REVISED

CODING & BILLING GUIDANCE DOCUMENT

Maternal Health

September 27 & 28, 2017

This webinar content will follow the Coding & Billing Guidance Document, Part II, version 5 June 2017, pages 48-58, in addition to resources provided by the WHB-Maternal Health Section and DMA Clinical Coverage Policies.

Methods of reimbursement

- Medicaid for Pregnant Women (MPW)
- Regular Adult Medicaid
- Presumptive Eligibility
- Third Party Insurance
- Self-pay

Details on how billing for each of these options is handled should be outlined in the health department Fee & Eligibility Policies & Procedures.

Health Departments that do not provide full scope OB care must bill for antepartum services using the following:

Antepartum* Package Services codes:

- 59425 - Antepartum care only, 4-6 visits
- 59426 visits. Antepartum care only, 7 or more Package vs Individual service billing

*Antepartum means "before birth." The antepartum period is also called the prenatal period. The antepartum period begins when a woman's pregnancy is diagnosed and ends once the baby is born.

Antepartum Services

- Antepartum services (use of E/M codes) are covered if

a. A pregnancy is diagnosed as high risk **and** requires more than the "normal amount" of services
   - Every 4 weeks for the first 24 weeks of gestation
   - Every 2-3 weeks until the 36th week of gestation
   - Weekly from 36th week until delivery or

b. Antepartum care is initiated less than three months before delivery, or

c. Patient is seen by a Physician or Advanced Practice Practitioner between one (1) and three (3) office visits as specified in **Clinical Coverage Policy- Obstetrics** located at: https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf

Antepartum Services

- ICD-10 diagnostic codes beginning with "O" are frequently used with high risk pregnancies that are billed using individual E/M codes
  - It may still be appropriate to bill an antepartum package (59425, 59426) for a patient with a high risk diagnosis ("O" codes)
  - ICD-10 Diagnostic codes in the "Z" and "O" categories may be billed together in some instances and is acceptable
  - Codes Z34.0 – Z34.9 (normal pregnancy codes) may be billed with appropriate "O" codes

Antepartum Services

- **Self-pay patients** seeking prenatal care from a LHD should be **billed using the appropriate E/M codes** and if applicable, the appropriate sliding fee (SFS). If the patient receives "presumptive Medicaid coverage" for any period during the pregnancy, those visits and services that are covered by Medicaid cannot be billed to the patient.

Non-High Risk and High Risk

- If there was no pre-defined high-risk diagnosis, then the termination of pregnancy date should be used as the end date/delivery date. This low risk pregnancy may be billed with a package code if four or more visits were completed before the termination. If less than four visits were provided an E/M code can be billed for each visit.
- If the patient was previously diagnosed with a high risk this pregnancy all visits could be billed with E/M codes, *provided the documentation supports high-risk status based on the diagnosis and more than "normal" number of visits for the patient's gestational age.

OB modifier

- If your agency keys Prenatal Visits as reportable services and uses the OB modifier (so they can be pulled out of the Medicaid Cost Study), the OB modifier goes on all services including labs that are included in the package billing, per the Medicaid Consultant NC Alliance for Public Health (Steven Garner).
- If the labs are included in the package billing code, then "yes" they need an OB modifier.
- If the labs are not included in the package billing code and Medicaid pays for them separately, then "no" they do not need an OB modifier

Modifier -24 Complications of Pregnancy, Unrelated Issues

- If a patient develops complications of pregnancy or the provider treats the patient for an **unrelated problem,** these visits are excluded from the maternity global package and can be reported separately. Append modifier -24 *Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues. Modifier -24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package

Modifier -24 Complications of Pregnancy, Unrelated Issues

- Dependent upon the payor, services billed using this modifier + unrelated diagnostic codes may only be paid after the global, package, and/or delivery has been billed
    - Consult specific payors for guidance

Pregnancy Medical Home

- Pregnancy Medical Home (PMH) services are defined as managed care services to provide obstetric care to pregnant Medicaid beneficiaries with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care. Remember that PMH services must be billed under a rendering Physician or Advanced Practice Practitioner identified on the CCNC contract.

Billing for PMH services

- **Incentive code S0280**: Physician or Advanced Practice Practitioners shall bill this incentive code after the pregnancy risk screening tool has been completed.
- **Incentive code S0281**: Physician or Advanced Practice Practitioners shall bill this incentive code after the postpartum visit is completed. The Physician or Advanced Practice Practitioner billing S0281 must be the same Physician or Advanced Practice Practitioner that bills the postpartum visit. DMA will only pay this incentive if an OB package code that includes postpartum care is billed. **In order for Physician or Advanced Practice Practitioners to receive reimbursement for incentive code S0281, they must bill within 60 days of the date of delivery.**

OB package and global codes that include postpartum care

- **59400** – Global fee-Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care;
- **59510** – Global fee-Routine obstetric care including antepartum care, cesarean delivery, and postpartum care;
- **59410** – Postpartum package-Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care;
- **59515** – Postpartum package- Cesarean delivery only; including postpartum care, ***or***
- **59430** – Postpartum care only (separate procedure**). typically used by most health departments due to not providing delivery.**

PMH Billing Scenario 1

- Patient who received a bilateral tubal ligation at the time of delivery returns to the LHD within 60 days of delivery for her postpartum visit in the Maternal Health (MH) clinic. There is no contractual arrangement for the LHD to bill for the delivery. Therefore, the LHD bills **59430** for the postpartum package and **S0281** for the PMH postpartum incentive, along with diagnosis code **Z39.2**. (AF modifier no longer required – do not use or you will not be paid). Service must be billed under the rendering physician name on the Pregnancy Medical Home contract with Community Care of NC (CCNC).
- If after 60 days postpartum, HCPCS code S0281 will not be reimbursed but the patient may return for the postpartum visit using CPT code 59430 under MPW until the end of the month that the 60th postpartum day falls.

PMH Billing Scenario 2

- Patient returns to LHD within 60 days of delivery for her postpartum visit. She needs to begin a contraceptive method and is seen in the Family Planning (FP) Clinic. Patient receives a Depo-Provera injection. LHD bills **59430** for the postpartum package, **S0281** for the PMH postpartum incentive with diagnosis code **Z39.2.** The depo injection **J1050 FP UD** billed with diagnosis **Z30.013** (initial injection) or **Z30.42** (surveillance of injection if the depo was provided at the hospital post-delivery).

PMH Billing Scenario 3

- Patient returns to LHD within 60 days of delivery for her postpartum visit. Patient has an IUD inserted at the postpartum visit in the FP Clinic. The LHD can bill **59430**, **S0281** and **codes for the contraceptive device and insertion**. Billing is as follows:
- Does not require "25" modifier with the insertion code (58300) when 59430 is billed because 59430 is a package code.
- The **FP UD** modifiers must be used on the contraceptive device if the LHD is using 340 B stock. **FP** modifier would be used on the insertion code 58300.

PMH Billing Scenario 3 (continued)

- The Physician or Advanced Practice Practitioner must include an appropriate diagnosis code for the contraceptive method and method counseling.
- LHD bills **59430** for the postpartum package and **S0281** for the postpartum incentive with ICD-10 **Z39.2**. Also bill **58300 FP** for the IUD insertion with ICD-10 of **Z40.30** and the appropriate HCPCS code for the IUD. (**J7300 FP UD** for the ParaGard IUD, **J7301 FP UD** for the Skyla IUD, **J7297 FP UD** for the Liletta IUD **J7298 FP UD** for the Mirena IUD, **Q9984 FP UD** Kyleena)

PMH Coverage Period

- **Postpartum Care Services:** Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs based on

DMA Clinical Coverage Policy 1E-5"Obstetrics" located at

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf

- This is when MPW coverage ends. Beneficiaries in other categories of Medicaid coverage may still be able to receive postpartum follow-up care after the end of the month which the 60th postpartum day occurs.

Additional Clarification- end of Postpartum coverage

- **The MPW coverage extends to the last day of the month in which the 60th postpartum day falls**.

  Example: Patient delivers a baby on May 15, 2017. 60th postpartum day is July 14, 2017. MPW coverage extends through July 31, 2017. A postpartum exam that occurs on or before July 31, 2017 will be covered by MPW.

Additional Clarification- end of Postpartum coverage

- The postpartum incentive code, S0281, is only paid for postpartum visits that occur **within 60 days postpartum**. In the example above, if the patient is seen for her postpartum visit on July 10th, the PMH practice can bill for the 59430 postpartum package AND the S0281 incentive code. If, however, the patient is not seen for her postpartum visits until July 20th, the 59430 postpartum package would be covered because the MPW extends through to the last day of the month in which the 60th postpartum day occurs, but the S0281 would not be covered because the patient was more than 60 days postpartum at the time of the postpartum visit.

Postpartum care after termination of pregnancy

- The patient is eligible through the postpartum period without a redetermination of eligibility.
- The postpartum period is at least 60 days following termination of the pregnancy **for any reason.**
- The postpartum period ends on the last day of the month in which the 60th day falls.
  - For example, the delivery occurs on June 10. The postpartum period ends on August 31.

Postpartum care after termination of pregnancy

- Exceptions to the postpartum eligibility are:
  a. The patient moves to another state with the intent to live there on a permanent basis.
  b. The patient is undocumented, they are only eligible for emergency services.
  c. The patient is found eligible only for presumptive eligibility.
  d. The patient applies after the termination of the pregnancy
     - income exceeds the MPW Poverty Level
     - MAF-M

Smoking and Tobacco Use Cessation and Counseling

- Physicians, Advanced Practice Practitioners and Health Departments can bill DMA for services using the following CPT codes:
  - 99406 – Intermediate visit (3-10 minutes)
  - 99407 – Intensive visit (over 10 minutes)
- These CPT codes can be billed "incident to" the physician by the following professional specialties:

-Licensed psychologists
-Clinical social workers
-Marriage/family counselors
-Advanced practice practitioners
-Certified clinical supervisors
-Psychological associates
-Professional counselors
-Clinical addiction specialists
-Clinical Nurse Specialists
-Registered Nurses

Smoking and Tobacco Use Cessation and Counseling

- In order for RNs to bill for tobacco cessation screening and counseling the following requirements apply:
  1. **Complete a qualified 5A's tobacco cessation training program.** A list of training options is available by contacting the Tobacco Prevention and Control Branch at http://www.tobaccopreventionandcontrol.ncdhhs.gov/ A list is also included at the end of this presentation.
  2. **Provide a Certificate of Training Completion** to their agency. The agency is responsible for maintaining this list for audit purposes.
  3. **Operate Under Standing Orders** – Each LHD must develop Standing Orders. A sample template for Standing Orders is available at http://www.ncpublichealthnursing.org/publications.htm#so or contact your Women's Health Regional Nurse Consultant.

RhoGam & 17P

- If RhoGam and 17P are administered during a routine prenatal visit, then the agency may bill the therapeutic injection code (96372) and the HCPCS code for RhoGam [RhoGam (J2790- full dose or J2788 - partial dose) or 17P CPT code for Makena (Q9986) – Brand new guidance as of 07/2017 or CPT code for Compound (Generic) Q9985 – Brand new guidance as of 07/2017
-]. If the agency received the 17P free it cannot be billed to the patient or third-party payor. Only bill for 17P if the agency is purchasing the medication.

RhoGam & 17P

- If the agency is billing a Pregnancy Medical Home package or global code for services, **report the office visit with the "OB" modifier and only bill the injection code and the medication specific CPT code.**
- If the patient is self-pay, or Medicaid is billed using individual E/M codes, the agency can bill the office visit (E/M code), **OR** a therapeutic injection and the vaccine code. Self-pay patients should be billed on SFS.

RhoGam & 17P

- The agency may bill a 99211 CPT code if a nursing assessment is completed along with the 17P medication
  - CPT code for Makena (Q9986) – Brand new guidance as of 07/2017
  - CPT code for Compound (Generic) Q9985 – Brand new guidance as of 07/2017

- If there is not documentation to support a nursing assessment, then bill a therapeutic injection fee (96372) and the 17P medication (Q9986 or Q9985), whichever is applicable.

Injections for agencies that are not the prenatal care provider

- For LHDs that do not provide prenatal care or are not the assigned PMH, but administer 17P by physician order, services delivered may be billed. The 17P medication cannot be billed to the patient or third-party payor if received free by the LHD. Only bill for 17P if the agency is purchasing the medication.

RhoGam & 17P (continued)

- The health department cannot bill a prenatal package code (59425 or 59426) if the RN provided multiple visits for 17P injections with documentation to support billing a 99211 CPT code. This service must be billed with the 99211 CPT code each visit because the agency is not the assigned prenatal care provider. The 17P medication is also billed at each visit if purchased by the health department. Again, the therapeutic injection (96372) and 99211 CPT codes cannot be billed on the same day of service

Vaccines administered during prenatal care or during the postpartum period

The only vaccines that are recommended to be routinely administered during prenatal care are Influenza and Tdap. These vaccines may be billed during a routine prenatal visit (E/M codes) using the following guidance:

- Bill administration CPT code 90471 or 90472 and
- Bill vaccine CPT code per immunization program rules and
- Bill or report the office visit E/M CPT as appropriate

- Self pay patients should be billed on the sliding fee scale

Vaccines administered during prenatal care or during the postpartum period

- If the agency is billing a Pregnancy Medical Home package or global code for services, **report the office visit (E/M CPT code) using the "OB" modifier and only bill the vaccine administration code and the immunization specific code.**

Vaccines administered during prenatal care or during the postpartum period

- MMR and Varicella are both **only administered** postpartum as they are live vaccines. If the postpartum visit is provided in FP or MH it is required that staff assess for immunization compliance and refer to immunization clinic for recommended vaccines.

Additional Resources

- **For additional program guidance please contact your Regional Maternal Health Consultant or visit the program website at http://whb.ncpublichealth.com/**
- **Clinical Coverage Policy- Obstetrics 1E-5**
  - https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf
- **Clinical Coverage Policy- Pregnancy Medical Home 1E-6**
  - https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E6_1.pdf
- **Fetal Surveillance 1E-4**
  - https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E4_1.pdf
- **Additional guidance on coding & billing is contained in the following document Maternal Health Billing and Coding Webinar - May 12, 2017 located at N.C. DPH: WHB: Training**

Tobacco Cessation Counseling Training Resources

- **On-Line Training Resources**
- Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic (free)
- Counseling for Change: An Online Tobacco Cessation Course ($20)
- http://www.rxforchange.ucsf.edu/ (free)
- **"A Guide for Counseling Women Who Smoke"**
- This manual outlines the components of the tobacco cessation best practice 5A's Smoking Cessation Counseling Method. The manual is available for download at http://whb.ncpublichealth.com/docs/2016-GuideforCounselingWomenWhoSmoke.pdf .
- A DVD entitled, "**Counseling from the Heart" is** a companion piece to the Guide. You can access the video at:
- Part 1: https://www.youtube.com/watch?v=iPmMp6Eqtvk
- Part 2: https://www.youtube.com/watch?v=wWiwb5RbLzI
- Part 3: https://www.youtube.com/watch?v=4A4ZR7O3AD0