ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Nurse Midwives, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

New and Clarified Claim Submission Policy for Nurse Midwife Services

This *ForwardHealth Update* provides new and clarified claim submission policy for nurse midwife services effective for claims and claim adjustments received on and after August 1, 2014, regardless of the date of service. This policy is being updated to reflect correct coding as described in the *Current Procedural Terminology* (CPT) code book.

This *ForwardHealth Update* provides new and clarified claim submission policy for nurse midwife services effective for claims and claim adjustments received on and after August 1, 2014, regardless of the date of service (DOS). This policy is being updated to reflect correct coding as described in the *Current Procedural Terminology* (CPT) code book.

For complete policy for nurse midwife services, providers should refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov/*. The Nurse Midwife and Physician service areas of the Online Handbook are being updated to reflect information in this *Update* and to simplify or consolidate information where appropriate. For reimbursement rate information, providers should refer to the applicable maximum allowable fee schedule on the ForwardHealth Portal.

Submitting Claims or Claim Adjustments for Separate Obstetric Care Components

When a provider does not meet the requirements to use global obstetric procedure codes on claims or claim adjustments for obstetric services, the provider is required to submit claims or claim adjustments for obstetric services as separate obstetric care components.

Claims or Claim Adjustments for Antepartum Care Visits

When submitting claims or claim adjustments for antepartum care as separate obstetric care components, the provider is required to use the following guidelines based on the number of antepartum care visits rendered:

- If the provider renders **three or fewer** antepartum care visits, the provider is required to submit a separate claim/claim detail (or adjustment) for **each** visit as follows:
  - ✓ Use the appropriate **evaluation and management (E&M) service code** representing the place of service (POS) and visit level.
  - ✓ Include modifier TH (Obstetrical treatment/services, prenatal or postpartum) with the E&M service code.
  - ✓ Indicate the quantity as "1.0."
  - ✓ Indicate the date of the visit as the DOS.
- If the provider renders **four to six** antepartum care visits, the provider is required to submit one claim/claim detail (or adjustment) covering **all** visits as follows:
  - ✓ Use the **antepartum care code** 59425 (Antepartum care only; 4-6 visits).
  - ✓ Indicate the quantity as "1.0."
  - ✓ Indicate the date of the last antepartum care visit as the DOS.

- If the provider renders **seven or more** antepartum care visits, the provider is required to submit one claim/claim detail (or adjustment) covering **all** visits as follows:
  - ✓ Use the **antepartum care code** 59426 (Antepartum care only; 7 or more visits).
  - ✓ Indicate the quantity as "1.0."
  - ✓ Indicate the date of the last antepartum care visit as the DOS.

The Attachment of this *Update* provides a table summarizing these guidelines.

Claims or Claim Adjustments for Multiple Deliveries

When there are multiple deliveries (e.g., twins or triplets), one claim or claim adjustment must be submitted for all of the deliveries as follows:

- On the first detail line of the claim or claim adjustment, the provider is required to indicate the appropriate global obstetric procedure code or delivery-only procedure code for the first delivery.
- The provider is required to indicate additional births on separate detail lines of the claim or claim adjustment, using the appropriate delivery-only procedure code for each subsequent delivery.

Correct Modifier to Use for Nurse Midwife Assistant at Surgery

Under certain circumstances, it is appropriate for a nurse midwife to be an assistant at surgery. In these circumstances, the nurse midwife is required to use modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) on the claim or claim adjustment to indicate his or her portion of the surgical assistance services provided. Wisconsin Medicaid reimburses surgical assistance services at 20 percent of the reimbursement rate allowed for the provider of the surgical procedure. Refer to the applicable fee schedule on the Portal for reimbursement amounts.

Nurse Midwife Services Provided in a Member's Home

Certain nurse midwife services may be provided in a member's home. Providers are reminded to follow CPT guidelines and report only services appropriate for the POS indicated on the claim or claim adjustment.

Note: Effective for claims and claim adjustments received on and after August 1, 2014 (regardless of DOS), providers should no longer use E&M office visit codes for antepartum care services provided in a member's home. Providers are required to use E&M home services codes 99341 through 99350 for E&M services provided in a member's home.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT
Submitting Claims or Claim Adjustments for Antepartum Care as Separate Obstetric Care Components

The table below summarizes the guidelines for submitting claims or claim adjustments for antepartum care as separate obstetric care components (to be used when the provider does not meet the requirements to use global obstetric procedure codes).

Total Antepartum Care Visits	Procedure Code to Submit	Allowable Modifier(s)	Quantity to Indicate	Date of Service to Indicate
1-3 (submit separate claim/claim detail for each visit)	Appropriate E&M service code representing place of service (e.g., home, clinic) and level of care	• TH (Obstetrical treatment/services, prenatal or postpartum) • TJ (Program group, child and/or adolescent) • AQ (Physician providing a service in a HPSA)	1.0	Date of visit
4-6 (submit one claim/claim detail covering all visits)	59425 (Antepartum care only; 4-6 visits)	AQ	1.0	Date of last antepartum care visit
7+ (submit one claim/claim detail covering all visits)	59426 (Antepartum care only; 7 or more visits)	AQ	1.0	Date of last antepartum care visit