Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – CMS-1500

Page updated: August 2020

Examples in this section are to help providers bill for Comprehensive Perinatal Services Program (CPSP)services on the *CMS-1500* claim form. Refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips

When completing claims, do not enter the decimal points in ICD-10-CM codes or dollar amounts. If requested information does not fit neatly in the *Additional Claim Information* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Combined Assessments and Initial Office Visit Within Four Weeks

Figure 1: Combined assessments and initial pregnancy-related office visit billed within four weeks.

HCPCS code Z1032 (initial antepartum office visit) with ZL modifier (indicating the office visit occurred within 16 weeks of the Last Menstrual Period) and code Z6500 (combined assessments) are entered in the *Procedures, Services or Supplies field* (Box 24D).HCPCS code 6500 is reimbursable only when a recipient receives all three initial nutritional, health education and psychosocial assessments and the initial pregnancy-related office visit within four weeks of entry into care.

An appropriate ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

In the *Date(s) of Service* field (Box 24A), the date of the office visit, October 1, 2015 is entered on claim line 1 as 100115. (This is the recipient's entry-into-care date.) The date of service entered on claim line 2 for HCPCS code Z6500 is October 14, 2015 (101415), which is the date of the last assessment. Enter Place of Service code 11 (office) in Box 24B.

Certification that all three assessments were rendered and the dates they were provided are entered in the *Additional Claim Information* field (Box 19). In this example, all three services were provided on the same date of service.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for both codes Z1032 and Z6500.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **NUTRITION, HEALTH EDUCATION AND PSYCHOSOCIAL ASSESSMENTS PROVIDED**

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	15				11		Z1032	ZL		18294	1		NPI	
2	10	14	15				11		Z6500			13583	1		NPI	
3															NPI	
4															NPI	

OR SUPPLIER INFORMATION

***Figure 1**:* Combined Assessments and Initial Pregnancy-Related Office Visit Billed Within Four Weeks.

Antepartum Nutrition, Psychosocial and Health Assessment Services

Figure 2: Billing follow-up antepartum nutritional counseling, psychosocial support and health education services.

Breast-Feeding

Follow-up antepartum nutritional counseling, psychosocial and health education codes are reimbursable for a variety of pre-delivery counseling services, including breast-feeding.

HCPCS code Z6204 (follow-up antepartum nutrition assessment), code Z6304 (follow-up antepartum psychosocial assessment) and Z6406 (follow-up antepartum health education assessment) are entered in the *Procedures, Services or Supplies* field (Box 24D). These services are reimbursed on an itemized basis only and must not be billed globally.

An appropriate ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

In the *Date(s) of Service* field (Box 24A), the date the nutrition assessment (Z6204) service was rendered, October 1, 2015, is entered on claim line 1 as 100115. The dates of service for codes Z6304 and Z6406 are respectively entered as 100115 and 110715.

Enter Place of Service code 11 (office) for each claim line in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Units for these codes are billed in 15-minute increments. (Refer to "Calculating Billing Units" in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* section of this manual for instructions to bill services rendered for more or less than 15 minutes.) Entering a 2 in the *Days or Units* field (Box 24G) for both codes Z6204 and Z6304 indicates that the provider spent at least 23 minutes each performing the psychosocial and nutrition assessments. Entering a 1 for code Z6406 indicates the provider spent at least 8 minutes performing the health education assessment.

This is a sample only. Please adapt to your billing situation.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15		11		Z6204			1682	2		NPI	
2	10 01 15		11		Z6304			1682	2		NPI	
3	11 07 15		11		Z6406			841	1		NPI	
4											NPI	

Figure 1: Combined Assessments and Initial Pregnancy-Related Office Visit Billed Within Four Weeks.

Antepartum Nutrition, Early and Frequent Prenatal Care

Figure 2: Billing follow-up antepartum nutritional counseling.

Figure 3: Early entry into care (modifier ZL).

The Department of Health Care Services (DHCS) established modifier ZL exclusively for use by CPSP providers. Modifier ZL, billed with the initial antepartum office visit (Z1032), adds $56.63 to the maximum reimbursement for the initial office visit.

Enter the date of the Last Menstrual Period in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14).

Enter HCPCS code Z1032 with modifier ZL (indicating the office visit occurred within 16 weeks of the Last Menstrual Period) in the *Procedures, Services or Supplies* field (Box 24D).

Enter an appropriate ICD-10-CM diagnosis code in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

In the *Date(s) of Service* field (Box 24A), enter the date of the office visit in a six-digit format. Enter Place of Service code “11” (office) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for code Z1032.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 08 15 15 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	15				11		Z1032	ZL		182 94	1		NPI	
2															NPI	
3															NPI	
4															NPI	

OR SUPPLIER INFORMATION

***Figure 3**:* Initial Comprehensive Pregnancy-Related Office Visit With ZL Modifier Certifying that the Patient was Seen Within 16 Weeks of Her Last Menstrual Period.

TAR and Claim for Reimbursement of Excess Services

Figures 5 and 6: TAR and claim information for reimbursement of excess services.

Providers may submit a *Treatment Authorization Request (TAR)* for approval of nutrition, psychosocial and/or health education services in excess of the maximums listed in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) List of Billing Codes* section of this manual.

The TAR and claim on the following pages illustrate how the TAR and claim were completed for Jane Doe, who required additional nutritional services due to diabetes.

Refer to the *TAR Completion* section of this manual for instructions to complete the TAR.

For the claim, enter HCPCS code Z6204 (follow-up antepartum nutrition assessment) in the *Procedures, Services or Supplies* field (Box 24D) on separate claim lines due to the different dates of service.

In the *Date(s) of Service* field (Box 24A), the first date of service, November 1, 2015, is entered on the claim line 1 as 110115 and the second date of service, November 7, 2015, is entered on claim line 2 as 110715. Enter Place of Service code 11 (office) in Box 24B.

Enter the date of the Last Menstrual Period in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14).

An appropriate ICD-10-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Because this claim is submitted with a diagnosis code, an ICD indicator is required between the dotted lines in the *ICD Ind.* area of Box 21. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.

In this case, 30 minutes of follow-up nutrition services were rendered on November 1, 2015, and 30 minutes were rendered on

November 7, 2015. A unit equals 15 minutes so a 2 is entered in the *Days or Units* field (Box 24G) for each claim line. (Refer to “Calculating Billing Units” in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) List of Billing Codes* section of this manual for instructions to bill services rendered for more or less than 15 minutes.)

Code Z6204 is reimbursable at $8.41 for each unit so $16.82 (2 x $8.41) is entered in the Charges field (Box 24F). The charges for both services are added together ($33.64) and entered in the *Total Charge* field (Box 28).

Note: The entire 11-digit TAR control number (in this case, 01234567890) is entered in the *Prior Authorization Number* field (Box 23).

STATE USE ONLY | SERVICE CATEGORY | 5 | TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO. | TYPE OF SERVICE REQUESTED: 2 DRUG [ ] OTHER [X] | REQUEST IS RETROACTIVE? YES [ ] NO [X] | IS PATIENT MEDI-CARE ELIGIBLE? YES [ ] NO [X] | PROVIDER PHONE NO. (916) 555-5555

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS
- MARY BROWN
- 1456 MAIN STREET
- ANYTOWN CA 958235555

3. PROVIDER NUMBER: XYZ123456

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:
1 [X] APPROVED AS REQUESTED [ ] DENIED [ ] DEFERRED
2 [ ] APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) [ ] JACKSON VS RANK PARAGRAPH CODE

BY *Sue Smith* MEDI-CAL CONSULTANT

REVIEW COMMENTS INDICATOR

34 I.D. # 67 | 35 DATE 100815 | 44

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.) 4 DOE, JANE
MEDI-CAL IDENTIFICATION NO. 5 90000000A95001 CHECK DIGIT 6

SEX 7 F | AGE 35 | DATE OF BIRTH 8 052180

STREET ADDRESS: 1234 MAIN STREET
CITY, STATE, ZIP CODE: ANYTOWN CA 98523
PHONE NUMBER: AREA (916) 555-5555

PATIENT STATUS: [X] HOME [ ] BOARD & CARE [ ] SNF / ICF [ ] ACUTE HOSPITAL

COMMENTS/EXPLANATION

DIAGNOSIS DESCRIPTION: DIABETES MELLITUS IN PREGNANCY
ICD-9-CM DIAGNOSIS CODE: D1D1D1D

MEDICAL JUSTIFICATION:
35-YEAR-OLD GRAV IV, PARA III, EDC 10-2-15 WITH HISTORY OF GESTATIONAL DIABETES. HAS MAINTAINED MARGINAL LEVELS OF ACCEPTABLE BLOOD SUGAR THROUGHOUT PREGNANCY. NEEDS ONE HOUR VISITS WEEKLY OF NUTRITIONAL FOLLOW-UP FOR REMAINDER OF PREGNANCY TO ASSURE ADEQUATE DIET, CONTROLLED BLOOD. ADDITIONAL SERVICES WILL PROVIDE NECESSARY SUPPORT SO PREGNANCY OUTCOME IS OPTIMIZED.

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)
36 1 2 3 4 5 6

LINE NO.	AUTHORIZED Y/N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9 Y	10 32	FOLLOW-UP ANTEPARTUM NUTRITIONAL INTERVENTION	32	11 Z6204	12 32	$ 26912
2	13	14			15	16	$
3	17	18			19	20	$
4	21	22			23	24	$
5	25	26			27	28	$
6	29	30			31	32	$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

Mary Brown | MD | 100615
SIGNATURE OF PHYSICIAN OR PROVIDER | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED
37 FROM DATE 060715 | 38 TO DATE 100215

TAR CONTROL NUMBER
39 OFFICE 01 | SEQUENCE NUMBER 23456789 | PI 1

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY 50-1 03/07

***Figure 5**: Correctly Filled Out TAR for Additional CPSP Services. Corresponds to the Claim on the Next Page.*

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA — CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 05 21 80 — SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN — STATE: CA

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE: 958235555 — TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [ ] NO — PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY — QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0

A. D1D1D1D B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 01234567891

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 01 15		11		Z6204			1682	2		NPI	
2	11 07 15		11		Z6204			1682	2		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 3364

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Mary Brown* DATE 11/30/15

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

33. BILLING PROVIDER INFO & PH # (916) 555-5555
JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — ***PLEASE PRINT OR TYPE*** — CR061653 — APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 6*:* Complete *CMS-1500* Claim Form. Corresponds to TAR on Preceding Page.

‹‹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.