Community-Based Adult Services (CBAS)

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This section includes information about billing Community-Based Adult Services (CBAS) services. CBAS centers offer a package of health, therapeutic and social services in a community-based day health care program. Services are provided according to a six-month individual plan of care (IPC) developed by the CBAS center's multidisciplinary team (MDT) in collaboration with the CBAS participant or authorized representative(s). The services are designed to prevent premature and unnecessary institutionalization and to keep participants as independent as possible in the community.

Pursuant to the *California Code of Regulations* (CCR), Title 22, Section 54429 and the *Welfare and Institutions Code* (W&I Code); Section 14107.3, it is illegal for providers to solicit participants to change CBAS centers and/or to provide gratuities to persons for participant enrollment. All complaints received by the Department of Health Care Services (DHCS) or the California Department of Aging (CDA) regarding these practices will be referred to the Audits and Investigation Division in DHCS for investigation.

For CBAS questions and additional information, providers may call the Telephone Service Center at 1-800-541-5555, or refer to the following sections in this manual:

- For billing codes and reimbursement rates, refer to *the Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates* section.
- For UB-04 claim form billing examples, refer to the *Community-Based Adult Services (CBAS) Billing Examples* section.
- For TAR procedures and required attachments, refer to the *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section.

Definitions

The following definitions apply to the CBAS program under Medi-Cal. For any word not defined in this section of the manual, its standard meaning shall apply.

- "Activities of Daily Living" or "ADL" means activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation and transferring.
- "Additional Services" means those services specified in the CBAS provisions of the current Medi-Cal 1115(a) Waiver, entitled "California Medi-Cal 2020", or as modified in any successor waivers and include physical therapy, occupational therapy, speech therapy, behavioral health services, registered dietitian services and transportation. Such services are included in the CBAS all-inclusive rate of reimbursement and shall be provided to all eligible CBAS participants as needed and as specified on the participant's IPC.

- “Care Coordination” means the process of obtaining information from, or providing information to, the participant, the participant's family, the participant's primary health care provider or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as identified by one or more members of the multidisciplinary team.
- “Core Services” means those services specified in W&I Code, Section 14550.5. and the CBAS provisions of the current.
- Medi-Cal 1115(a) Waiver, entitled “California Medi-Cal 2020”, or as modified in any successor waivers and include professional nursing services, social services, personal care services, therapeutic activities and meal services. Such services are included in the CBAS all-inclusive rate of reimbursement and shall be provided to all eligible CBAS participants on each day of attendance at the CBAS center.
- “Facilitated Participation” means an interaction to support a participant's involvement in a group or individual activity, whether or not the participant takes an active part in the activity itself.
- “Group Work” means a social work service in which a variety of therapeutic methods are applied within a small group setting to promote participants' self-expression and positive adaptation to their environment.
- “Instrumental Activities of Daily Living” or “IADL” means functions or tasks of independent living, including medication management, hygiene, money management, accessing resources, meal preparation and transportation.
- “Meal Service” means services specified in W&I Code, Section 14550.5(d).
- “Personal Care Services” means those services specified in W&I Code, Section 14550.5(b)(1).
- “Personal Health Care Provider” means the participant's personal physician, physician's assistant or nurse practitioner, operating within their scope of practice.
- “Professional Nursing” means services provided by a registered nurse or licensed vocational nurse functioning within their scope of practice.
- “Professional Nursing Services” means those services specified in W&I Code, Section 14550.5(a).

- “Psychosocial” means a participant's psychological status in relation to the participant's social and physical environment.
- “Social Services” means those services specified in W&I Code, Section 14550.5(b)(2).
- “Therapeutic Activities” means services specified in W&I Code, Section 14550.5(c).

Provider Assistance

CBAS providers should contact the following agencies for questions about the CBAS program:

- ‹‹For *Treatment Authorization Request* (TAR) questions, contact the Los Angeles Medi-Cal Field Office, Integrated Systems of Care Division at (800) 541-5555.›› (For participants enrolled in Medi-Cal managed care, contact the participant’s Managed Care Plan [MCP].)
- For claims questions, call the Telephone Service Center (TSC) at 1-800-541-5555.
- ‹‹For questions related to certification of a CBAS center, call the CDA CBAS Bureau at (916) 419-7545.››
- For questions related to licensure of a center, call the California Department of Public Health, Central Applications Branch in Sacramento at (916) 552-8632.

Program Requirements

CBAS centers must provide all of the following services as specified on the participant’s IPC:

- Medical services (the personal health care provider may be separately reimbursed; the CBAS center staff physician may not be separately reimbursed)
- Core Services, as defined and specified in W&I Code, Section 14550.5 – provided each day of attendance and included in the CBAS center’s daily rate:
  - Professional nursing services (at least one of the following must be documented in the participant’s health record each day of attendance):
    - ❖ Observation, assessment, and monitoring of the participant's general health status and changes in their condition, risk factors, and the participant's specific medical, cognitive or mental health condition or conditions upon which admission to the CBAS center was based

- ❖ Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications and intervention, as needed, based upon the assessment and the participant's reactions to their medications
- ❖ Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms
- ❖ Supervision of the provision of personal care services for the participant, and assistance as needed
- ❖ Provision of skilled nursing care and intervention, within scope of practice, to participants, as needed, based upon an assessment of the participant, their ability to provide self-care while at the CBAS center and any health care provider orders

– Personal care services and/or social services (at least one of the following must be documented in the participant’s health record each day of attendance):

- ❖ Personal care services
  - Supervision of, and/or assistance with, activities of daily living or instrumental activities of daily living
  - Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior or wandering
- ❖ Social Services
  - Observation, assessment, and monitoring of the participant's psychosocial status
  - Group work to address psychosocial issues
  - Care coordination

- Therapeutic activities (at least one of the following must be documented in the participant's health record each day of attendance):
  - ❖ Group or individual activities to enhance the social, physical or cognitive functioning of the participant
  - ❖ Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities

  Note: The CBAS physical therapy and occupational therapy maintenance programs are considered part of *Therapeutic Activities*. The maintenance program hours count toward the CBAS center's minimum required therapy hours as specified in CCR, Title 22, Section 54423.
- One meal per day of attendance in accordance with CCR, Title 22, Section 54331, except for those participants receiving tube feedings or intravenous feedings who cannot eat food

  Note: A meal is to be offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or hydration. Special meals are to be provided when prescribed by the participant's personal health care provider.

- Additional services – provided as specified on the participant's IPC and included in the CBAS center's daily rate:
  - Physical therapy services provided by a licensed, certified or recognized physical therapist within their scope of practice. Pursuant to Section 1570.7(n) of the *Health and Safety Code* (H&S Code), physical therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team."

- Occupational therapy services provided by a licensed, certified, or recognized occupational therapist within their scope of practice. Pursuant to Section 1570.7(n) of the H&S Code, occupational therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team."
- Speech therapy services provided by a licensed, certified or recognized speech therapist or speech therapy assistant within their scope of practice to restore or improve function when there is an expectation that the participant's condition will improve significantly in a reasonable period of time as determined by the multidisciplinary assessment team.
- Registered dietitian services provided by a registered dietician within their scope of practice for the purpose of assisting the CBAS participant and caregivers with proper nutrition and good nutritional habits, nutrition assessment, and dietary counseling and education if needed.
- Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within their scope of practice. Pursuant to CCR, Sections 54325 and 78337 such licensed, certified, or recognized mental health professional includes a licensed psychiatrist, licensed psychologist, licensed clinical social worker, or an advanced practice mental health registered nurse within their scope of practice; or services provided by one of the following when in consultation with one of the above specified mental health professionals as listed: recognized psychiatric/psychological assistant; licensed marriage, family and child counselor; licensed marriage and family therapist; certified rehabilitation counselor or recognized associate clinical social worker within their scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified MCP, County Mental Health programs, or appropriate behavioral health professionals or services.

  Note: "In consultation with" is not meant to imply a supervisory relationship. All staff must remain within their scope of practice
- Transportation provided or arranged, to and from the CBAS participant's place of residence and the CBAS center, when needed.

Assessment and Transition Days

Assessment and transition days are defined as days of service at a CBAS center in which CBAS services are provided for two to four hours for potential participants who meet one or more of the following:

- For assessment days:
  - The participant requires assessment at the initial presentation to a CBAS center.
  - The participant requires re-assessment for admission to a new CBAS center when the participant chooses to attend a different center or must relocate from another CBAS center because of closure of the CBAS center, or because the participant's place of residence has changed or the caregiver(s) has moved.
  - The participant requires re-assessment after a prolonged absence from the center during which the TAR expired.

    Note: Ongoing reassessments of the participants are not considered "assessment days" as defined here. Ongoing reassessments should be conducted on a regular day of services.
- For transition days:
  - The participant requires a "trial" of CBAS services as part of the discharge plan from an institutional setting.
  - The participant requires a new "trial" of CBAS services as part of the discharge plan from an institutional setting when the first trial failed or was not completed, and the participant did not successfully transition from the institutional setting.
  - The participant requires a new "trial" of CBAS services as part of the discharge plan from an institutional setting when the participant has been readmitted to an institutional setting and is now ready for discharge again.

Assessment and transition days do not require authorization and may be billed directly via the claims system.

Notes:

- If the last assessment day and the first regular day of CBAS are the same day, the provider may bill for either the assessment day or the first regular day of CBAS services, but not both.
- For the Medi-Cal managed care member, the provider should contact the participant's MCP for instructions on assessment and transition days.

Provider Requirements

A prospective CBAS provider must first obtain an Adult Day Health Care (ADHC) license issued by the Department of Public Health and then be certified by the Department of Aging to participate in the Medi-Cal program.

CBAS providers must comply with the following requirements:

- CBAS Special Terms and Conditions (STC) and Standards of Participation (SOPs) of the current Medi-Cal 1115(a) Demonstration Waiver, entitled Medi-Cal 2020, or as modified in any successor waivers,
- State statutes and regulations:
  - California *Health and Safety Code* (H&S Code), Division 2, Chapter 3.3
  - California *Welfare and Institutions Code* (W&I Code), Division 9, Chapter 8.7
  - *California Code of Regulations* (CCR), Title 22, Division 3; AND
  - CCR, Title 22, Division 5
- Federal Home and Community-Based Settings requirements specified in the *Code of Federal Regulations* (CFR), Title 42, section 441.301(c)(4):
  - The setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving Medi-Cal Home and Community-Based Services.
  - The setting must ensure that the individual selected the CBAS center from among setting options, including non-disability specific settings. The setting options must be identified and documented in the person-centered service plan and must be based on the individual's needs and preferences.
  - The setting must ensure an individual's rights of privacy, dignity, respect and freedom from coercion and restraint.
  - The setting must optimize but not regiment individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
  - The setting must facilitate individual choice regarding services and supports, and who provides them.

- Federal Home and Community-Based Person-Centered Planning requirements specified in the CFR, Title 42, section 441.301(c)(1) through (3)

Existing ADHC laws and regulations will continue to remain in effect until such time as they are updated and republished. DHCS retains the right to change these requirements at a later date as necessary. DHCS will provide advance notice should these requirements be modified.

Note: CBAS providers are strongly urged to become familiar with the above-listed statutes, regulations and 1115(a) Medi-Cal Demonstration Waiver. The extensive information contained in these references cannot be completely duplicated in this provider manual.

Personal Health Care Provider

Pursuant to W&I Code, Section 14526.1, a completed history and physical (H&P), including a request for CBAS services signed by the participant's personal health care provider, shall be maintained in the participant's health record.

Pursuant to W&I Code, Section 14528.1, the personal health care provider shall have and retain responsibility for the participant's care. The CBAS center’s physician may not complete the H&P if the participant has a personal health care provider at the time the information is due.

If the participant is enrolled in Medi-Cal managed care, the CBAS center has the responsibility to communicate directly with the participant’s MCP and follow all managed care instructions regarding obtaining information from the participant’s personal health care provider.

If the participant does not have a personal health care provider during the initial assessment process to determine eligibility for CBAS services, the CBAS center staff physician may conduct the initial H&P for the participant. The CBAS center shall make all reasonable efforts to assist the participant in establishing a relationship with a personal health care provider. If the participant is enrolled in Medi-Cal managed care, the CBAS center has the responsibility to work with the participant's MCP to assist the participant in locating a personal health care provider and establishing a relationship with them.

If the CBAS center or the participant's MCP is unable to locate a personal health care provider for the participant, or if the participant refuses to establish a relationship with a personal health care provider, the CBAS center shall do both of the following:

- Document the lack of a personal health care provider relationship in the participant's health record.
- Continue to document all efforts taken to assist the participant in establishing a relationship with a personal health care provider, including efforts to work with the participant's MCP.

A personal physician for one or more of a CBAS center's enrolled participants may serve as the CBAS center staff physician. When a personal physician serves as the staff physician, the physician shall have a personal health care services arrangement with the CBAS center that meets the criteria set forth in Section 1395nn(e)(3)(A) of Title 42 of the United States Code.

A personal care physician, a CBAS staff physician, or an immediate family member of the personal care physician or CBAS staff physician, shall comply with ownership interest restrictions as provided under Section 654.2 of the Business and Professions Code.

Eligible Recipients

To be eligible for CBAS services, recipients must meet the following eligibility and medical necessity criteria:

- The individual must be Medi-Cal eligible and 18 years of age or older.
- The individual must be enrolled in a Medi-Cal MCP unless the individual is not eligible to enroll in managed care.
- The individual must meet the specified medical criteria of any one or more of the following categories:
  - **Category 1**: Nursing Facility-A (NF-A) level of care or above:
    - ❖ Has been determined by DHCS to meet the NF-A level of care or above, and
    - ❖ Meets eligibility and medical necessity criteria contained in Sections 14525(a), (c), (d) and (e); 14526.1(d)(1), (3), (4) and (5); and 14526(e) of the W&I Code (summarized in a. through e. below):
      - The individual is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner or other health care provider has, within their scope of practice, requested CBAS services for the person.
      - The individual requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health or mental health professional to improve, stabilize, maintain or minimize deterioration of the medical, cognitive or mental health condition.
      - The individual requires CBAS services, as defined in W&I Code, Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the CBAS program to support the individual and their family or caregiver in the living arrangement of their choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing nursing or continuous nursing care.
      - Any individual who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through CBAS, placement to a more costly institutional level of care would be likely to occur.

- Except for individuals residing in an ICF/DD-H, the individual must meet all of the following:
  - The individual has one or more chronic or post-acute medical, cognitive or mental health conditions that are identified by the individual's personal health care provider as requiring one or more of the following: monitoring, treatment or intervention, without which the individual's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization.
  - The individual's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
    - The individual lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
    - The individual resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the individual.
    - The individual has family or caregivers available, but those individuals require respite to continue providing sufficient and necessary care or supervision to the individual.
  - A high potential exists for the deterioration of the individual's medical, cognitive or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization or other institutionalization if CBAS services are not provided.
  - The individual's condition or conditions require CBAS services, on each day of attendance that are individualized and designed to maintain the ability of the individual to remain in the community and avoid emergency department visits, hospitalizations or other institutionalization.

- **Category 2**: Organic, acquired or traumatic brain injury and/or chronic mental disorder:
  - ❖ Has been diagnosed by a physician as having an organic, acquired or traumatic brain injury, and/or has a chronic mental disorder; AND
  - ❖ Meets CBAS eligibility and medical necessity criteria specified above in A.2.; AND
  - ❖ Demonstrates a need for assistance or supervision with at least:
    - Two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene; or
    - One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.
- **Category 3**: Alzheimer's disease or other dementias:
  - ❖ Individuals have moderate to severe Alzheimer's disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease (see guide to stages below):
    - Stage 5: Moderately severe cognitive decline. Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential.
    - Stage 6: Severe cognitive decline. Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities.
    - Stage 7: Very severe cognitive decline. This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement; AND
  - ❖ Meets CBAS eligibility and medical necessity criteria specified above in A.2.

- **Category 4**: Mild cognitive impairment including Alzheimer's disease or other dementias:
  - ❖ Individuals have mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease, characterized by one or more of the following:
    - Decreased knowledge of recent events
    - Impaired ability to perform challenging mental arithmetic
    - Decreased capacity to perform complex tasks
    - Reduced memory of personal history
    - The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations; AND
  - ❖ Meets CBAS eligibility and medical necessity criteria specified above in A.2.; AND
  - ❖ The individual must demonstrate a need for assistance or supervision with two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.
- **Category 5**: Developmental disabilities:
  - ❖ Meets the criteria for regional center eligibility; AND
  - ❖ Meets CBAS eligibility and medical necessity criteria specified above in A.2.

CBAS Eligibility Determination

Determination of eligibility for CBAS includes all of the following:

- An initial face-to-face (F2F) review by a registered nurse with level of care determination experience. The eligibility determination shall be performed by the individual's MCP, or by DHCS or its contractor(s) for individuals exempt from managed care.
- The initial F2F review is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses.
- Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every 12 months for individuals determined by the MCP as clinically appropriate.
- Reauthorization of CBAS services shall be granted when the eligibility and medical necessity criteria specified above have been met and the individual's condition would likely deteriorate if the CBAS services were denied.
- Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by an MCP requires a F2F review.

Note: The manner in which determination is made regarding whether or not the individual meets the eligibility and medical necessity criteria for CBAS authorization may vary between fee-for-service and managed care, and from one MCP to another MCP. It is the CBAS provider's responsibility to be familiar with and compliant with DHCS and MCP processes for determination of eligibility for CBAS services.

Billing Carry-Over Days

CBAS services are authorized per calendar month for up to six months, or for up to 12 months for individuals determined by the MCP to be clinically appropriate. Providers may bill for up to the number of days approved on the TAR for the specified month. In addition, up to four (4) carry-over days may be billed per month.

A separate claim is not required when billing carry-over days. They may be billed on the same claim as other CBAS services for that month following the same “single-line” billing guidelines as defined in the *Community-Based Adult Services (CBAS) Billing Examples* section of the Part 2 manual. The date of service for the carry-over service should reflect the day the participant actually received the service. For reimbursement guidelines and additional information about carry-over days, providers may refer to the *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section in the Part 2 manual.

Carry-over days may be billed only after all other authorized service days have been exhausted for the current month and may not be billed during the first month of an authorized TAR period. In addition, when billing carry-over days, appropriate medical necessity documentation must be provided on or with the claim form as stated in the *Community-Based Adult Services (CBAS): IPC and TAR Form Completion* section in the Part 2 manual.

Reimbursement: Other Health Coverage/Medicare

CBAS services provided to fee-for-service participants are exempt from Other Health Coverage (OHC) requirements and are not covered by Medicare. Providers may bill Medi-Cal directly.

PACE, PLTCCM

CBAS services that are part of a Program for All-inclusive Care for the Elderly (PACE), or Primary Long Term Care Case Management (PLTCCM) projects, are reimbursed at the capitated rate for each project. For more information about MCPs, refer to the *MCP: An Overview of Managed Care Plans* section in the Part 1 manual.

FQHCs and RHCs

CBAS centers owned and operated by clinics designated as Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) are reimbursed at the same rate as all other CBAS centers.

Billing Procedures

For those participants in fee-for-service Medi-Cal, CBAS services for each participant are billed on the UB-04 claim form. For those participants enrolled in an MCP, providers should contact that plan for billing procedures information.

When preparing and submitting a claim, follow instructions in the

UB-04 Completion: Outpatient Services section and refer to *the Community-Based Adult Services (CBAS) Billing Examples* section. Items specific to CBAS should be completed as follows:

- Enter “O/P MEDI-CAL” in the Payer field (Box 50).
- Enter facility type code “89” (special facility – other) as the first two digits in the *Type of Bill* field (Box 4). The third digit in the *Type of Bill* field is a frequency code. For original CBAS claims, the frequency code is “1.” Enter the type of bill code as “891” for original claims.

Note: Type of bill codes are defined by the National Uniform Billing Committee (NUBC). Instructions for developing type of bill codes are found in the *National Uniform Billing Data Element Specifications* manual.

- Enter the appropriate service code in the HCPCS/Rates field (Box 44). Refer to “CBAS Codes and Rates” in the *Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates* section of this manual.
- Enter revenue code “001” to reflect the total charges (Box 42). Refer to the *UB-04 Completion: Outpatient Services* section of this manual for more information.
- Use the approved Medi-Cal rate when computing the *Total Charges* (Box 47).
- For initial assessment days without subsequent attendance, enter the reason for non-attendance in the *Remarks* field (Box 80) of the claim.
- For transition days, enter in the Remarks field of the claim that the *Physician Authorization/Medical Information* form is on file at the center.
- Leave fields 82 and 83 blank.

‹‹For ASC X12N 837 v.5010 claim billing, the specific dates of service must be entered in the *Remarks Record*.››

‹‹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.