

To:
Federally Qualified
Health Centers
Nurse Midwives
Nurse Practitioners
Physician Assistants
Physicians
Rural Health Clinics
HMOs and Other
Managed Care
Programs

Wisconsin Medicaid provides options for providers submitting claims for obstetric services

Effective for dates of service (DOS) on and after January 1, 2003, providers submitting claims for obstetric (OB) services provided to Medicaid recipients may choose to submit claims for either the separate components or total (global) OB services.

Effective for dates of service (DOS) on and after January 1, 2003, Wisconsin Medicaid offers providers choices of how and when to file claims for obstetric (OB) care. Providers may choose to submit claims using either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the DOS.

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery. The exception to this rule is in the case of multiple births, where more than one delivery may be reimbursed (see “Delivery” section for details).

Separate obstetric care components

Providers should use the following guidelines when submitting claims for separate OB components.

Antepartum care

Antepartum care includes dipstick urinalysis, routine exams and recording of weight, blood pressure, and fetal heart tones.

Providers should refer to the table that follows as a guide for submitting claims for a specific number of antepartum care visits. Providers should provide all antepartum care visits before submitting a claim to Wisconsin Medicaid.

Providers should use local procedure codes W6000 — “antepartum care; initial visit” — and W6001 — “antepartum care; two or three visits” — when submitting claims for the first through third antepartum care visits with a provider or provider group. For example, if a

This Update provides claims submission instructions for obstetric (OB) services, including:

- Submitting claims using either separate component or global OB procedure codes.
- Services included in the reimbursement rate of each component.
- Services excluded from the reimbursement rate of OB services and separately reimbursable by Wisconsin Medicaid.
- Submitting claims for complications of OB care.
- Submitting claims for unrelated services provided during the OB period.
- Requesting adjustments for pregnancies with an unusually high number of antepartum visits.
- Submitting fee-for service claims when Medicaid HMOs or other insurance reimburses part of the care.

| Antepartum care claims submission guide | | | |
|---|-----------------|--------------------------------------|----------|
| Total visit(s) | Procedure code* | Description | Quantity |
| 1 | W6000 | Antepartum care; initial visit | 1.0 |
| 2 | W6000 | Antepartum care; initial visit | 1.0 |
| | W6001 | Antepartum care; two or three visits | 1.0 |
| 3 | W6000 | Antepartum care; initial visit | 1.0 |
| | W6001 | Antepartum care; two or three visits | 2.0 |
| 4-6 | 59425 | Antepartum care only; 4-6 visits | 1.0 |
| 7+ | 59426 | 7 or more visits | 1.0 |
| *Claims for these codes should be submitted with the following types of service (TOS): <ul style="list-style-type: none"> • Physicians, physician assistants, and nurse practitioners use TOS "2." • Assistant surgeons during delivery use TOS "8." • Nurse midwives use TOS "9." | | | |

total of two to three antepartum care visits is performed, the provider should indicate procedure code W6000 and a quantity of "1.0" for the first DOS. For the second and third visits, the provider should indicate procedure code W6001 and a quantity of "1.0" or "2.0," as indicated in the table above. The date of the last antepartum care visit is the DOS.

Note: Do not use evaluation and management procedure codes when submitting claims for the first three antepartum care visits. Use of these codes may result in improper reimbursement.

Similarly, for *Current Procedural Terminology* (CPT) codes 59425 — "antepartum care only; 4-6 visits" — and 59426 — "antepartum care only; 7 or more visits" — the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed "1.0."

Occasionally, a provider may be unsure of whether a recipient has had previous antepartum care visits with another provider. If the recipient is unable to provide this information, the provider should assume the first time he or she sees the recipient is the first antepartum visit.

Note: Reimbursement for procedure codes W6000, W6001, 59425, and 59426 is limited to once per pregnancy, per recipient, per billing provider. A telephone call between patients and providers does not qualify as an antepartum visit.

Delivery

Delivery includes patient preparation, placement of fetal heart or uterine monitors, insertion of catheters, delivery of the child and placenta, injections of local anesthesia, induction of labor, and artificial rupture of membranes.

Providers who perform vaginal or cesarean deliveries may submit claims using the appropriate delivery codes. A clinic or group may submit claims for the delivery component separately and should indicate the provider who performed the delivery as the performing provider, rather than the primary OB provider.

When there are multiple deliveries (e.g., twins, triplets), providers should submit one claim for all of the deliveries. On the first detail line of the HCFA 1500 claim form, indicate the appropriate procedure code for the first delivery. Indicate additional births on separate detail lines of the claim form, using the appropriate delivery procedure code for each delivery. Wisconsin Medicaid does not recognize the CPT modifiers "-51" or "-22."

When there are multiple deliveries (e.g., twins, triplets), providers should submit one claim for all of the deliveries.

In accordance with the standards of the American College of Obstetricians and Gynecologists, postpartum care includes both the routine post-delivery hospital care and an outpatient/office visit.

Induction or inhibition of labor

Pitocin drip and tocolytic infusions are not separately reimbursable when provided on the date of delivery. Induction or inhibition of labor are only reimbursable when physician services are documented in the medical record and when performed on dates other than the delivery date. The service is indicated using CPT code 59899 — “Unlisted procedure, maternity care and delivery” — with supporting documentation attached to the claim.

Postpartum care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

Wisconsin Medicaid reimbursement for postpartum care includes hospital *and* office visits following vaginal or cesarean delivery. In accordance with the standards of the American College of Obstetricians and Gynecologists, postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting claims for postpartum care, the DOS is the date of the post-hospital discharge office visit. To receive reimbursement, the recipient *must* be seen in the office. The length of time between a delivery and the office postpartum visit should be dictated by good medical practice. Wisconsin Medicaid does not dictate an “appropriate” period for postpartum care; however, the industry standard is six to eight weeks following delivery. A telephone call

between patients and providers does *not* qualify as a postpartum visit.

Delivery and postpartum care

Providers who perform both the delivery and postpartum care may use either the separate delivery and postpartum codes or the delivery including postpartum care CPT procedure codes 59410, 59515, 59614, or 59622, as appropriate. The DOS for the combination codes is the delivery date. However, if the recipient fails to return for the postpartum visit, the provider must adjust the claim to reflect delivery only or the reimbursement will be recouped through audit.

Global obstetric care

Providers may continue to submit claims using global OB codes. Providers choosing to submit claims for global OB care must perform all of the following:

- A minimum of six antepartum visits.
- Vaginal or cesarean delivery.
- The post-delivery hospital visit and a minimum of one postpartum office visit.

When submitting claims for total OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS. Refer to the Attachment of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable OB procedure codes. All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global OB care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery

procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider must adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the patient's medical record. (Refer to the section on postpartum care.)

Group claims submission for global obstetric care

When several OB providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and postpartum care to the same recipient during the period of pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. When submitting the claims, providers should indicate the group Medicaid billing number and identify the primary OB provider as the performing provider.

Separately covered pregnancy-related services

Services that may be reimbursed separately from the global or component obstetrical services include:

- Administration of RH immune globulin.
- Amniocentesis, chorionic villous sampling, and cordocentesis.
- Epidural anesthesia. (Refer to the Physician Services Handbook for epidural anesthesia claims submission information.)
- External cephalic version.
- Fetal biophysical profiles.
- Fetal blood scalp sampling.
- Fetal contraction stress and non-stress tests.
- Harvesting and storage of cord blood.
- Insertion of cervical dilator.

- Laboratory tests, excluding dipstick urinalysis.
- Obstetrical ultrasound and fetal echocardiography.
- Sterilization. (Refer to the Physician Services Handbook for sterilization limitations.)
- Surgical complications of pregnancy (e.g., incompetent cervix, hernia repair, ovarian cyst, Bartholin cyst, ruptured uterus, or appendicitis).

Unusual pregnancies

Providers treating recipients whose pregnancies require more than the typical number of antepartum visits or result in complications during delivery may seek additional reimbursement by submitting an Adjustment Request Form. The provider should include a copy of the medical record and/or delivery report specifying the medical reasons for the extraordinary number of antepartum or postpartum visits. A medical consultant will review the materials and determine the appropriate level of reimbursement.

Wisconsin Medicaid does not recognize the CPT “-22” modifier.

Complications of pregnancy

Complications of pregnancy or delivery, such as excessive bleeding, pregnancy-induced hypertension, toxemia, hyperemesis, or premature (not-artificial) rupture of membranes, and other complications during the postpartum period may all be reported and reimbursed separately from obstetrical care. The nature of these complications should be fully documented in the patient's medical record.

Providers treating recipients whose pregnancies require more than the typical number of antepartum visits or result in complications during delivery may seek additional reimbursement by submitting an Adjustment Request Form.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at www.dhfs.state.wi.us/medicaid/.

Unrelated conditions

Any evaluation and management services performed that are related to the pregnancy are included in reimbursement for obstetrical care. However, conditions unrelated to the pregnancy may be separately reimbursed by Wisconsin Medicaid. These include:

- Chronic hypertension.
- Diabetes.
- Management of cardiac, neurological, or pulmonary problems.
- Other conditions (e.g., urinary tract infections) with a diagnosis other than complication of pregnancy.

Health Personnel Shortage Area incentive reimbursement

All OB procedure codes are eligible for the Health Personnel Shortage Area (HPSA) incentive reimbursement. Submit claims indicating the appropriate HPSA modifier “-HP” or “-HK” to receive a 50% bonus incentive. Refer to the Medicine and Surgery section of the Physician Services Handbook for further information.

Other insurance/private pay prior to Wisconsin Medicaid eligibility

Wisconsin Medicaid OB payments apply only to services provided while the person is eligible as a Medicaid recipient. Services provided prior to Wisconsin Medicaid eligibility are not included in the number of antepartum visits, the delivery, or postpartum care.

Fee-for-service recipients subsequently enrolled in a Medicaid managed care program

Wisconsin Medicaid will reimburse the equivalent of one global OB fee per recipient, per delivery, per single provider or provider

group, whether the reimbursement is made through fee-for-service or through a Medicaid managed care program.

When a recipient who is initially eligible for fee-for-service Medicaid enrolls in a Medicaid managed care program during her pregnancy and receives care from the same provider or clinic when eligible for Medicaid fee-for-service and when enrolled in a Medicaid managed care program, her provider may be paid a global fee by the managed care program after fee-for-service has paid for antepartum care. The provider is then required to submit an adjustment(s) to have the fee-for-service Medicaid payment recouped.

If the provider does not submit the adjustment(s) in this situation, Wisconsin Medicaid will recoup the fee-for-service payment(s) through audit. If the recipient receives less than total OB care while enrolled in the Medicaid managed care program, Wisconsin Medicaid reimburses her provider no more than the global maximum allowable fee or the sum of the individual components for services. Wisconsin Medicaid will, on audit, recoup any amount paid under fee-for-service that is above the global fee or the combined maximum allowable fee for the services if billed separately.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

ATTACHMENT

Medicaid-allowable obstetric services procedure codes

Wisconsin Medicaid covers the following local and *Current Procedural Terminology* (CPT) procedure codes for obstetric care.

| Procedure code | Description |
|--|---|
| Local codes | |
| W6000 | Antepartum care; initial visit |
| W6001 | Antepartum care; two or three visits |
| CPT codes* | |
| 59400 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care |
| 59409 | Vaginal delivery only (with or without episiotomy and/or forceps); |
| 59410 | including postpartum care |
| 59412 | External cephalic version, with or without tocolysis |
| 59414 | Delivery of placenta (separate procedure) |
| 59425 | Antepartum care only; 4-6 visits |
| 59426 | 7 or more visits |
| 59430 | Postpartum care only (separate procedure) |
| 59510 | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care |
| 59514 | Cesarean delivery only; |
| 59515 | including postpartum care |
| 59610 | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery |
| 59612 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); |
| 59614 | including postpartum care |
| 59618 | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery |
| 59620 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; |
| 59622 | including postpartum care |
| <p>*Claims for these codes should be submitted with the following types of service (TOS):</p> <ul style="list-style-type: none"> • Physicians, physician assistants, and nurse practitioners use TOS "2." • Assistant surgeons during delivery use TOS "8." • Nurse midwives use TOS "9." | |