


Purpose/Objectives

This webinar is in an effort to clarify billing/coding expectations within Maternal Health clinical services being provided in Local Health Departments (LHD).

Objectives

- Review current Division of Medical Assistance (DMA) billing/coding guidance
- Review current Pregnancy Medical Home (PMH) billing/coding guidance
- Re-emphasize Women's Health Branch (WHB) Memo dated 5/16/16



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Sliding Fee Scale (SFS)/Encounter Forms

SFS

- Maternal Health programs include all services funded in whole/part by maternal health dollars (from the WHB) such as:
 - Healthy Mothers, Healthy Children (Title V)
 - State Funds
 - Other special grants to provide a service
- The fee for service must slide to 0%

Encounter Forms

- All services provided should be indicated on the Encounter Form whether reportable or billable
- Due to edits/audits related to the National Correct Coding Initiative
 - The practice of billing a 99211, "establishes" the patient
 - A subsequent office visit can only be billed using an established patient E/M code



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Examples of Coding & Billing


Scenario 1

A patient initiates care at the LHD's prenatal clinic. Patient has never been seen at the LHD and the intake visit is performed by a nurse. The nurse codes the encounter as a nurse visit – 99211 and codes for standard laboratory samples to be collected under a standing order.

When the patient returns to clinic for her initial Obstetrical exam, which is the correct way to code for this visit?

A. Code the visit as a new comprehensive E/M visit - 99204, since this is the patient's first visit with the provider.


B. Code the visit as an established comprehensive E/M visit - 99215, since the patient was established to the LHD at the initial intake visit with the nurse.



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Scenario 1

B. Code the visit as an established comprehensive E/M visit - 99215, since the patient was established to the LHD at the initial intake visit with the nurse.



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Example


Scenario 2

A patient initiates care at the LHD's prenatal clinic. Patient has never been seen at the LHD and the intake visit is performed by a nurse. The nurse codes the encounter for standard laboratory sample collection (by standing order) only.

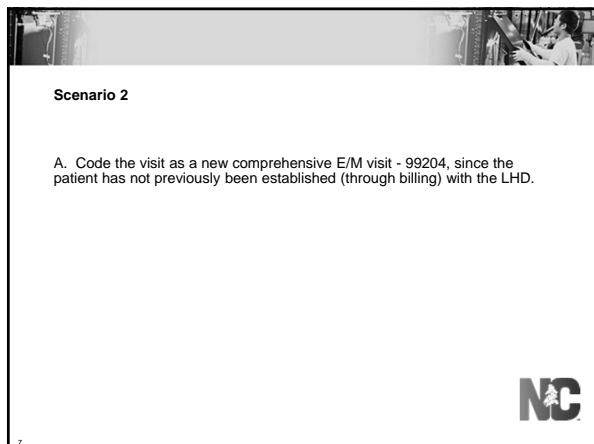
When the patient returns to clinic for her initial Obstetrical exam, which is the correct way to code for this visit?

A. Code the visit as a new comprehensive E/M visit - 99204, since the patient has not previously been established (through billing) with the LHD.

B. Code the visit as an established comprehensive E/M visit – 99215, since the patient was previously seen at the initial intake visit by a nurse.



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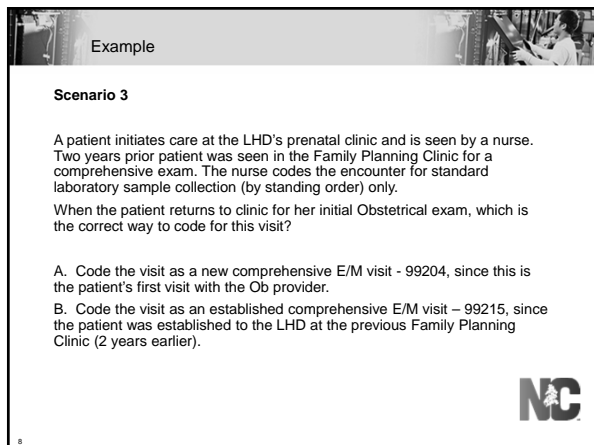


Scenario 2

A. Code the visit as a new comprehensive E/M visit - 99204, since the patient has not previously been established (through billing) with the LHD.

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Example

Scenario 3

A patient initiates care at the LHD's prenatal clinic and is seen by a nurse. Two years prior patient was seen in the Family Planning Clinic for a comprehensive exam. The nurse codes the encounter for standard laboratory sample collection (by standing order) only.

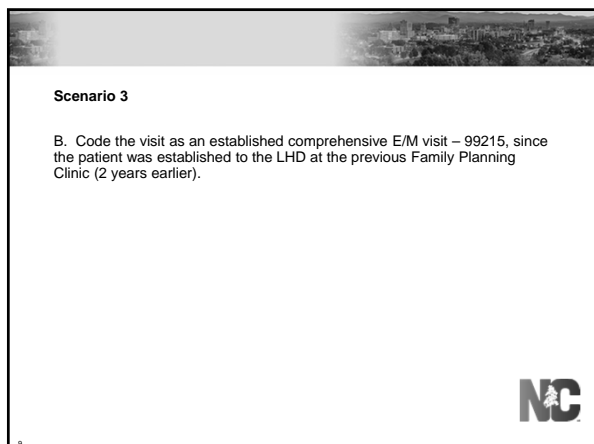
When the patient returns to clinic for her initial Obstetrical exam, which is the correct way to code for this visit?

A. Code the visit as a new comprehensive E/M visit - 99204, since this is the patient's first visit with the Ob provider.

B. Code the visit as an established comprehensive E/M visit - 99215, since the patient was established to the LHD at the previous Family Planning Clinic (2 years earlier).

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Scenario 3

B. Code the visit as an established comprehensive E/M visit - 99215, since the patient was established to the LHD at the previous Family Planning Clinic (2 years earlier).

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Example


Scenario 4

A patient initiates care at the LHD's prenatal clinic. Patient has never been seen at the LHD for prenatal care. This visit is performed by a nurse who codes the encounter using standard laboratory sample collection CPT codes (by standing order) only. A nurse office visit (99211) is not coded. Four years prior patient was seen in the Family Planning Clinic for a comprehensive exam.

When the patient returns to clinic for her initial Obstetrical exam, which is the correct way to code for this visit?

A. Code the visit as a new comprehensive E/M visit – 99204, since the patient has not been seen by a provider in the agency in the previous 3 years.


B. Code the visit as an established comprehensive E/M code 99215, since the patient was established to the LHD at the previous visit in the Family Planning Clinic.



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Scenario 4


A. Code the visit as a new comprehensive E/M visit – 99204, since the patient has not been seen by a provider in the agency in the previous 3 years.



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Standing Orders & Enhanced Role Registered Nurses (ERRN)


- Standing orders
 - Must follow the North Carolina Board of Nursing (NCBON) template, found at the Public Health Nursing website
 - www.ncpublichealthnursing.org/publications.htm
- Orders must be in place for a nurse to provide and/or order medical services
- The only level of Evaluation/Management (E/M) service that may be billed by an RN is 99211
- Billing private party payors, other than Medicaid
 - Ensure compliance is being met with the guidelines consistent with the specific insurer's supervision and "incident to" definitions
- ERRNs must be in compliance with training & rostering



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Childbirth Education


- Childbirth Education Classes
 - Refer to **NC DMA Clinical Coverage Policy 1M2 Childbirth Education**
<https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1m2.pdf>
 - Provider must have childbirth education training as specified in the policy
 - Use HCPCS code S9442
 - Maximum of 4 hours per day
 - Can be billed up to 10 hours of instruction per patient/pregnancy
- Group Prenatal Care (PNC) (i.e., CenteringPregnancy®)
 - Currently does not have specific coding distinguishing that it is "group"
 - Proceed with using the traditional care schedule of coding for individual patients' provider visits
 - Bill for childbirth education in addition to PNC if group PNC sessions meet the NC DMA requirements for Childbirth Education



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



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Tobacco Cessation and Counseling/Skilled Nurse Home Visits

- Registered nurses in LHDs may also bill incident to the physician
 - RN must have a standing order to provide and bill for these services
 - They must have attended a certified smoking cessation counseling training
 - See the "Tobacco Cessation" section of the DPH website at <http://www.publichealth.nc.gov/lhd/> for a sample standing order and billing information
- Tobacco cessation counseling may be billed in addition to the package or global fee for PNC
- Skilled Nurse Home Visits
 - Follow requirements in **NC DMA Clinical Coverage Policy 1M-6**
 - Rendered by an RN skilled in Maternity Care
 - Bill using HCPCS Code T1001




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Forms of Payment

Prenatal patients may have LHD services paid for in a variety of ways:


- Full Medicaid Coverage
 - Benefits and services available to patients during and beyond the parameters of pregnancy
- Presumptive Eligibility (PE) – is short term, limited prenatal coverage to ensure access to care while the Medicaid application is being processed
 - PE covers the following services:
 - Ambulatory antepartum care
 - Pharmacy
 - Laboratory
 - Diagnostic tests
 - Agencies should complete PE at the time of the positive pregnancy test or at the first PNC visit even if the patient indicates the application for Medicaid/Medicaid for Pregnant Women has been completed
 - Services rendered during the PE period may not be billed to the patient



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Forms of Payment


- Medicaid for Pregnant Women (MPW)
 - Patients who do not qualify for full Medicaid coverage (i.e., coverage that extends beyond the pregnancy period) may be eligible for MPW, which covers a broad range of healthcare services
 - Covers care for condition(s) that may complicate a pregnancy and the postpartum period
 - Pregnant patients enrolled in any category of Medicaid, including MPW are exempt from co-pays for medical care and prescriptions
 - Coverage ends on the last day of the month in which the 60th postpartum day occurs



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Forms of Payment

- Private party insurance
 - Billed at 100% of the charge
 - If the LHD has a contract with the insurance carrier the remaining balance (minus copays) is to be billed to the patient based on where they fall on SFS
 - If there is no contract with the insurance carrier, then the full amount of services rendered will fall on SFS (copay deduction not required)
 - Bill using E/M or Package codes in accordance with the payors billing guidance
- Self Pay
 - Charges assessed based on financial eligibility
 - Patients should be billed using the E/M codes & SFS




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Billing for Antepartum Care

NC DMA Clinical Coverage Policy 1E-5:


- LHDs that do not bill for delivery services, **must** bill for antepartum services provided to patients who are seen according to the traditional care schedule using the following guidance:
- Antepartum Package Services codes are based on number of visits
 - 59425 – Antepartum care only, 4 - 6 visits
 - 59426 – Antepartum care only, 7 + visits
- LHD that provide delivery services are eligible to bill using global codes that include delivery



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Billing for Antepartum Care

- An uncomplicated pregnancy follows this traditional care schedule as described in **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1:**
 - Every 4 weeks for the first 28 weeks of gestation
 - Every 2- 3 weeks until the 36th week of gestation
 - Weekly from the 36th week of gestation until delivery
- The patient may be seen more frequently than the traditional care schedule if the provider determines and documents that the patient and/or pregnancy warrants additional care
- <http://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf>




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Billing for Antepartum Care

NC DMA Clinical Coverage Policy 1E-5, Section 3.2.2:


- Individual Antepartum Services (use of E/M codes) are covered if:
 - Documentation supports the pregnancy as High Risk (based on diagnosis) AND requires more than the traditional care schedule of services for gestational age; OR
 - Antepartum care is initiated less than (3) months prior to delivery; OR
 - Patient is seen for only (1 - 3) office visits
- ICD-10 diagnostic codes beginning with "O" are frequently used with high risk pregnancies that are billed using individual E/M codes



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Billing for Antepartum Care


- 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



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**Billing for Antepartum Care - 24
Modifier Issues Unrelated to Pregnancy**

- If the provider treats a patient for a problem unrelated to the pregnancy, these visits are excluded from the maternity package and can be billed separately
- Append Modifier 24 Unrelated E/M service by the same provider during the prenatal period to all E/M services that address unrelated issues as to alert the payor
- The order of diagnostic codes for billing is as follows:
 - First -> Unrelated pregnancy DX code
 - Second -> Z33.1 Pregnancy state, incidental
- 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




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**Billing for Antepartum Care -24
Modifier, Example**

A maternal health patient presents to the LHD clinic with an Upper Respiratory Infection. The patient is seen by a provider and treated.

- The visit may be billed outside the prenatal package using an appropriate E/M code with the -24 modifier and the following diagnostic codes:
 - First -> Unrelated pregnancy DX code (code to describe the URI)
 - Second -> Z33.1 Pregnancy state, incidental




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Billing for Antepartum Care – Therapeutic Injections

RhoGam or 17 Alpha-Hydroxyprogesterone caproate (17P) provided during the course of PNC

- If the agency plans to bill PNC using a package or global code for OB services and a provider E/M office visit is conducted the same day as a therapeutic injection administration, then the office visit should be billed as follows:
 - Report the office visit (CPT codes 99212 – 99215) with an OB modifier
 - Bill the therapeutic injection CPT code 96372
 - Bill the specific medication HCPCS code
 - RhoGam J2790 - Full dose
 - RhoGam J2788 - Partial dose
 - 17P - J1725 (may only be used for Makena if the medication has been purchased by the agency)
 - 17P – J3490 (may only be used for Compounded at pharmacy if the medication has been purchased by the agency)




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Billing for Antepartum Care – Therapeutic Injections

Injections provided outside of a prenatal visit

- Regardless of the pavor, a therapeutic injection administration and a Nurse E/M office visit may not be billed on the same day of service
- If a package or global code will be billed for OB services and the therapeutic injection was the only reason for the visit, the following are billing options:
 - #1
 - Report the nurse office visit – CPT code 99211 with the OB modifier as part of the total number of visits in the package and bill the HCPCS code for the specific medication
 - Do not bill the therapeutic injection CPT code 96372
 - Documentation must be present to support billing for a Nurse office visit OR
 - #2
 - Bill the therapeutic injection – CPT 96372 with the HCPCS code for the specific medication
 - Do not report the office visit CPT code 99211
 - Self-pay patients should be billed on SFS




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Billing for Antepartum Care – Therapeutic Injections

Injections for agencies that are not the PNC provider


- When an RN provides multiple visits for a patient not receiving prenatal services at that particular agency, these visits may be billed in one of two manners:
 - #1
 - Utilize CPT code 99211 (supportive documentation is present) and
 - HCPCS J1725 (Makena) or
 - HCPCS J3490 (Compound 17P)
 - #2
 - Utilize CPT code 96372 and
 - HCPCS J1725 (Makena) or
 - HCPCS J3490 (Compound 17P)
- Regardless of the number of visits for 17P administration during pregnancy, an agency that is not providing PNC services may not bill a package code (59425 or 59425)



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Billing to Antepartum Care - Vaccines


- If the patient is self-pay or services are billed using individual E/M codes, the agency can bill in the following manner:
 - The provider E/M office visit CPT code (99212 – 99215)
 - Vaccine CPT code and
 - A vaccine administration CPT code 90471 or 90472
- Self-pay patients will be billed on a SFS
- MMR and Varicella are only administered postpartum. If the patient is seen in Family Planning or Maternal Health Clinics, healthcare providers must assess for immunization compliance and refer to immunization clinic as required.
- If a patient comes to clinic only to receive an immunization, (not during the course of routine PNC), then the agency is to bill in the following manner:
 - A vaccine code and
 - Administration fee



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Billing to Antepartum Care - Vaccines

- The only vaccines that are recommended to be routinely administered during pregnancy are:
 - Influenza
 - Tetanus, Diphtheria, and Pertussis (Tdap)
- These vaccines may be billed during routine PNC visits as follows:
 - 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
- Vaccine administration and the vaccine specific CPT codes should be billed on the date the vaccine is administered




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Pregnancy Medical Home (PMH) Program

Billing for PMH incentives:


- Risk screening:
 - Bill incentive code S0280 – use after pregnancy screening tool has been completed
 - Will only pay once per gestational period
 - Complete the risk screening form at the first PNC visit when OB history and exam are completed and reviewed by the provider
 - Must be completed and signed by an RN or licensed provider including advanced practice practitioners
- Services must be billed to Medicaid in the following manner:
 - Rendering provider NPI number identified on the Community Care of North Carolina (CCNC) contract and
 - Health Department's billing NPI number



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PMH - Submitting billing to Medicaid


- Patients who complete all PNC at the LHD, bill the antepartum package using the delivery date
- Patients who are "Lost-to-follow-up", use the date of the last kept visit (it is recommended to wait until after patient's due date to file)
- If it is the policy of the LHD to transfer patient's care to another OB provider (at a pre-determined number of weeks gestation), use the last date of service at the LHD for package billing
- If patient transfers care to another provider for the remainder of the pregnancy, use the date of transfer



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PMH – New Recommendations - Billing


- Agencies must bill under the facility's NPI, as well as the rendering NPI listed on the PMH contract
- When determining which rendering NPI number to use with a package or global code, Health Departments should use the following:
 - Package code
 - NPI of the last provider that saw the patient in the office
 - Global billing
 - NPI of the provider that delivered the patient



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PMH - Postpartum


- Bill incentive code S0281 once the comprehensive postpartum visit has been completed
 - Date of service must be within 60 days of delivery
 - Cannot be billed for a pregnancy that terminates by a spontaneous or therapeutic abortion
 - Will only pay once per gestational period



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Maternity/Obstetrical Billing


- Preventative visit codes should never be billed for the 1st prenatal exam
- All PNC visits that will be billed using a package or global code should be coded in the following manner:
 - An E/M CPT code and
 - Reported with an OB modifier
 - Or utilize a separate tracking system for OB package or global services
- All PNC visits should be billed or reported
- When a pregnancy is billed to Medicaid with a prenatal package or global fee code, individual prenatal visits should be:
 - Entered into HIS or billing system and
 - Accompanied by an appropriate E/M code as "0" charge and
 - Accompanied by an OB modifier (as report status only)
 - Or reported in a separate tracking system
- This is important to assure appropriate Medicaid cost settlement



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Maternity/Obstetrical Billing - Postpartum


- Postpartum care should be billed using an OB package code or global OB code, not an office visit (E/M) CPT code for Full Medicaid Coverage or MPW
- OB package codes that include postpartum care include the following:
 - 59400 – Global fee; Routine Obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, &/or forceps) and postpartum care
 - 59510 – Global fee; Routine Obstetrical care including antepartum, cesarean delivery, and postpartum care
 - 59410 – Postpartum package; Vaginal delivery only (with or without episiotomy &/or forceps) and postpartum care
 - 59515 – Postpartum package; Cesarean delivery only, including postpartum care or
 - 59430 – Postpartum care only (separate procedure, typically used when an agency does not bill for delivery)



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Postpartum Visits


- Visit occurs within 60 days of delivery
 - Bill using CPT code 59430 (or an appropriate global code if the agency provides delivery services)
 - PMH incentive using HCPCS code S0281
- Visit occurs after 60th day following delivery
 - PMH incentive (HCPCS code S0281) will not be reimbursed if the visit occurs more than 60 days after delivery.
 - The postpartum package CPT code 59430 will be reimbursed by MPW until the coverage expires
 - For patients who transition to "Be Smart", the postpartum clinic visit date is recognized as the Annual Exam Date (AED)



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Maternity/Obstetrical Billing – Depression Screening

- Providers must use a validated screening tool in the manner in which it is intended to maintain integrity/validity of reported results
- Screenings should be performed 1x each trimester and postpartum
- During the prenatal course of pregnancy, a provider may choose from the following:
 - PHQ-2 is included in the State Maternal Health Forms DHHS 3963C-1 and 3963C-2
 - If positive, then a PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS) must be completed
 - PHQ-2 is not required if the agency chooses to use the PHQ-9 or an other validated depression screening tool
 - PHQ-2 cannot be billed
 - PHQ-9
 - Bill on the date of service using CPT code 96127




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Maternal/Obstetrical Billing – Depression Screening

Edinburgh Postnatal Depression Scale (EPDS)

- Can be used during both the antenatal and postpartum periods
- Postpartum agency visit can occur in either
 - Maternal Health
 - Family Planning
- The comprehensive postpartum visit reimbursement includes depression screening with a validated tool. No CPT code for depression screening may be billed in addition to the postpartum package and incentive codes
- Depression screening is only reimbursable if completed in an agency setting



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Examples of Billing & Coding Scenarios

Scenario 5

A patient reported smoking ½ pack of cigarettes/day throughout her pregnancy, and delivered at 38 4/7 weeks gestation. No additional problems were identified during pregnancy (physical or behavioral). Patient was seen following the traditional care schedule as described in **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1**. Total number of clinical visits was 9. Which is the correct way to bill Medicaid for this patient's antepartum care?

A. Bill individual E/M codes since the patient was high risk due to use of tobacco


B. Bill the antepartum package code 59426 for 7 or more visits because the patient was seen in prenatal clinic per the traditional care schedule



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Scenario 5

B. Bill the antepartum package code 59426 for 7 or more visits because the patient was seen in prenatal clinic per the traditional care schedule



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Example

Scenario 6

A patient reported smoking ½ pack of cigarettes/day throughout the pregnancy. Delivery was at 38 3/7 weeks gestation. The patient was assessed and diagnosed with Fetal Growth Restriction. The provider recommended more frequent care during the 3rd trimester. This is outside of the traditional care schedule as described in **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1**. The total number of clinic visits was 15. Which is the correct way to bill Medicaid for this patient's antepartum care?

A. Bill individual E/M codes since the patient was high risk due to the use of tobacco and diagnosis of FGR, as well as attending additional visits (outside of the traditional care schedule)


B. Bill the antepartum package code 59426 for 7 + visits



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Scenario 6

A. Bill individual E/M codes since the patient was high risk due to the use of tobacco and diagnosis of FGR, as well as attending additional visits (outside of the traditional care schedule)



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Example


Scenario 7

A patient was diagnosed with gestational diabetes toward the end of the 2nd trimester of pregnancy. Delivery was at 39 2/7 weeks gestation. The patient received nutrition counseling/ follow-up by the Certified Diabetes Educator in the WIC program. Patient's blood sugars were well-controlled with the help of proper diet and physical activity. No additional problems (physical or behavioral) were identified during the remainder of the pregnancy. Patient was seen following the traditional care schedule as described in **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1**. The total number of clinical visits was 12.

Which is the correct way to bill Medicaid for this patient's antepartum care?

A. Bill individual E/M codes since the patient was high risk due to the diagnosis of gestational diabetes


B. Bill the antepartum package code 59426 for 7 or more visits because the patient was seen in prenatal clinic per the traditional care schedule



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Scenario 7

B. Bill the antepartum package code 59426 for 7 + visits because the patient was seen in prenatal clinic per the traditional care schedule



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Example

Scenario 8

A patient was seen at the LHD's prenatal clinic for her first 3 visits (at 8, 12, and 16 weeks) before transferring care to another Obstetrical provider. According to **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.2**, which is the correct way to bill Medicaid for this patient's antepartum care?

A. Bill individual E/M codes for each of the 3 visits


B. Bill the antepartum package code 59425



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Scenario 8

A. Bill individual E/M codes for each of the 3 visits




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Example

Scenario 9

A patient began PNC in the LHD's prenatal clinic at 32 5/7 weeks gestation. The patient was seen 4 times and delivered at 39 weeks. According to **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.2**, which is the correct way to bill Medicaid for this patient's antepartum care?


A. Bill individual E/M codes for each of the prenatal visits
B. Bill the antepartum package code 59425



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Scenario 9

A. Bill individual E/M codes for each of the prenatal visits



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Example

Scenario 10

A patient initiated PNC at the LHD's at 26 2/7 weeks gestation. The patient was seen 4 times and delivered at 39 2/7 weeks. According to **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1**, which is the correct way to bill Medicaid for this patient's antepartum care?

- A. Bill individual E/M codes for each of the prenatal visits
- B. Bill the antepartum package code 59425

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Scenario 10

- B. Bill the antepartum package code 59425

NC

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Example

Scenario 11

Patient initiated PNC at the LHD in the 8th week of gestation. Patient was seen for 6 visits before deciding to transfer care to another Obstetrical practice. At this time pregnancy is 31 weeks gestation. According to **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1**, which is the correct way to bill Medicaid for this patient's antepartum care?


- A. Bill individual E/M codes for each of the prenatal visits
- B. Bill the antepartum package code 59425

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Scenario 11


B. Bill the antepartum package code 59425



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Prenatal Patients with High Risk Diagnosis


- The decision of whether to report each visit and bill a CPT package code 59425 or 59426 at the end of the pregnancy or bill individual E/M codes at each clinic visit should be reflective of the care provided
- Billing is not determined solely on whether the patient has a high risk diagnosis. The agency must consider the amount of care that was provided throughout the pregnancy
- If care provided goes "above and beyond" what is considered "routine care", then the agency may bill individual E/M codes
- If multiple visits are extended with documentation reflective of such, then the agency may bill E/M codes



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Opportunities for Agency Decision – High Risk Pregnancies

- When providing prenatal/antepartum care to patients with a high risk diagnosis, the agency will need to determine if the patient was seen more than the "routine care" for an uncomplicated pregnancy. An agency may use either of the following standards as defined:
 - **ACOG** definition: with early entry into PNC, a normal number of visits would equal 13
 - **NC DMA Clinical Coverage Policy 1E-5, section 3.2.1**, as defined as:
 - Every 4 weeks for the first 28 weeks of gestation
 - Every 2-3 weeks until the 36th week of gestation
 - Weekly from the 36th week of gestation until delivery
- The agency can choose to bill the prenatal package code (59425 or 59426) even if the patient is seen more than the "normal" number of visits
- The agency's decision on how they bill should be reflected in policy
- Answers to the next two examples will be based on agency policy



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Example


Scenario 12

A patient was diagnosed with gestational diabetes toward the end of the 2nd trimester of pregnancy. Delivery occurred at 39 1/7 weeks gestation. The patient received nutrition counseling/follow-up by the Certified Diabetes Educator in the WIC program. Patient's blood sugars were well-controlled with the help of a proper diet and physical activity until week 33. Provider then determined that patient would require insulin therapy. No additional problems were identified during the remainder of pregnancy (physical or behavioral). Beginning with week 33, patient was seen weekly in clinic. This is more often than the traditional care schedule as described in **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1**. The total number of prenatal visits was 13.

Which is the correct way to bill Medicaid for this patient's antepartum care?

A. Bill individual E/M visits since the patient was high risk due to the diagnosis of gestational diabetes and was seen more than the traditional care schedule

B. Bill the antepartum package code 59426 for 7 or more visits




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Scenario 12

A. Bill individual E/M visits since the patient was high risk due to the diagnosis of gestational diabetes and was seen more than the traditional care schedule

B. Bill the antepartum package code 59426 for 7 or more visits



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Example

Scenario 13

A patient initiated PNC at the LHD's in the 20th week of gestation. The patient was seen at 24 & 28 weeks. The provider diagnosed the patient with gestational diabetes and was seen weekly through 36 weeks at which time the patient delivered. According **NC DMA Clinical Coverage Policy 1E-5, Section 3.2.2**, which is the correct way to bill Medicaid for this patient's antepartum care?

A. Bill individual E/M codes for each of the prenatal visits


B. Bill the antepartum package code 59426



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Scenario 13

A. Bill individual E/M codes for each of the prenatal visits
 B. Bill the antepartum package code 59426



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Questions ~

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