X.E. Community-Based Adult Services (CBAS)

CBAS is an outpatient facility-based program that delivers skilled nursing care, social services, therapeutic activities, personal care, family/caregiver training and support, nutrition services, and transportation to approved beneficiaries. The services are designed to prevent premature and unnecessary institutionalization and to keep recipients as independent as possible in the community.

Partnership HealthPlan of California is responsible for authorization and payment of CBAS services provided to members in all of Partnership's covered counties.

Authorization:

All CBAS services require an approved Partnership TAR. Please refer to the Partnership Health Services Department policy for more information regarding the authorization process and requirements, found here.

Codes and Rates:

The following billing codes and rates are to be used when billing for CBAS services:

HCPCS Code	Description
H2000	Comprehensive multidisciplinary evaluation
S5102	Day care services, adult; per diem
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter

Billing:

A. Claims are to be submitted to Partnership on a UB 04 Claim Form or electronically via the 837 format. For more information on how to get set up with Partnership for electronic billing, click here.

B. Claims must be billed with a type of bill (Box4) of '0891' (special facility – other, initial claim). All following claims must be billed with a type of bill of '089'.

C. CBAS Regular Days are billed on the service lines as follows:
   1. Revenue code 3103
   2. CBAS Regular Days as the description
   3. The specific date of service. Note: claims cannot be billed in the from/through billing format. Each DOS must be billed on a separate line
   4. The corresponding HCPCS code for the service.
   5. Service Unit of '1'
   6. Total billed charges for that DOS.

D. CBAS Carry-over Days are billed on the service lines as follows:
   1. Revenue code 3103
   2. CBAS Carry Over Days as the description
   3. The specific date of service. Note: claims cannot be billed in the from/through billing format. Each DOS must be billed on a separate line.
   4. The corresponding HCPCS code for the service.
   5. Service Unit of '1'
   6. Total billed charges for that DOS.

Note: For carry-over days, the appropriate medical necessity documentation must be entered in the Remarks field (Box 80) or as an attachment to the claim.

E. Enter the NPI number of the CBAS center in the NPI field (Box 56).

F. Enter the Treatment Authorization Request (TAR) number in the Treatment Authorization Codes field (Box 63)

G. Enter an appropriate ICD-9-CM code in Box 67.

Note: For additional information on how to complete the UB 04 Claim form, please refer to the Partnership Medi-Cal Provider Manual, click here.

Billing Reminders:

- Verify eligibility
- All services require an approved Partnership TAR
- Submit your claims electronically
- Claims cannot be billed in the from-through format
- Partnership's one year billing limit applies
- Claims must be billed with codes H2000, S5102, or T1023 only