Comprehensive Perinatal Services Program

Introduction

Purpose

The Comprehensive Perinatal Services Program (CPSP) is a benefit of the Medi-Cal program. This module will familiarize participants with the wide range of services available to pregnant Medi-Cal recipients enrolled in CPSP from pregnancy through 60 days after the month of delivery. Recipient and provider participation is voluntary.

Module Objectives

- Determine who can offer CPSP services
- Identify CPSP reimbursement bonuses
- Recognize CPSP services and billing codes
- Demonstrate claim forms billing requirements
- Clarify the *Treatment Authorization Request* (TAR) process
- Review the CPSP summary billing form
- Provide the link for a current listing of Perinatal Services Coordinators (PSCs)

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Description

The CPSP provides a wide range of services to pregnant women, from pregnancy through 60 days after the month of delivery. Medi-Cal fee-for-service providers may apply to enroll as a CPSP provider. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education. This approach has shown a reduction in both low-birth weight prevalence and health care costs for women and infants.

Notes:

CPSP Provider Participation

Eligibility

A CPSP provider must be in one of the categories listed below:

- Physician in general practice, family practice, obstetrics (OB)/gynecology, or pediatrics
- Group medical practice, if at least one member is one of the physician types identified above
- Certified Nurse Midwife (CNM)
- Clinic (FQHC, hospital, community or county)
- Alternative Birthing Center

Participation Requirements

Providers must meet the following prerequisites:

- Possess a current provider number/National Provider Identifier (NPI).
- Complete an application to participate as a CPSP provider.

Suggested provider and/or staff:

- Complete the “Provider Overview” and “Steps to Take” training courses.

Note: Refer to the CPSP website (*www.cdph.ca.gov/programs/cpsp*) for information about training for new CPSP providers and new staff of existing CPSP providers.

Notes:

Enrollment Process

To receive information regarding CPSP services, providers should contact their local PSC at the local health jurisdiction (county health department). Refer to the CPSP website (*www.cdph.ca.gov/programs/cpsp*) for more information.

CPSP Administration

Perinatal Services Coordinator (PSC)

CPSP services are rendered by enrolled fee-for-service providers and Medi-Cal managed care providers. PSCs play a major role in administrating CPSP within their local health jurisdictions (LHJs). PSCs are employed by 61 LHJs and perform the following:

- Inform potential providers regarding the CPSP program and provider training
- Distribute, review and make recommendations to complete CPSP provider applications
- Make recommendations to the California Department of Public Health, Maternal Children and Adolescent Health Division regarding provider enrollment approval
- Conduct outreach services to eligible women regarding CPSP
- Provide technical assistance regarding CPSP implementation to providers
- Monitor the implementation of CPSP through quality assurance activities

Update to CPSP Practitioner Definition

The definition of a Comprehensive Perinatal Services Program (CPSP) practitioner has been updated. It is now defined in *Welfare and Institutions Code* (W&I Code), Section 14134.5 and *California Code of Regulations* (CCR), Title 22, Section 51179.7.

W&I Code Section 14134.5 states a comprehensive perinatal provider means any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above named providers, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section. Section 14134.5 also states that, except where existing law prohibits the employment of physicians, a health care provider may employ or contract with all of the following medical and other practitioners for the purpose of providing comprehensive services delineated in this section;

- Physicians, including a general practitioner, a family practice physician, a pediatrician, or an obstetrician-gynecologist
- Certified nurse-midwives
- Licensed midwives
- Nurses
- Nurse practitioners
- Physician assistants
- Social workers
- Health and childbirth educators
- Registered dietitians

CCR, Title 22, Section 51179.7 states a comprehensive perinatal practitioner means any one of the following:

- A physician who is either:
  - A general practice physician, or
  - A family practice physician, or
  - A pediatrician, or
  - An obstetrician-gynecologist.
- A Certified Nurse Midwife as defined in Section 51170.2.
- A Registered Nurse who is licensed as such by the Board of Registered Nursing and who has one year experience in the field of Maternal and Child Health.
- A Nurse Practitioner as defined in Section 51170.3.
- A Physician's Assistant as defined in Section 51170.1.
- A social worker who either:
  - Holds a Master's Degree or higher in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year of experience in the field of Maternal and Child Health, or
  - Holds a Master's Degree in psychology or Marriage, Family and Child counseling and has one year of experience in the field of Maternal and Child Health, or
  - Holds a Baccalaureate Degree in social work or social welfare from a college or university with a Social Work Degree program accredited by the Council on Social Work Education and who has one year experience in the field of Maternal and Child Health.
- A health educator who either has:
  - A Master's Degree (or higher) in Community or Public Health Education from a program accredited by the Council on Education for Public Health and who has one year of experience in the field of Maternal and Child Health, or
  - A Baccalaureate Degree with a major in Community or Public Health Education and who has one year of experience in the field of Maternal and Child Health.

- A childbirth educator who is:
  - Licensed as a Registered Nurse by the Board of Registered Nursing and has one year experience in a program which complies with the “Guidelines for Childbirth Education” (last published in 1981), herein incorporated by reference in its entirety and available from the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, South West, Suite 300 East, Washington, D.C., 20024-2588 or
  - A Certified Childbirth Educator who has completed a training program and is currently certified to teach that method of childbirth education by the American Society for Psychoprophylaxis in Obstetrics, or Bradley, or the International Childbirth Education Association.
- A dietitian who is registered, or is eligible to be registered by the Commission on Dietetic Registration, the credentialing agency of the American Dietetic Association, with one year of experience in the field of perinatal nutrition.
- A comprehensive perinatal health worker who:
  - Is at least 18 years of age, is a high school graduate or equivalent, and has at least one year of full-time paid practical experience in providing perinatal care.
  - Provides services in a clinic that is either licensed or exempt from licensure under Section 1200 et. seq. and 1250 et seq. of the Health and Safety Code, under the direct supervision of a comprehensive perinatal practitioner as defined in Section 51179.7 (a) (1).
- A licensed vocational nurse who is licensed under Section 2516 of the Business and Professions Code and who has one year of experience in the field of Maternal and Child Health.
- A licensed midwife as defined in Section 51191.

Case Coordinator

The case coordinator must be a trained CPSP practitioner who can ensure that the client receives optimal prenatal care by promoting ongoing communication with all of the health care team members. Case coordination includes the following:

- Coordination and development of an Individualized Care Plan (ICP) for the client
- Modification of care plan as needed
- Assisting the client with practical arrangements such as transportation, referrals and special appointments when necessary

Verifying all of the client’s documentation in the chart is complete, up-to-date and available to all team members

CPSP Policies

Supervision Requirements for CPSP Services Delivery

CPSP services must be provided by or under the personal supervision of a physician. The CCR, 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.”

Note: Each provider’s protocols must define how personal supervision by a physician occurs and is documented.

Tobacco Cessation Counseling for Pregnant and Postpartum Women

Providers must offer one, face-to-face smoking/tobacco cessation counseling session and a referral to a tobacco cessation quitline to pregnant and postpartum recipients, as recommended in *Treating Tobacco Use and Dependence: 2008 Update*, a U.S. Public Health Service Clinical Practice Guideline.

Such counseling and referral services must be provided to pregnant and postpartum recipients without cost sharing. These services are required during the prenatal period through the postpartum period (on the last day of the month in which the 60th day following delivery occurs).

General Guidelines

The following policies apply to CPSP:

- CPSP services are not intended to be provided to inpatients.
- CPSP services are in addition to, not a replacement for, the services that are part of the American College of Obstetrics and Gynecology (ACOG) visit standards.
- Only the Medi-Cal provider enrolled in CPSP may bill for services.
- Reimbursement is made directly to the CPSP provider only.
- Reimbursement for nutritional, psychosocial and health education services is made on an itemized basis (per visit) and must not be billed globally.
- An approved TAR is required to bill for nutritional, psychosocial and health education services in excess of the maximum units of service allowable.
- Medi-Cal may recoup payment if a recipient's records lack documentation to establish that services were provided as billed.
- CPSP participation is voluntary for the recipient and the provider.

Reimbursement of Services

Only Medi-Cal providers enrolled in CPSP can be reimbursed for the following CPSP services:

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

Program Benefits Comparison (Obstetrics Services vs. CPSP Services)

Obstetrical Services Maximum Allowable Reimbursement Table

Obstetrical Services Rendered	Maximum Allowable Reimbursement
Z1032 (initial comprehensive antepartum office visit)	$126.31
Z1034 (antepartum office visit) – $60.48 per visit x 13 visits	$786.24
59409 (vaginal delivery)	$544.28
Z1038 (postpartum office visit)	$60.48
Allowable Reimbursement:	$1,517.31

CPSP Reimbursement Bonus Services Maximum Allowable Reimbursement Table

CPSP Reimbursement Bonus Services Rendered	Maximum Allowable Reimbursement
Early entry into care “ZL” Modifier (within 16 weeks of LMP)	$56.63
Total Available Bonuses:	$56.63

CPSP Support Services Rendered Maximum Allowable Reimbursement Table

CPSP Support Services Rendered	Maximum Allowable Reimbursement
Initial support services: Z6200, Z6300, Z6402 ($16.83 each x 3)	$50.49
Individual support services: $33.64 per hour (up to 21.5 hours)	$723.26
Group classes: $11.24 per patient per hour (up to 27 hours)	$303.48
Coordination fee: $85.34	$85.34
Vitamin/mineral supplements: 30-day supply. Restricted to 10 in 9 months.	$30.00
Allowable Reimbursement:	$1,192.57

Note: Maximum reimbursement for routine OB and CPSP services (before TAR) = $2,766.51

Note: 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.

Note: Maximum allowable reimbursement without authorization if <u>all</u> support services are provided and billed. In high-risk circumstances, additional support services may be requested through the TAR process.

CPSP Billing

Reimbursement Bonus Services

Modifier ZL (Early entry into care)

1. Modifier ZL must be billed with HCPCS code Z1032 and certifies that the recipient was seen within 16 weeks of her Last Menstrual Period (LMP).
   True☐ False☐
2. Enter the LMP date in _____ on the *CMS-1500* claim form or in _____ _____ on the *UB-04* claim form.
3. To be reimbursed for modifier ZL, providers must add $56.63 to their usual and customary fee for Z1032.
   True☐ False☐
4. Modifier ZL is restricted to CPSP providers and will only be reimbursed _____ per recipient, per pregnancy.

See the Appendix for the Answer Key

Billing Example: Reimbursement Bonuses (Modifier ZL)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 08 15 18 QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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	18			11		Z1032	ZL		18294	1		NPI	
2														NPI	
3														NPI	
4														NPI	

I OR SUPPLIER INFORMATION

Sample: *CMS-1500* claim form

Non-Physician Medical Practitioners

Non-Physician Medical Practitioners are identified with specific modifiers:

Practitioner	Modifier	Multiple Modifier
Physician assistant	U7	99
Nurse Practitioner	SA	99
Certified Nurse Midwife	SB	99

When billing Z1032 and the bonus modifier ZL, use the modifier 99 (multiple modifiers) for non-medical practitioners.

Example:

99 = U7 + ZL – Physician Assistant

99 = SA + ZL – Nurse Practitioner

99 = SB + ZL – Certified Nurse Midwife

Billing Example: Non-Physician Medical Practitioner (Modifier 99)

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

2

3a PAT. CNTL. # | b. MED. REC. # | 4 TYPE OF BILL: 731

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME: a | b DOE, JANE

9 PATIENT ADDRESS: a | b | c | d | e

10 BIRTHDATE: 08241980 | 11 SEX: F | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31–37 OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH

38

39–41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	INITIAL OFFICE VISIT	Z103299	100118	1	18294		
	COMBINED ASSESSMENTS	Z6500	100118	1	13583		
001	PAGE ____ OF ____	CREATION DATE		TOTALS	31877		

50 PAYER NAME: O/P MEDI-CAL | 51 HEALTH PLAN ID | 52 REL INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE: 31877 | 56 NPI: 0123456789 | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P REL | 60 INSURED'S UNIQUE ID: 90000000A95001 | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: D1D1D1D
0

67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE / DATE | a. OTHER PROCEDURE CODE / DATE | b. OTHER PROCEDURE CODE / DATE | 75

c. OTHER PROCEDURE CODE / DATE | d. OTHER PROCEDURE CODE / DATE | e. OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI: 1234567890 QUAL | LAST | FIRST
77 OPERATING NPI | QUAL | LAST | FIRST
78 OTHER NPI | QUAL | LAST | FIRST
79 OTHER NPI | QUAL | LAST | FIRST

80 REMARKS
SUE SMITH, NP. NPI: 0123456789.
LINE 1: LMP 010118. 99 = SA + ZL.
LINE 2: PSYCHOLOGICAL ASSESSMENT 100118.
HEALTH ASSESSMENT 100118.
NUTRITION ASSESSMENT 101118.

81CC a b c d

UB-04 CMS-1450 © 2005 NUBC | OMB APPROVAL PENDING | NUBC National Uniform Billing Committee LIC9213257 | THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: *UB-04* Claim Form

Combined Assessment Billing (HCPCS Code Z6500)

1. This code can only be billed if all _____ initial assessments and the initial pregnancy-related office visit code _____ are rendered within a _____-_____ _____.
2. The date of the last assessment must be shown as the date of service.
   True ☐ False ☐
3. Z6500 is reimbursable once in ____ _____ unless the provider certifies on the claim that the recipient has become pregnant again within the _____-_____ period.
4. If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, you must bill the initial assessments separately.
   True ☐ False ☐

See the Appendix for the Answer Key

Billing Example: Combined Assessments (HCPCS Code Z6500)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **NUTRITION, HEALTH EDUCATION AND PSYCHOSOCIAL ASSESSMENTS PROVIDED ON 101418**

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	18				11		Z1032	ZL		18294	1		NPI	
2	10	14	18				11		Z6500			13583	1		NPI	
3															NPI	
4															NPI	

I OR SUPPLIER INFORMATION

Sample: *CMS-1500* Claim Form

Individual Assessment Billing (Z6200, Z6300 and/or Z6402)

1. 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.

   True ☐ False ☐

Sequence of Services

The sequence for providing the initial assessments (nutrition, health education and psychosocial) and the initial pregnancy-related office visit code (Z1032) may be rendered in _____ _____ and at ____ _____ during the patient's care.

Intervention Services

The provider must complete the initial assessment within the discipline area (nutrition, health education or psychosocial) _____ rendering any intervention services within that discipline.

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

See the Appendix for the Answer Key

Breastfeeding-Related Services

Nutrition, psychosocial and health education counseling services related to breastfeeding are reimbursable using the following codes:

- Nutrition services: HCPCS codes Z6200 thru Z6208
- Psychosocial services: HCPCS codes Z6300 thru Z6308
- Health education services: HCPCS codes Z6400 thru Z6414

Reimbursable conditions include, but are not limited to, the following:

- Breastfeeding education following the CPSP “Steps to Take” guidelines
- Persistent discomfort to the woman while breastfeeding
- Infant weight-gain concerns
- Milk extraction
- Suck dysfunction of the infant

Billing Tip: 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 the *HCPCS/Rate* field (Box 44) of the *UB-04* claim form.

Treatment Authorization Requests (TAR)

Additional CPSP Services

Providers may submit TARs for nutrition, psychosocial or health education services in excess of the basic allowances if the provider documents that additional services are medically necessary.

TARs for 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 Delivery (EDD)
- Explanation of why the basic CPSP services will not be sufficient

TAR Example for Reimbursement of Excess Services

STATE USE ONLY

SERVICE CATEGORY

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.

2 TYPE OF SERVICE REQUESTED: DRUG [ ] OTHER [X]

REQUEST IS RETROACTIVE? YES [ ] NO [X]

IS PATIENT MEDI-CAL ELIGIBLE? YES [ ] NO [X]

PROVIDER PHONE NO. (916) 555-5555

PLEASE TYPE YOUR NAME AND ADDRESS HERE

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

3. PROVIDER NUMBER XYZ123456

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

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)
4 DOE, JANE

MEDI-CAL IDENTIFICATION NO.
5 90000000A95001 SUFFIX 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

DIAGNOSIS DESCRIPTION: DIABETES MELLITUS IN PREGNANCY

ICD-9-CM DIAGNOSIS CODE D1D1D1D

MEDICAL JUSTIFICATION:
35-YEAR-OLD GRAV IV, PARA III, EDC 10-2-18 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.

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 I.D. # 34 67 DATE 35 10 08 18 REVIEW COMMENTS INDICATOR 44

COMMENTS/EXPLANATION

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 — SIGNATURE OF PHYSICIAN OR PROVIDER | MD — TITLE | 100618 — DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED
37 FROM DATE 06 07 18 38 TO DATE 10 02 18

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

Sample: *Treatment Authorization Request* Form

TARs for FQHCs, RHCs and IHS/MOAs

TARs are not required for FQHCs, RHCs and IHS/MOAs. Claims for CPSP services provided that exceed the basic allowances will not be denied for the absence of a TAR. However, FQHCs, RHCs and IHS/MOAs must meet the same documentation requirements that would otherwise be necessary to obtain a TAR. This information must be maintained in the client's medical record and be available for review by the Department of Health Care Services (DHCS). Required documentation should include:

- EDD
- Clinical findings of the high-risk factors
- Explanation as to why the basic CPSP services are not sufficient
- Description of services being requested
- Anticipated benefit or outcome for the additional services, etc.

Share of Cost (SOC)

Recipients who choose to participate in the CPSP program and receive CPSP services are required to _____ or _____ their SOC _____ _____ even if the obstetrical services are billed globally.

See the Appendix for the Answer Key

CPSP Support Services

Calculating Billing Units

- CPSP support services are billed in units. One unit equals ____ _____.
- Fractions of units are calculated as shown below:
  - 00 thru 07 minutes equals 0 units, not billable
  - 08 thru 22 minutes equals 1 unit
  - 23 thru 37 minutes equals 2 units
  - 38 thru 51 minutes equals 3 units, etc.
- Exceptions: Z6200, Z6300 and Z6402 are billed in 30-minute units.

CPSP Billing Codes

Initial assessments must be rendered prior to billing any follow-up assessments.

CPSP Billing Codes Table

Service	HCPCS Code	Description	Maximum Units of Service
Office Visits	Z1032 ZL	Initial comprehensive pregnancy-related office visit performed within 16 weeks of LMP	1
Initial Comprehensive Services	Z6500	Initial comprehensive nutrition, psychosocial and health education assessments and development of care plan; first 30 minutes each assessment (total 90 minutes), (includes ongoing coordination of care); the three assessments must be completed within four weeks of the “initial visit” (either the pregnancy-related visit or any one of the three initial assessments)	1
Nutrition Services	Z6200	Initial nutrition assessment and development of care plan; first 30 minutes	1
Nutrition Services	Z6202	Each subsequent 15 minutes (max. 1½ hours)	6
Nutrition Services	Z6204	Follow-up antepartum nutrition assessment, treatment and/or intervention; individual, each 15 minutes (max. 2 hours)	8
Nutrition Services	Z6206	Group, per patient, each 15 minutes (max. of 3 hours)	12
Nutrition Services	Z6208	Postpartum nutritional assessment, treatment and/or intervention, including development of care plan, individual, each 15 minutes (max. 1 hour)	4
Nutrition Services	S0197	Prenatal vitamin-mineral supplement, 30-day supply. Restricted to 10 in 9 months.	10

CPSP Billing Codes Table (continued)

Service	HCPCS Code	Description	Maximum Units of Service
Comprehensive Psychosocial Services	Z6300	Initial psychosocial assessment and development of care plan; first 30 minutes	1
Comprehensive Psychosocial Services	Z6302	Each subsequent 15 minutes (max. 1½ hours)	6
Comprehensive Psychosocial Services	Z6304	Follow-up antepartum psychosocial assessment, treatment, and/or intervention; individual, each 15 minutes (max. 3 hours)	12
Comprehensive Psychosocial Services	Z6306	Follow-up antepartum psychosocial assessment, treatment and/or intervention, group, per patient, each 15 minutes (max. 4 hours)	16
Comprehensive Psychosocial Services	Z6308	Postpartum psychosocial assessment, treatment, and/or intervention, including development of care plan, individual, each 15 minutes (max. 1½ hours)	6

CPSP Billing Codes Table (continued)

Service	HCPCS Code	Description	Maximum Units of Service
Comprehensive Health Education Services	Z6400	Client orientation (health education) each 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6402	Initial health education assessment and development of care plan, first 30 minutes	1
Comprehensive Health Education Services	Z6404	Initial health education assessment and development of care plan, each subsequent 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6406	Follow-up antepartum health education assessment, treatment, and/or intervention, individual, each 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6408	Follow-up antepartum health education assessment, treatment, and/or intervention, group, per patient, each 15 minutes (max. 2 hours)	8
Comprehensive Health Education Services	Z6410	Perinatal education, individual, each 15 minutes (max. 4 hours)	16
Comprehensive Health Education Services	Z6412	Perinatal education group per patient, each 15 minutes (max. 16 units per day) 72 units per pregnancy	16 per day
Comprehensive Health Education Services	Z6414	Postpartum health education assessment, treatment and/or intervention, including development of care plan, individual, each 15 minutes (max. 1 hour)	4

Notes:

Billing Code Summary

Patient Billing

Type of Billing – Physician Services	Billing Code	Number of Units Used (1 Unit = 15 Minutes) Initial and Date Each Unit Used per Visit
Obstetrical (# Visits)		
Initial Comprehensive Office Visit	**Z1032**	
Early Entry LMP Reimbursement Bonus	**ZL**	**Use with Z1032 only**
Antepartum Office Visit – 13 Visits	**Z1034**	1 2 3 4 5 6 7 8 9 10 11 12 13
Postpartum Office Visit	**Z1038**	
Prenatal Vitamins – 30 day supply, 10 in 9 months	**S0197**	1 2 3 4 5 6 7 8 9 10
CPSP Services		
Initial Comprehensive Assessment	**Z6500***	*** All 3 completed within**
1. Health Education – 30 min	*Date:*	**4 weeks of initial visit (Z1032)**
2. Nutrition – 30 min	*Date:*	
3. Psychosocial – 30 min	*Date:*	
Nutrition		
Initial Assessment – Individual 30 min	**Z6200**	**Don't use if Z6500 is billed**
Additional Initial Assessment – 1.5 hrs	**Z6202**	1 2 3 4 5 6
Follow-up Intervention/Reassessment – 2 hrs	**Z6204**	1 2 3 4 5 6 7 8
Follow-up Intervention – Group 3 hrs	**Z6206**	1 2 3 4 5 6 7 8 9 10 11 12
Postpartum – Individual 1 hr	**Z6208**	1 2 3 4
Psychosocial		
Initial Assessment – Individual 30 min	**Z6300**	**Don't use if Z6500 is billed**
Additional Initial Assessment – 1.5 hrs	**Z6302**	1 2 3 4 5 6
Follow-up Intervention/Reassessment – 3 hrs	**Z6304**	1 2 3 4 5 6 7 8 9 10 11 12
Follow-up Intervention – Group 4 hrs	**Z6306**	1 2 3 4 5 6 7 8 9 10 11 12
		13 14 15 16
Postpartum – Individual 1.5 hrs	**Z6308**	1 2 3 4 5 6
Health Education		
Client Orientation – Individual 2 hrs	**Z6400**	1 2 3 4 5 6 7 8
Initial Assessment – Individual 30 min	**Z6402**	**Don't use if Z6500 is billed**
Additional Initial Assessment – 2 hrs	**Z6404**	1 2 3 4 5 6 7 8
Follow-up Intervention/Reassessment – 2 hrs	**Z6406**	1 2 3 4 5 6 7 8
Follow-up Education Assessment /Intervention Group – 2 hrs	**Z6408**	1 2 3 4 5 6 7 8
Perinatal Education – Individual 4 hrs	**Z6410**	1 2 3 4 5 6 7 8 9 10 11 12
		13 14 15 16
Group Education – 18 hrs	**Z6412**	1 2 3 4 5 6 7 8 9 10 11 12
		13 14 15 16 17 18 19 20 21 22 23 24
		25 26 27 28 29 30 31 32 33 34 35 36
		37 38 39 40 41 42 43 44 45 46 47 48
		49 50 51 52 53 54 55 56 57 58 59 60
		61 62 63 64 65 66 67 68 69 70 71 72
Postpartum – Individual 1 hr	**Z6414**	1 2 3 4

FQHC/RHC/IHS-MOA Billing Code Summary

RHC/FQHC billing codes:

Straight Medi-Cal and Emergency/Pregnancy only – Revenue Code: **0521 and HCPCS Code T1015**

Medi-Cal Managed Care billing codes:

Revenue Code 0521 and HCPCS Code T1015 SE

IHS-MOA billing codes:

Straight Medi-Cal and Emergency/Pregnancy only – Revenue Code: **0520 and HCPCS Code T1015**

Note: IHS-MOA provider type does not bill for the managed care wrap as of August 2018

	Fee for Service Code	Billing Code	Number of Units Used (1 Unit = 15 Minutes) Please Initial and Date Each Unit Used per Visit											
Obstetrical Care														
Initial Antepartum	Z1032	T1015	1											
Antepartum – 13 visits	Z1034	T1015	1	2	3	4	5	6	7	8	9	10	11	12	13
Postpartum	Z1038	T1015	1											
NOTE: All provider types are restricted to Medi-Cal frequency limits for OB care (fee-for-service, FQHC, RHC, IHS)														
Nutrition														
Initial Assessment	Z6200	T1015		1	**30 minutes**									
Additional Assess – 1.5 hrs	Z6202	T1015	1	2	3	4	5	6						
Follow-Up (F/U) Intervention/Reassessment – Individual 2 hrs	Z6204	T1015	1	2	3	4	5	6	7	8				
F/U Intervention – Group 3 hrs	Z6206	T1015	1	2	3	4	5	6	7	8	9	10	11	12
Postpartum – Individual 1 hr	Z6208	T1015	1	2	3	4								
Psychosocial														
Initial Assessment	Z6300	T1015		1	**30 minutes**									
Additional Init Assess 1.5 hrs	Z6302	T1015	1	2	3	4	5	6						
F/U Intervention/Reassessment – Individual 3 hrs	Z6304	T1015	1	2	3	4	5	6	7	8	9	10	11	12
F/U Intervention – Group 4 hrs	Z6306	T1015	1	2	3	4	5	6	7	8	9	10	11	12
			13	14	15	16								
Postpartum – Individual 1.5 hrs	Z6308	T1015	1	2	3	4	5	6						
Health Education														
Client Orientation – Indiv. 2 hrs	Z6400	T1015	1	2	3	4	5	6	7	8				
Initial Assessment – Individual 30 min	Z6402	T1015		1	**30 minutes**									
Add'l Init Assessment – 2 hrs	Z6404	T1015	1	2	3	4	5	6	7	8				
F/U Intervention/Reassessment – Individual 2 hrs	Z6406	T1015	1	2	3	4	5	6	7	8				
F/U Ed Assess/Intervention – Group 2 hrs	Z6408	T1015	1	2	3	4	5	6	7	8				
Perinatal Education – Individual 4 hrs	Z6410	T1015	1	2	3	4	5	6	7	8	9	10	11	12
			13	14	15	16								
Group Education – 18 hrs	Z6412	T1015	1	2	3	4	5	6	7	8	9	10	11	12
			13	14	15	16	17	18	19	20	21	22	23	24
			25	26	27	28	29	30	31	32	33	34	35	36
			37	38	39	40	41	42	43	44	45	46	47	48
			49	50	51	52	53	54	55	56	57	58	59	60
			61	62	63	64	65	66	67	68	69	70	71	72
Postpartum – Individual 1 hr	Z6414	T1015	1	2	3	4								

Special Appendix

HIPAA-Compliant CPSP Billing Code Conversions

DHCS will discontinue the use of current Medi-Cal interim codes Z1032, Z6200, Z6202, Z6204, Z6206, Z6208, Z6210, Z6300, Z6302, Z6304, Z6308, Z6400, Z6402, Z6404, Z6408, Z6410, Z6412, Z6414 and Z6500 for CPSP services. These interim codes will be replaced by HIPAA-compliant codes and HCPCS code modifiers to comply with the provisions of HIPAA of 1996, Public Law 104-91, *Code of Federal Regulations*, Title 45, Part 162.1000. Watch for these code and effective date changes in the monthly Medi-Cal provider bulletins and *NewsFlash* articles.

Resource Information

References

The following reference materials provide Medi-Cal billing and policy information.

Provider Manual References

Part 2

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health)

Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes (ind health cd)

Pregnancy: Comprehensive Perinatal Services Program (CPSP) (preg com)

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

Pregnancy: Comprehensive Perinatal Services Program (CPSP) Billing Examples – UB-04 (preg com exu)

Comprehensive Perinatal Services Programs (CPSP) List of Billing Codes (preg com lis)

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural)

Other References

CPSP website: (*www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/default*)

Note: For a list of CPSP Perinatal Services Coordinators (PSCs), click “Contact your Local Coordinator” under “Providers.”

Appendix

Acronyms

Acronym	Description
AEVS	Automated Eligibility Verification System
AGOG	American Congress of Obstetricians and Gynecologists
APCC	Affiliate Primary Care Clinics
BCCTP	Breast and Cervical Cancer Treatment Program
BIC	Benefits Identification Card
CE	Childbirth Educator
CEC	Client Eligibility Certification
CDF	Clinic Dispensing Fee
CHDP	Child Health and Disability Prevention
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
COS	Category of Service
CPHW	Comprehensive Perinatal Health Worker
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
DOS	Date of Service
E&C	Education & Counseling
E&M	Evaluation and Management
EDD	Expected Date of Delivery
EIN	Employer Identification Number
FAM	Fertility Awareness Method
FDA	Food and Drug Administration

Acronym	Description
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FIG	Federal Income Guidelines
FPACT	Family Planning, Access, Care and Treatment
FPG	Federal Poverty Guidelines
FPL	Federal Poverty Limit
FQHC	Federally Qualified Health Centers
HAP	Health Access Program
HCPCS	Healthcare Procedure Coding System
HE	Health Educator
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPV	Human Papilloma Virus
ICP	Individualized Care Plan
IHS-MOA	Indian Health Services Memorandum of Agreement
IUC	Intrauterine Contraceptive
LAM	Lactational Amenorrhea Method
LMP	Last Menstrual Period
LMS	Learning Management System
LVN	Licensed Vocational Nurse
MFT	Marriage Family Therapist
NDC	National Drug Code
NFP	Natural Family Planning
NMP	Non-Physician Medical Practitioner
NP	Nurse Practitioner
NPI	National Provider Identifier
OB	Obstetrics

Acronym	Description
OC	Oral Contraceptives
OFP	Office of Family Planning
OHC	Other Health Coverage
PA	Physician Assistant
PACT	Planning, Access, Care and Treatment
PCC	Primary Care Clinics
PE4PW	Presumptive Eligibility for Pregnant Women
PE	Presumptive Eligibility
PID	Pelvic Inflammatory Disease
POS	Point of Service
PPBI	Policies, Procedures and Billing Instructions
PSC	Perinatal Services Coordinator
QP	Qualified Provider
RAD	Remittance Advice Details
RD	Registered Dietician
REC	Retroactive Eligibility Certification
RHC	Rural Health Clinics
RN	Registered Nurse
SOC	Share of Cost
SSApp	Single Streamlined Application
SSI	Social Security Insurance
SSN	Social Security Number
STI	Sexually Transmitted Infection
TAR	Treatment Authorization Request
TCN	TAR Control Number
TIN	Taxpayer Identification Number
TSC	Telephone Service Center
UTI	Urinary Tract Infection
W&I Code	Welfare and Institutions Code

Module C Answer Key

Knowledge Review 1:

Question 1: Modifier ZL must be billed with HCPCS code Z1032 and certifies that the recipient was seen within 16 weeks of her Last Menstrual Period (LMP). True or false?

Answer 1: True

Question 2: Enter the LMP date in _____ _____ on the *CMS-1500* claim form or in _____ _____ on the *UB-04* claim form.

Answer 2: Box 14, Box 80 Remarks

Question 3: To be reimbursed for modifier ZL, providers must add $56.63 to their usual and customary fee for Z1032. True or false?

Answer 3: True

Question 4: Modifier ZL is restricted to CPSP providers and will only be reimbursed _____ per recipient, per pregnancy

Answer 4: Once

Knowledge Review 2

Question 1: This code can only be billed if all _____ initial assessments and the initial pregnancy-related office visit code _____ are rendered within a _____-_____ _____.

Answer 1: Three, Z1032, four-week period

Question 2: The date of the last assessment must be shown as the date of service. True or false?

Answer 2: True

Question 3: Z6500 is reimbursable once in ____ _____ unless the provider certifies on the claim that the recipient has become pregnant again within the _____-_____ period.

Answer 3: Six months, six-month

Question 4: If fewer than three initial assessments are performed, or the initial assessments are not performed within four weeks of entry into care, you must bill the initial assessments separately. True or false?

Answer 4: True

Knowledge Review 3

Question 1: 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. True or false?

Answer 1: True

Question 2: The sequence for providing the initial assessments (nutrition, health education and psychosocial) and the initial pregnancy-related office visit code (Z1032) may be rendered in _____ _____ and at ____ _____ during the patient's care.

Answer 2: Any order; any time

Question 3: The provider must complete the initial assessment within the discipline area (nutrition, health education or psychosocial) _____ rendering any intervention services within that discipline.

Answer 3: Before

Knowledge Review 4

Question 1: Recipients who choose to participate in the CPSP program and receive CPSP services are required to _____ or _____ their SOC _____ _____ even if the obstetrical services are billed globally.

Answer 1: pay, obligate; each month; 15 minutes

Legend

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

Symbol	Description
*	Medical justification is required for these codes. See the Pregnancy: Early Care and Diagnostic Services (preg early) section in the appropriate Part 2 manual for applicable policy and billing information.
†	Refer to the *Abortions* (abort) section in the appropriate Part 2 manual for specific billing information
ǁ	Refer to the *Genetic Counseling and Screening* (gene coun) section in the Part 2 manual for applicable policy and billing information.
§	Refer to the *Pathology: Molecular Pathology* (path molec) section in the Part 2 manual for applicable billing with an appropriate diagnosis code.
‡	Refer to the *Pregnancy: Early Care and Diagnostic Services* (preg early) section in the appropriate Part 2 manual for applicable diagnosis and frequency billing restrictions.
+	Refer to the *Immunizations* (immune) section in the appropriate Part 2 manual for specific billing information.
€	For use only in high-risk situations while pregnant.
¦	Frequency limited to once per month.
£	Refer to the *Non-Injectable Drugs* (non inject) section in the appropriate Part 2 provider manual for specific billing information.
¥	Refer to the *Injections: Drugs A-D Policy* section in the appropriate Part 2 manual for specific billing information.
^	Refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 manual for specific billing information.
◊	The responsible party, the physician, is required to be certified, regardless of whether performing or merely supervising the ultrasound for nuchal translucency measurement
⌂	CDC Sexually Transmitted Diseases Treatment Guidelines 2015, MMWR 2015:64.
∞	There is a $14.99 claim limit for all contraceptive supplies dispensed onsite on a single date of service. Refer to the ***Drugs: Onsite Dispensing Price Guide*** section for the “Family PACT rate per unit.”

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