

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE**

Policy/Procedure Number: CLPM-20		Lead Department: Claims	
Policy/Procedure Title: Community Based Adult Services (CBAS)		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 9/1/25		Next Review Date: 01/01/2026 Last Review Date:	
Applies to:	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> Employees
Reviewing Entities:	<input type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input checked="" type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD		<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> FINANCE <input type="checkbox"/> PAC
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING <input checked="" type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: <i>Lisa Malvo</i>			Approval Date: 9/1/25

I. RELATED POLICIES:

A. N/A

II. IMPACTED DEPTS:

A. Claims

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide, for providers, the general guidelines and billing requirements for CBAS services.

VI. POLICY / PROCEDURE:

CBAS is an outpatient facility-based program that delivers skilled nursing care, social services, therapeutic activities, personal care, family/caregiver training and support, nutrition services, and transportation to approved beneficiaries. The services are designed to prevent premature and unnecessary institutionalization and to keep recipients as independent as possible in the community.

Partnership is responsible for authorization and payment of CBAS services provided to members in all of Partnership's covered counties.

Partnership reimburses network CBAS providers an all-inclusive per member, per day of attendance rate.

1. Authorization:

All CBAS services require an approved Partnership TAR. Please refer to the Partnership Health Services Department policy for more information regarding the authorization process and requirements.

2. Codes:

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The following codes should be used when billing CBAS services:

HCPCS Code	Description
H2000	Comprehensive multidisciplinary evaluation
S5102	Day care services, adult; per diem
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter

3. Billing:

Claims are to be submitted to Partnership on a UB-04 claim form or electronically via the 837 format. For more information on how to get set up with Partnership for electronic billing, see CLPM-08 of this manual.

Claims must be billed with a Type of Bill (Box 4) of "0891" (Special Facility – Other, Initial Claim). All following claims must be billed with Type of Bill "089".

a. CBAS Regular Days are billed on the service lines as follows:

- 1) Revenue code 3103.
- 2) CBAS Regular Days as the description.
- 3) The specific date of service. Note: claims cannot be billed in the from/through billing format.
- 4) The corresponding HCPCS code for the service.
- 5) Service unit of "1".
- 6) Total billed charges for that date of service.

b. CBAS Carry-Over days are billed on the service lines as follows:

- 1) Revenue code 3103.
- 2) CBAS Carry-Over days as the description.
- 3) The specific date of service. Note: Claim cannot be billed in a from/through format. Each DOS must be billed on a separate line.
- 4) The corresponding HCPCS code for the service.
- 5) Service unit of "1".
- 6) Total billed charges for that date of service.

Note: For carry-over days, the appropriate medical necessity documentation must be entered in the Remarks field (Box 80) or as an attachment to the claim.

- c. Enter the NPI number of the CBAS center in the NPI field (Box 56).
- d. Enter the TAR number in the Authorization field (Box 63).
- e. Enter an appropriate ICD-10-CM code in Box 67.

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4. Billing Reminders:

- a. Verify eligibility.
- b. All services require an approved TAR.
- c. Submit your claims electronically or via paper.
- d. Claims cannot be billed in a from/through format.
- e. Partnership has a One Year Billing Limit.
- f. Claims must be billed with codes H2000, S5102, or T1023 only.

VII. REFERENCES:

A.

VIII. DISTRIBUTION:

A. PARTNERSHIP4ME PowerDMS Policies & Procedures

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Claims Department

X. REVISION DATES: 9/1/25