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.

![Figure 1: Combined Assessments and Initial Pregnancy-Related Office Visit Billed Within Four Weeks.](image-url)
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.

![Claim Form](image)

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

**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).
**Figure 5:** Correctly Filled Out TAR for Additional CPSP Services. Corresponds to the Claim on the Next Page.
**Figure 6:** Complete CMS-1500 Claim Form. Corresponds to TAR on Preceding Page.

Part 2 – Pregnancy: CPSP Billing Examples – CMS-1500
«Legend»

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

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