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 provide 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

‹‹**CBAS Codes and Rates for Emergency Remote Services**››

‹‹**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››

All codes are to be billed with revenue code 3103 (adult day care, medical and social, daily).

‹‹The above modifiers are defined as follows:

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

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

S5102 with a modifier should be used when any CBAS Emergency Remote Services is provided excluding Personal Care or Home Health Care services provided in the participant's home.

S5136 with a modifier should be used when only Personal Care is provided by CBAS in the participant's home.

Q5001 with a modifier should be used when only Home Health Care services are provided by CBAS in the participant's home.››

FQHC Codes

For specific billing codes for a CBAS center operated by a Federally Qualified Health Center (FQHC), refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* sections in this manual.

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. 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.››