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# Pregnancy: Comprehensive Perinatal Services Program (CPSP)

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The Comprehensive Perinatal Services Program (CPSP) is a benefit of the Medi-Cal program. The program offers a wide range of services to pregnant Medi-Cal recipients from the date of conception through 60 days after the month of delivery. CPSP services are not intended to be provided to inpatients. Recipient and provider participation is voluntary.

CPSP services are in addition to, not a replacement for, the services that are part of the American College of Obstetricians and Gynecologists (ACOG) visit standards.

**Note:** For assistance in completing claims for CPSP services, refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples* section in this manual.

## Provider Participation

### Eligible Providers

«Hospital outpatient departments, community clinics, county clinics, individual physicians, physician groups, licensed midwives, and Certified Nurse Midwives (CNMs) are eligible to provide these services.» Providers must have a current provider number and complete an application to participate as a CPSP provider. Eligibility and training information, including a “CPSP Overview for Providers” and “Provider Training Manuals,” is available to new CPSP providers and new staff of existing CPSP providers on the CPSP website: [www.cdph.ca.gov/programs/CPSP](http://www.cdph.ca.gov/programs/CPSP).

### Applying to Become a CPSP Provider

To apply or receive information regarding CPSP services, providers should contact their local Perinatal Services Coordinator (PSC) at the local county health jurisdiction. The PSC directory includes an updated coordinator list and is found on the CPSP website: [www.cdph.ca.gov/programs/CPSP](http://www.cdph.ca.gov/programs/CPSP).

Additional information on CPSP services is available by calling the CPSP toll-free line at 1-866-241-0395, the California MMIS Fiscal Intermediary Health Access Programs (HAP) hotline at 1-800-257-6900 or by addressing correspondence to:

CPSP Applications  
California Department of Public Health  
Maternal, Child and Adolescent Health Division  
MS 8306  
1615 Capitol Avenue  
P.O. Box 997420  
Sacramento, CA 95899-7420

**Note:** CPSP providers who intend to purchase an Electronic Health Records (EHR) system are strongly encouraged to contact their local PSC prior to purchasing a system. A local PSC can provide the necessary technical assistance to collect the minimum CPSP data elements required for the system to comply with CPSP regulations and generally help identify any areas of non-compliance.

### «List of CPSP Practitioners»

Certified or enrolled CPSP providers may employ or contract with any or all of the following practitioners for the purpose of providing CPSP services:

- Physicians, including general practitioners, family practice physicians, pediatricians, or obstetrician-gynecologists
- Certified Nurse Midwives (CNMs)
- Registered Nurses (RNs)
- Nurse Practitioners (NPs)
- Licensed Vocational Nurses (LVNs)
- Physician Assistants (PAs)
- Health Educators
- Childbirth Educators
- Registered Dietitians
- Comprehensive Perinatal Health Workers
- Social Workers
- Psychologists
- Marriage, Family and Child Counselors
- Licensed Midwives (LMs)

## **Policies and Reimbursement**

### **Introduction**

The following policies apply when providing comprehensive perinatal services:

- «Services must be provided by or under the personal supervision of a physician, with the exception of a CNM or LM as follows:
  - A CNM or LM who is a Medi-Cal provider is eligible to become a certified or enrolled CPSP provider without physician supervision. For more information on the physician supervision and billing requirements for CNMs/LMs, refer to the *Non-Physician Medical Practitioners (NMP)* section in this manual.»
- California Code of Regulations, Title 22, Section 51179.5, defines personal supervision as “evaluation, in accordance with protocols, by a licensed physician, of services performed by others through direct communication, either in person or through electronic means.” Each provider’s protocols must define how personal supervision by a physician occurs and is documented.
- Only the Medi-Cal enrolled CPSP provider may bill for services. Reimbursement is made directly to the CPSP provider.
- Reimbursement for nutritional, psychosocial, and health education services will be made only on an itemized basis and must not be billed globally.
- Nutritional, psychosocial and health education services in excess of the maximum units of service require a *Treatment Authorization Request (TAR)*. Refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) List of Billing Codes* section of this manual for information about maximum units of service.

## **Non-Reimbursable Services**

### **Tobacco Cessation**

Refer to the *Pregnancy: Early Care and Diagnostic Services* section of this manual for information about provider requirements regarding pregnant and postpartum recipients who use tobacco.

## **Reimbursable Services**

### **Services Reimbursable to CPSP Providers Only**

Providers who choose not to apply to become CPSP providers may continue to provide obstetrical services under Medi-Cal's existing program. However, only Medi-Cal-certified or enrolled CPSP providers may be reimbursed for the following:

- Nutritional, psychosocial and health education services
- Vitamin and mineral supplements
- Client orientation
- Case coordination

**Note:** If a CPSP provider contracts with an OB provider who is also CPSP certified, both providers should contact their county CPSP coordinator for information about billing for CPSP services.

### **Traditional Maternity Services**

CPSP providers also may be reimbursed for "Traditional" maternity services.

### **CPSP and Obstetrical Out-of-Clinic Services**

Hospital-based outpatient departments/clinics and non-hospital-based clinics that are certified CPSP providers may bill for CPSP and obstetrical services that are provided off-site or out-of-clinic. These outpatient departments and clinics may bill for CPSP and obstetrical services that are provided in off-site locations such as a physician's office, a school auditorium or a mobile van operated by a clinic.

Hospital based outpatient departments/clinics and non-hospital-based clinics may bill for off-site CPSP and obstetrical services by using the following HCPCS codes with Place of Service code "99" (other) for Medical Services providers and facility type code "14" for Outpatient providers:

<b>HCPCS Code</b>	<b>Description</b>
Z6200 thru Z6500	Comprehensive perinatal services
Z1032, Z1034, Z1038	Antepartum and postpartum visits

## **Date of Entry Into Care**

Entry into care is the date of the initial pregnancy-related office visit or the first initial assessment, whichever is provided first. Certain CPSP services, as outlined in this section, must be rendered within a limited number of weeks after a recipient enters into care.

## **Pregnancy-Related Services**

Refer to the *Pregnancy: Early Care and Diagnostic Services* section of this manual for additional information.

## **Billing Combined Assessments**

HCPCS code Z6500 (combined assessments) may only be billed when a recipient receives all three initial nutritional, health education and psychosocial assessments and the initial pregnancy-related office visit (Z1032) within four weeks of entry into care. The date of the last assessment must be shown as the date of service, and the provider must certify in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that all three initial assessments were provided and enter all dates of service, even if all assessments were rendered on the same date.

HCPCS code Z6500 is reimbursable once in six months unless the provider certifies on the claim that the recipient has become pregnant again within the six-month period.

Claims for HCPCS code Z6500 are not reimbursable if the individual assessment codes (Z6200, Z6300 and Z6402) have been billed by the same provider, for the same recipient, within the previous six months. Conversely, claims for the individual assessment codes are not payable if HCPCS code Z6500 has been billed by the same provider, for the same recipient, within the previous six months.

See *Figure 1* in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples* section of this manual for a claim example.

## **Billing Individual Assessments**

If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, the provider must bill for the actual assessments performed using the individual assessment codes (Z6200, Z6300 and/or Z6402).

## Sequence of Services

The three initial assessments (nutrition, health education and psychosocial) and the initial pregnancy-related office visit (HCPCS code Z1032) may be provided in any order and at any time during the patient's care. For example, if a patient does not consent to receive an initial psychosocial assessment until seven weeks after entry into care, the individual assessment (code Z6300), and any subsequent interventions, may still be performed and billed.

## Intervention Services

The provider must complete the initial assessment within the discipline area (nutrition, health education or psychosocial) before rendering any intervention services within that discipline. Subsequent interventions (HCPCS codes Z6204, Z6206, etc.) may be provided before completing the remaining initial assessments. For example, providers who complete the initial psychosocial assessment may perform psychosocial interventions prior to completing the remaining two initial assessments.

**Note:** Client orientation (code Z6400) and/or group perinatal education (code Z6412) may be rendered before the initial health education assessment is completed.

## Breast-Feeding-Related Services

Nutritional counseling services (HCPCS codes Z6200 thru Z6208), psychosocial support services (HCPCS codes Z6300 thru Z6308) and health education services (HCPCS codes Z6400 thru Z6414) related to breast-feeding are covered by CPSP. When billing these services to CPSP, the appropriate HCPCS code should be entered in the *Procedures, Services, or Supplies* field (Box 24D) of the *CMS-1500* claim form or *HCPCS/Rates* field (Box 44) of the *UB-04* claim form.

Medical Services providers refer to Figure 2 in *the Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – CMS-1500* section for a claim example. Outpatient providers refer to Figure 7 in *the Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – UB-04* section.

## Pasteurized Donor Human Breast Milk

«HCPCS code T2101 (human breast milk processing, storage and distribution only), to be billed per 3 ounces per unit, 35 ounces per day, only good for 30 days; can be used for medically necessary pasteurized donor human milk (PDHM) when obtained from a licensed and approved facility. Coverage may be up to 12 months of age. For more information, refer to the [Pregnancy: Postpartum and Newborn Referral Services](#) section in this manual.

HCPCS code K1005 (disposable collection and storage bag for breast milk, any size, any type, each).»

## Preventive In-Home Services

CPSP services provided in a recipient's home may be reimbursed if the services are "preventive." HCFA regulation 42 CFR 440.130 (c) defines "preventive services" as "services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to (1) prevent disease, disability, and other health conditions or their progression, (2) prolong life, and (3) promote physical and mental health and efficiency."

## Eligible In-Home Services Providers

«Only physicians and other licensed personnel (such as CNMs, LMs, RNs, LVNs, nurse practitioners, PAs and licensed social workers) may provide in-home CPSP services. Services rendered by a Certified Nursing Assistant (CNA) are not reimbursable.»

Providers should indicate in the *Remarks* area or *Additional Claim Information* field (Box 19) of the claim the license number and type of professional that provided the in-home preventive service.

## Hospital Reimbursement: Outpatient Providers

Use of the hospital outpatient facility is not separately payable with HCPCS codes Z6200 thru Z6500. Therefore, the hospital outpatient room rate (Z7500) will be denied when billed with codes Z6200 thru Z6500.

HCPCS codes Z1032, Z1034 and Z1038 are reimbursed as a common office procedures at 80 percent of the allowed rate when the facility type is outpatient ("13"). HCPCS code Z7600 is payable when billed with Z1032, Z1034 or Z1038. These codes must cover the facility cost.

## **Incentives for Early and Frequent Prenatal Care**

### **Introduction**

Early and frequent prenatal care billed by CPSP providers may include a reimbursement bonus.

### **Billing Initial Office Visit: Modifier ZL**

Modifier ZL is exclusively used to bill with HCPCS code Z1032 (initial comprehensive antepartum office visit). Billing with this modifier adds \$56.63 to the reimbursement and certifies that the visit occurred within 16 weeks of the patient's last menstrual period [LMP] (up to and including pregnancies of 16 weeks and 0/7ths days gestation only). The date of the LMP is entered in *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14) on the *CMS-1500* claim form and in the *Remarks* field (Box 80) on the *UB-04* claim form. Modifier ZL is reimbursable only once during a pregnancy. Claims billed in excess of this limit will be denied.

**Note:** When billing modifier ZL, providers must add \$56.63 to the total charges.

Medical Services providers see *Figure 3* in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – CMS-1500* section for a claim example. Outpatient providers see *Figure 1* in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – UB-04* section for a claim example.

### **Billing Initial Office Visit: Early Entry Rendered by NMP**

«When billing for entry into care within 16 weeks of LMP and the service is rendered by a Non-Physician Medical Practitioner (NMP), use the appropriate multiple modifiers instead of modifier ZL. NMPs include Certified Nurse Midwives (CNMs), Licensed Midwives (LMs), Nurse Practitioners (NPs) and Physician Assistants (PAs). In the *Remarks* field (Box 80) or *Additional Claim Information* field (Box 19), include the NMP name, California license number and type of NMP (for example, CNM, LM, NP or PA).»

<b>Type of NMP</b>	<b>HCPCS Multiple Modifier</b>	<b>Note in <i>Remarks</i> Field (Box 80) or <i>Additional Claim Information</i> Field (Box 19) when Billing with Modifier 99</b>
CNM	99	Modifier 99 = SB + additional modifiers as appropriate
LM	99	Modifier 99 = U9 + additional modifiers as appropriate
NP	99	Modifier 99 = SA + additional modifiers as appropriate
PA	99	Modifier 99 = U7 + additional modifiers as appropriate



## Modifier Tips

The preceding multiple modifier must be used whenever billing for a service that requires a multiple NMP modifier, not just when billing for early entry into care. Modifiers are not required when billing for HCPCS codes Z6200 thru Z6500.

## Special Reimbursement

### Basic OB Service

The following chart illustrates the special bonus available through CPSP for early entry into care.

Services Rendered	Maximum Allowable Reimbursement
Early entry into care (within 16 weeks of LMP)	\$56.63

### CPSP Support Services

Services Rendered	Maximum Allowable Reimbursement
Individual support services: \$33.64/hour (up to 21.5 hours)	\$723.26
Group classes: \$11.24/patient/hour (up to 27 hours)	\$303.48
Coordination fee*	\$85.34
Prenatal vitamins, \$3.00/30-day supply (up to 300-day supply)	\$30.00
Allowable Reimbursement	\$1,142.08†

## **Share of Cost**

### **Requirements**

Recipients who choose to participate in the CPSP program are required to pay or obligate their Share of Cost each month even if the obstetrical services are billed globally.

## **Treatment Authorization Requests**

### **Additional CPSP Services**

Comprehensive perinatal services are covered subject to the requirements specified on the preceding pages. Providers may submit a *Treatment Authorization Request* (TAR) for nutrition, psychosocial, or health education services in excess of the basic allowances if the provider documents those additional services are medically necessary.

TARs requesting additional services must be completely filled out and include the following information:

- Amount of time/number of services being requested
- Anticipated benefit or outcome of additional services
- Clinical findings of the high risk factors involved in the pregnancy
- Description of the services being requested
- Expected Date of Confinement (EDC)
- Explanation of why the basic CPSP services will not be sufficient

Enter the entire 11-digit TAR Control Number on the claim when billing for additional TAR authorized services. A copy of the TAR is not required when billing. Do not combine TAR and non-TAR services on the same claim form.

See Figures 5 and 6 in the *Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples* section of this manual for a TAR and claim example.

## **Billing Instructions**

### **Introduction**

Use the following instructions when billing for CPSP services:

- Comprehensive perinatal service procedure codes must be billed as individual charges for each date of service. “From-through” billing format cannot be used.
- When a rendering provider number is required (for example, physician group billing), the provider number of the comprehensive perinatal physician must be used as the rendering provider. Do not use group provider numbers for the rendering provider.
- Medi-Cal may recoup payments if an audit shows that the patient records lack documentation to establish that services were provided as billed.
- Patients who receive Medi-Cal benefits following the birth of a child also may receive CPSP interventions in any area or discipline when an initial assessment is performed prior to the intervention.

### **Calculating Billing Units**

CPSP support services are billed in units. One unit equals 15 minutes. Fractions of units are calculated this way:

- 00 thru 07 minutes equals 0 units, which is not payable
- 08 thru 22 minutes equals 1 unit
- 23 thru 37 minutes equals 2 units
- 38 thru 51 minutes equals 3 units

**Exceptions:** HCPCS code Z6500 (see information elsewhere in this section). HCPCS codes Z6200, Z6300 and Z6402 are billed in 30-minute units.

**<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	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.
*	The coordination fee is only reimbursable if all three initial assessments and the initial pregnancy-related office visit are provided within four weeks of entry into care.
‡	Maximum allowable reimbursement without authorization if all support services are provided and billed. In high risk circumstances, additional support services may be requested through the TAR process.