Maternity & OBGYN Billing FAQ

FAQs compiled from the Maternity & OBGYN Billing Webinar held Tuesday, December 14, 2021.

Q: Can you please review the Consent for Sterilization Form process?

A: Providers must complete the following steps when submitting a MSA-1959 or HHS-687:

- Complete a cover sheet according to Document Management Portal instructions.
- Fax the cover sheet and completed consent form to Medicaid Payments Division, Sterilization Consent Form Approval. Do not fax invoices.
- Wait for a response. MDHHS will notify the submitter of the status of their consent review within seven business days. When notified that the consent form has been accepted and is on file, inform other providers via a copy of the response.
- Providers may then submit claims (either electronic or hard copy) to MDHHS. The Remarks section or Comment Record must include the statement "Consent on File."
- When sterilization claims are received with this information in the Remarks section, the claim is forced for payment if the submitted invoice matches the consent form on file.

If there is no response from MDHHS within five working days, review the request submitted to insure that MDHHS received the fax (i.e., confirm that the fax is working, make sure the cover sheet included the necessary provider contact information, etc.) and resend the information if necessary.
For additional information, refer to the Medicaid Provider Manual, chapter 4.6 Procedure for Submitting the Consent for Sterilization Form.

Q: FQHC's received a File Transfer Application (FTA) memo from August 2020 which stated that the Date of Service for antepartum care only should be the delivery date and not the to and from dates of the prenatal visits. Does the information in this presentation supersede that memo?

A: Clinics should continue to bill following the guidelines in the provider alert from August of 2020. For additional information, please review the August 25, 2020: Clinic Antepartum Only Services provider alert.

Q: How should c-section twins be billed?

A: Per NCCI Guidelines, if multiple infants were delivered by cesarean delivery, providers should report the appropriate CPT code for the cesarean delivery (global maternity care or cesarean delivery only) on line one. When the delivery was

significantly more difficult than usual, modifier 22 (Increased Procedural Service) may be appended to the delivery code. When modifier 22 is appended, documentation must support the substantial additional work and the reason for the additional work, such as:

- Increased intensity or time
- Increased technical difficulty of performing the procedure
- Severity of the patient's condition
- Increased physical and mental effort required

Providers should attach a copy of the medical records with the claim that supports the procedures performed and must use a diagnosis code that represents the multiple birth. For additional information, please refer to the Medicaid Provider Manual, chapter 6.15 Maternity Care Services.

Q: Can we complete the MSA-2218 after the procedure is done?

A: No, the MSA-2218 Acknowledgement of Receipt of Hysterectomy Information must be completed with the beneficiary, and the beneficiary must be advised that the sterilization will not be performed for at least 30 days (but within 180 days) after signing the MSA-1959/HHS-687 except in cases of emergency abdominal surgery or premature delivery.

Q: Regarding FQHC NST billing and provider same-day visits: can both be billed since the NST is outside the OB package?

A: Clinics will only receive one PPS rate per date of service per beneficiary. All services rendered on the same date must be reported on one claim form; if the claim reflects a face-to-face encounter and has the appropriate payment code and visit code, the claim will be reimbursed at the PPS rate minus the primary payment. There is no additional payment that would be made for the NST since it is rendered on the same date.

Q: When billing out 59410 (vaginal delivery with postpartum), is there any criteria that needs to be taken into consideration? Can providers bill out delivery and then add antepartum visits to the claim? And would this be the same for Rural Health Clinics billing globally?

A: 59410 is Obstetrical care and can be billed separately or within the global code, depending on the services that are provided by each medical group. Rural Health Clinics (RHC's) should continue to bill as they have been in regard to the antepartum care. For additional information or specific scenario questions, please contact Provider Support by e-mail at ProviderSupport@Michigan.gov or by phone at 1-800-292-2550.

Q: How should a provider bill twins where one was delivered via c-section and one vaginal?

A: If one infant is delivered vaginally and one or more delivered by cesarean, report the appropriate CPT code for the cesarean delivery (global maternity or cesarean delivery only) on line one, and the appropriate CPT code for the vaginal delivery (delivery-only) on line two. It is appropriate in this instance to append modifier 51 (Multiple Procedures) to the vaginal delivery code. For additional information, please refer to the Medicaid Provider Manual, chapter 6.15 Maternity Care Services.

Q: Can a provider bill global delivery codes to Medicaid, and not need to split bill?

A: Providers do not need to split bill if all services were provided by the single office or medical group. For additional information or specific scenario questions, please contact Provider Support by e-mail at ProviderSupport@Michigan.gov or by phone at 1-800-292-2550.

Q: If billing non global care (example: 59409) and the patient has medical issues post-partum from delivery at the same hospitalization, can a separate E&M code be billed?

A: High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus, and therefore require more services than those provided in a routine pregnancy. When high-risk pregnancies require more visits than described for routine obstetrical care and more laboratory data than normally required, the additional services are covered in addition to the global obstetrical package. If beneficiary visits are required due to conditions unrelated to the pregnancy, they are also covered in addition to the global obstetrical package. Medicaid follows CPT guidelines for reporting high-risk pregnancy services.

Q: What does DMP stand for?

A: DMP is the Document Management Portal, found under the External Links drop-down menu in CHAMPS. Providers use the DMP to submit medical documentation electronically which is required for claims processing. For additional information, please review the available Document Management Portal (DMP) resources on the CHAMPS >> External Links webpage.

Q: Is a TCN number required in billing?

A: No, a Transaction Control Number (TCN) is not required to bill. Submitted claims are assigned a TCN after the claim has been received by Medicaid to confirm receipt of the submission of the claim. The TCN can then be used for future tracking and status inquiry purposes.

Q: If billing a global package, should providers bill with delivery date only? Or first date seen to the delivery date?

A: MDHHS advises billing with delivery date only, however it is possible in some instances for the claim to pay either way. For additional information or specific scenario questions, please contact Provider Support by e-mail at ProviderSupport@Michigan.gov or by phone at 1-800-292-2550.

Q: When will the 2022 Fee Schedule be uploaded?

A: The Fee Schedule is generally uploaded by the end of the first quarter of each year. MDHHS encourages providers to check the Provider Specific Information page for updates.

Q: Are the documents from the presentation available for download/printing?

A: A recording of the presentation is available for review on the Medicaid Provider Trainings webpage along with downloadable resources from the presentation.