46	3.00	20.46	7
Clindamycin	150 mg caps	28	0.92	25.76	3.00	28.76	30
Clindamycin	100 mg ovules/3pk	1	29.70	29.70	2.00	31.70	30
Clindamycin	2% tube	1	35.86	35.86	2.00	37.86	30
Clindamycin SR	2% tube	1	52.50	52.50	2.00	54.50	30
Clotrimazole	1% tube	1	6.82	6.82	2.00	8.82	30
Clotrimazole	2% tube	1	7.16	7.16	2.00	9.16	30
Clotrimazole	100 mg pack	1	6.21	6.21	2.00	8.21	30
Clotrimazole	200 mg pack	1	7.57	7.57	2.00	9.57	30
Doxycycline	100 mg caps/tabs	28	0.14	3.92	3.00	6.92	30
Doxycycline	100 mg caps/tabs	56	0.14	7.84	3.00	10.84	30
Doxycycline	100 mg caps/tabs	14	0.14	1.96	3.00	4.96	7
Estradiol	0.5 mg tabs	30	0.18	5.40	3.00	8.40	30
Estradiol	1 mg tabs	30	0.22	6.60	3.00	9.60	30
Estradiol	2 mg tabs	30	0.31	9.30	3.00	12.30	30
Fluconazole	150 mg tab	1	9.65	9.65	2.00	11.65	30
Imiquimod	5% pack	1	124.73	124.73	2.00	126.73	30
Metronidazole Gel	0.75% tube	1	\$ 35.04	\$ 35.04	\$ 2.00	\$ 37.04	30
Metronidazole	250 mg tabs	56	0.08	4.48	3.00	7.48	30
Metronidazole	250 mg tabs	28	0.08	2.24	3.00	5.24	7
Metronidazole	500 mg tabs	4	0.22	0.88	3.00	3.88	7
Metronidazole	500 mg tabs	28	0.22	6.16	3.00	9.16	30
Metronidazole	500 mg tabs	14	0.22	3.08	3.00	6.08	7
Miconazole	100 mg pack	1	6.75	6.75	2.00	8.75	30
Miconazole	200 mg pack	1	13.77	13.77	2.00	15.77	30
Miconazole	2% tube	1	7.17	7.17	2.00	9.17	30
Miconazole	4% tube	1	7.30	7.30	2.00	9.30	30
Miconazole	200 mg 2% pack	1	8.94	8.94	2.00	10.94	30
Nitrofurantoin SR	100 mg caps	20	1.51	30.20	3.00	33.20	30

Please see **Family PACT**, page 9

Family PACT (continued)

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Nitrofurantoin	100 mg caps	40	1.28	51.20	3.00	54.20	30
Ofloxacin* (PID only)	200 mg tabs	56	2.17	121.52	3.00	124.52	30
Ofloxacin* (PID only)	400 mg tabs	28	4.35	121.80	3.00	124.80	30
Podofilox	0.50% pack	1	76.88	76.88	2.00	78.88	30
Probenecid	500 mg tabs	2	0.71	1.42	3.00	4.42	30
SMX/TMP	400-80 mg tabs	28	0.12	3.36	3.00	6.36	7
SMX/TMP	800-160 mg tabs	14	0.15	2.10	3.00	5.10	7
Terconazole	0.40% tube	1	43.43	43.43	2.00	45.43	30
Terconazole	0.80% tube	1	39.74	39.74	2.00	41.74	30
Terconazole	80 mg pack	1	34.05	34.05	3.00	37.05	30
Tinidazole	250 mg tabs	8	1.38	11.04	3.00	14.04	7
Tinidazole	500 mg tabs	4	2.76	11.04	3.00	14.04	7

* Ofloxacin tablets are only payable when secondary ICD-9-CM diagnosis codes 614.0, 614.2 or 615.0 are included in the other diagnosis *Code* field (Box 68) of the *UB-92 Claim Form*.

		Reimbursement
Contraceptive Supplies	Unit	Per Unit
Male Condoms	each	\$ 0.28
Female Condoms	each	2.76
Spermicidal Suppositories	each	0.53
Spermicidal Film	each	0.69
Spermicidal Gel/Jelly/Cream/Foam	gram	0.21
Lubricant (non-spermicidal)	gram	0.03
Nonoxynol 9 Contraceptive Sponge	each	2.35
Basal Body Thermometer	each	5.53

Providers who choose not to claim a dispensing fee should continue to claim only the actual acquisition cost of the drug. Reimbursement is the lesser of the amount billed or the Medi-Cal upper payment limit.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at www.familypact.org.



Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered under the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

San Bernardino

April 12, 2007

8:30 a.m. – 4:30 p.m.

Clarion Hotel & Convention Center
295 North E Street
San Bernardino, CA 92401
(909) 381-6181

Oakland

June 7, 2007

8:30 a.m. – 4:30 p.m.

Park Plaza Hotel
150 Hegenberger Road
Oakland, CA 94621
(510) 635-5000

For a map and directions to these locations, go to the Family PACT Web site (www.familypact.org) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the appropriate location.

Registration

To register for an orientation and update session, go to the Family PACT Web site (www.familypact.org) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the “Registration” link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Please see Family PACT, page 11

Family PACT (continued)

Check-In

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance

Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information

For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at www.familypact.org.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

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Remove and replace: *Contents for Pharmacy Billing and Policy iii/iv **
cal child ser 1 thru 24

Remove and replace
at the end of the
HCFA 1500 Completion
section: *Code Correlation Guide 1/2 **

Remove and replace: dura 1 thru 8

Remove: dura bil dme 1 thru 30
Insert: dura bil dme 1 thru 25

Insert new section at
the end of the *Durable*
Medical Equipment (DME):
Bill for Therapeutic
Anti-Decubitus section: dura bil wheel 1 thru 10

Remove and replace: dura cd 7 thru 10 *
dura ex 3/4, 11 thru 14
ortho 1/2
tar field 9/10
tax 1/2 *

* Pages updated due to ongoing provider manual revisions.