Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates

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The billing codes and reimbursement rates listed in this section are used when completing *Treatment Authorization Requests* (TARs) and/or claims for Community-Based Adult Services (CBAS) participants. The billable reimbursement rate is determined by the date of service. For general CBAS information, refer to the *Community-Based Adult Services (CBAS)* section in this manual.

CBAS Codes and Rates

The following billing codes and rates are used for CBAS services provided in center and under Emergency Remote Services (ERS).

CBAS Codes and Rates for In-Center Services

HCPCS Code	Description	Modifier(s)	Rate*
H2000	Comprehensive multidisciplinary evaluation	N/A	$80.08
S5102	Day care services, adult; per diem	N/A	$76.27
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	N/A	$64.83

‹‹S5102 without a modifier should be used when CBAS services are provided in the center.

CBAS Codes and Rates for Emergency Remote Services Provided via Telehealth››

HCPCS Code	Description	Modifier(s)	Rate*
S5102	Day care services, adult; per diem	CR, SC†	$76.27

Note: ‹‹CBAS ERS telehealth visits must be billed with S5102 as the primary billing code, with one of the modifiers (CR or SC) defined in this section and must be billed with revenue code 3103 (adult day care, medical and social, daily).››

The modifiers for CBAS ERS are defined as follows:

- CR: Catastrophe/disaster related (Public Emergency)
- SC: Medically necessary service or supply (Personal Emergency)

CBAS Codes and Rates for Emergency Remote Services Provided in the Home

HCPCS Code	Description	Modifier(s)	Rate*
S5102	Day care services, adult; per diem	CR, SC†	$76.27
S5136	Companion care, adult (e.g., IADL/ADL); per diem provided in the participant's home/residence	CR, SC†	$.01
Q5001	Home health care; per diem provided in the participant's home/residence	CR, SC†	$.01

The modifiers for CBAS are defined as follows:

- CR: Catastrophe/disaster related (Public Emergency)
- SC: Medically necessary service or supply (Personal Emergency)

S5102 with a modifier (CR or SC) should be used when CBAS ERS are provided in the participant's home, and must be billed in conjunction with either of the following:

- S5136 with a modifier should be used when personal care services are provided by CBAS in the participant's home.
- Q5001 with a modifier should be used when home health care services are provided by CBAS in the participant's home.

Revenue code 3103 must be used with all ERS billing regardless of it being provided via telehealth or in the home.

‹‹RHC and FQHC Billing

CBAS is not a covered Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) service. However, CBAS is a Medi-Cal benefit that a RHC or FQHC may provide through either the fee-for-service delivery system or Medi-Cal Managed Care.

For Medi-Cal members enrolled in a Medi-Cal Managed Care Plan (MCP), participation in the CBAS is subject to the plan's review, and eligibility is determined by the member's MCP.

Each type of fee-for-service CBAS service provided requires the submission of the correct revenue code and procedure code combination when billing Medi-Cal to ensure the claim is eligible for reimbursement. Providers must enter remarks in Box 80 of the *UB-04* claim form explaining non-attendance on assessment days or confirming valid physician authorization and the required form for transition days. RHCs and FQHCs are also responsible for tracking the allowable limits for assessment days and the lifetime limit for transition days.››

‹‹RHC and FQHC Reimbursement

CBAS services provided by RHCs and FQHCs are reimbursed only at the established CBAS rates and must meet all applicable CBAS program requirements, including the use of appropriate CBAS billing codes, which define the authorized scope and level of service When CBAS services are provided to MCP members and paid by MCPs, those services are not eligible for the differential rate (wrap) payment.

CBAS services provided by RHCs or FQHCs must be excluded from the Prospective Payment System (PPS) rate calculation.

RHC and FQHC CBAS Codes for In-Center Services

Revenue Code	Procedure Code	Description
3103	None	CBAS regular day of service (a minimum of four hours) or transition day, excluding transportation time. Refer to appropriate CBAS codes listed above.
3101	99205	CBAS initial assessment (with subsequent attendance). Assessment days are limited to three per participant. A center may not bill for additional assessment days within 12 months of the last date of service. If the participant transfers to a new center, the new center may bill up to three assessment days without being subject to the previous center's 12-month restriction.
3101	T1015	CBAS initial assessment day (without subsequent attendance). A statement explaining why the Medi-Cal member did not return to the center after the assessment must be entered in the claim's Remarks section.
3103	T1023	CBAS transition day. Limited to five days per Medi-Cal member for their lifetime. A statement confirming that the Physician Authorization and Medical Information form is on file at the center must be entered in the claim's Remarks section.››

CBAS Provider Reimbursement

The Department of Health Care Services (DHCS) will reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are exempt from enrollment in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary per rates listed above.

Managed Care Plans (MCPs) will reimburse contracted CBAS providers pursuant to a rate structure that will include an all-inclusive rate per day of attendance per plan beneficiary or be otherwise reflective of the acuity and/or level of care of the MCP beneficiary population served by the CBAS provider. MCPs will reimburse contracted CBAS providers at the rate the CBAS provider would have been paid by DHCS for CBAS services under the fee-for-service delivery system, unless the plan and contracted CBAS provider mutually agree to a different reimbursement amount. MCP payments will be sufficient to enlist enough providers so that care and services are available under the managed care plan at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCPs may include incentive payment adjustments and performance and/or quality standards in their rate structure in paying CBAS providers.

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.
*	Effective for dates of service on or after April 1, 2012.
†	Modifier CR is to be used for Emergency Remote Services when there is a Public Health Emergency or other disaster-related declaration, while modifier SC is to be used when the individual is unable to go to the center/clinic due to medical/health-related circumstances.