Posted August 15, 2023

Billing Guidelines for Changes to Maternity Care Reimbursement

Effective October 1, 2023

Purpose:

In accordance with the Bipartisan Budget Act of 2018, effective October 1, 2023, practitioners rendering services to women with a diagnosis of pregnancy are required to bill a participant's private insurance carrier for all maternity services, when applicable, prior to billing the Department. As a result, coding/billing changes are required to align as closely as possible with commercial payers, particularly at it relates to billing global maternity care, for instances when customers have primary third-party liability (TPL) sources. This billing transition applies to customers covered under both Medicaid fee-for-service (FFS) and HealthChoice Illinois (HCI) managed care organization (MCO) plans.

Global Maternity Care Billing Description:

The global obstetric (OB) care package is a complete one-time billing structure that includes professional services for the provision of prenatal care visits and the delivery. The global OB care period begins on the date of the initial prenatal visit. *Global OB billing methodology will apply only to customers with primary TPL*.

General Billing Guidelines:

- The visit which confirms a pregnancy is not part of the global OB care package. This visit should be billed separately using an appropriate level office/other outpatient evaluation and management visit code.

- Global OB care billing methodology applies only when services are billed to primary TPL sources using this coding methodology.

- When the customer has Medicaid primary, providers must continue to bill individual maternity care service codes as described below, taking note of the coding changes effective October 1, 2023. This includes Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Encounter Rate Clinics (ERCs) billing a medical encounter.

- When billing global OB care codes, the date of service is the delivery date. Reimbursement for global OB care is inclusive of the customer's antepartum care and the delivery when rendered by the same provider or provider group.

- Claims submitted for global OB codes must be billed along with the initial prenatal visit code 0500F to capture the date of the initial prenatal visit for Health Effectiveness Data and Information Set (HEDIS) measure reporting purposes. **Procedure*:*** bill the initial prenatal visit code 0500F **with no modifier** on a separate service line of the same claim containing the appropriate global OB care code. Reimbursement for the 0500F service line will be $0, as payment for the initial prenatal care service is inclusive of reimbursement of the global OB code.

- Postpartum care must be billed separately from global OB procedure codes using the individual postpartum care code, even if primary TPL considers the postpartum care inclusive of the global OB code. The Department has chosen to carve out postpartum care visits from global OB care for the purposes of capturing information needed for HEDIS measures and accurately reimbursing postpartum visit bonus payments when applicable.

- Services unrelated to pregnancy should continue to be documented and billed separately with the appropriate evaluation & management code. The condition/diagnosis unrelated to the pregnancy, allowing the service as separately payable, should be the primary diagnosis code on the claim. These evaluation & management visits should ***not*** be billed with the U5 modifier. The U5 modifier should be used only to identify a subsequent prenatal care visit and distinguish it from other types of visits.

- For maternity care already in progress on the October 1, 2023 effective date of this billing transition:
    - Providers should continue billing for antepartum care and the delivery using individual maternity service codes, taking note of the coding changes as described below, when Medicaid is primary.
    - Providers must void any paid prenatal visit claims billed to HFS primary when the delivery occurs on/after October 1, 2023 and the provider is required to bill the TPL source(s) using global OB care coding. The provider may bill HFS following adjudication by all applicable TPL sources.

Global OB Care Billing:
*As a reminder, these codes are billable only when Medicaid is not primary.

59400 – Routine obstetric care, including antepartum care and vaginal delivery (with or without episiotomy and/or forceps)

59510 – Routine obstetric care, including antepartum care and cesarean delivery

59610 – Routine obstetric care, including antepartum care and vaginal delivery (with or without episiotomy and/or forceps) after previous cesarean delivery

59618 – Routine obstetric care, including antepartum care and cesarean delivery following attempted vaginal delivery after previous cesarean delivery

Postpartum Care Billing:
*Please note, coverage of 0503F will be discontinued effective 10/01/2023 in lieu of CPT 59430 for billing of a postpartum care visit.

59430 - Postpartum care code

Postpartum care begins after the customer is discharged from the hospital stay for delivery and extends throughout the postpartum period of 12 months. The provider is allowed to bill for a second postpartum visit, effective 10/8/2021, per the December 21, 2021 provider notice, though should adhere to the coding changes addressed in these billing guidelines effective October 1, 2023.

As a reminder, postpartum bonus payments were introduced effective January 1, 2023. In accordance with the February 21, 2023 provider notice, bonus payments will be reimbursed at a rate of $75 per visit and are dependent upon reporting of the actual delivery date on the postpartum visit claim. Providers must include the actual delivery date in Loop 2300, Segment DTP*454 'Initial Treatment Date', of the 837P, or via Direct Data Entry (DDE) in MEDI. The provider is eligible for bonus payments if a postpartum visit occurs within the first 26 days following the delivery date, and/or if a postpartum visit occurs within 27-89 days following the delivery date, as reported on the claim. Each of these time periods will have a limit of one payable bonus payment. Payment of a bonus payment for the 27-89 days post-delivery time period is not dependent upon there having been a payment during the first 26-days post-delivery time period. For instances when more than one claim is received during the same time period, the bonus payment will be reimbursed on the first claim received.

Individual Maternity Service Billing:

This billing methodology must be used when Medicaid is primary. In some cases, maternity services may also be billed separately using individual maternity service codes when the patient has TPL and must bill the primary payer source(s) using individual maternity service codes. For example:

- When multiple providers who are not in the same provider group render maternity services
- When the pregnancy ends early (e.g., miscarriage or premature delivery with less than four antepartum visits)
- Antepartum care only
- Delivery service only

0500F with U4 modifier – Initial prenatal care visit
The U4 modifier will drive reimbursement for the initial prenatal care visit when not inclusive of global OB care. **The U4 modifier may not be used when billing global OB care codes.**

Appropriate level office/other outpatient evaluation & management visit code, with the U5 modifier* - Subsequent prenatal care visits

The U5 modifier must be used to identify the E/M visit code as a prenatal care visit and will drive reimbursement at the increased prenatal care rate effective January 1, 2023 per the February 21, 2023 provider notice. Any Maternal Child Health add-ons applicable to these E/M visit codes will also be reimbursable.

59409 - Vaginal delivery only (with or without episiotomy and/or forceps)

59514 - Cesarean delivery only

59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)

59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

59430 - Postpartum care

Global OB Codes used with Multiple Births:

To accurately capture the work performed, billing and coding need to be specific to every gestation.

1) **Vaginal delivery:**
    a. Baby #1: Submit using the global OB CPT code appropriate for vaginal delivery, as well as the initial prenatal care code 0500F with no modifier and $0 charge on the same claim.
    b. Baby #2 and beyond: Submit using the unlisted procedure code with the applicable description “twin, triplet, etc.” in the NTE segment of the electronic 837P. A separate service line using the unlisted procedure code and applicable description should be submitted for each multiple delivery.

2) **Cesarean delivery:**
    a. Baby #1 and beyond: Submit **(*only once)** using the global OB CPT code appropriate for cesarean delivery, as well as the initial prenatal care code 0500F with no modifier and $0 charge on the same claim.

3) **Vaginal delivery, followed by Cesarean delivery:**

    If one baby is delivered vaginally and the other(s) by cesarean section, bill the correct code for each delivery type with separate charges in the following manner, and *attach both delivery reports to the claim*.
    a. Baby #1: Submit using the individual maternity procedure code appropriate for vaginal delivery only, as well as the initial prenatal care code 0500F with no modifier and $0 charge on the same claim.
    b. Baby #2 and beyond: Submit **(*only once)** using the global OB CPT Code appropriate for cesarean delivery.

Note*:* Cesarean delivery codes should be reported only once regardless of the number of babies delivered.

Multiple Births Submitted as Individual Maternity Care Services:

When global OB care billing is not applicable, maternity services are separately billed using individual maternity service codes.

1) **Vaginal delivery:**
    a. Submit for baby #1 using the individual maternity procedure code appropriate for vaginal delivery only. Submit for baby #2 and beyond using the unlisted procedure code and a separate service line for each additional baby. Enter the description “twin, triplet, etc.” in the NTE segment of the electronic 837P.

2) **Cesarean delivery:**

a. Baby #1 and beyond: Submit **(*only once)** using the individual maternity service code appropriate for cesarean delivery only.

3) **Vaginal delivery, followed by Cesarean delivery:**

If one baby is delivered vaginally and the other(s) by cesarean section, bill the correct code for each delivery type with separate charges in the following manner, and *attach both delivery reports to the claim*.

a. Baby #1: Submit using the individual maternity procedure code appropriate for vaginal delivery only.

b. Baby #2 and beyond: Submit **(*only once)** using the individual maternity procedure code appropriate for cesarean delivery.

Note*:* Cesarean codes should be reported only once regardless of the number of babies delivered.

Quality Reporting:

The Department requires quality tracking in accordance with HEDIS guidelines. Providers must report three (3) HEDIS measures:

1. **Initial Prenatal Visit date** – recorded as the date of service billed as CPT 0500F.
   Note: When billing individual maternity care codes, 0500F must be billed as an individual maternity service with the U4 modifier for separate reimbursement.

   When billing global OB care due to TPL requirements, 0500F must be billed with no modifier and $0 charge on the same claim as the applicable global OB code. The 0500F service line will pay at $0 but allow capture of the initial prenatal visit service date for HEDIS measures.

2. **Delivery date** – recorded as the date of service billed with the delivery code.

3. **Postpartum Care date** – recorded as the date(s) of service billed with the postpartum care code.