Unbundled Maternal Health Global Payment – Frequently Asked Questions (FAQ)

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1. To clarify, this change is for a patient with traditional Medicaid coverage and not listed with an MCO?
Answer: MCOs are Iowa Medicaid. This coverage applies to Traditional (Regular) Medicaid and MCOs.

2. Will the recording and sides be available somewhere that we can send to coders that are not available the listening sessions?
Answer: Yes, the recording and slides are posted: https://hhs.iowa.gov/initiatives#unbundled-maternal-health-global-payment

3. Does this apply to Rural Health Clinics?
Answer: Yes, if the RHC provides Maternal Health Care, this process will apply. Please put the TH on the shadow line that correlates with the unbundling of their claims. Not on the encounter code.

4. Assuming this will not significantly impact RHC billing as we currently bill individual visits in the clinic (payment at RHC rate) and the delivery in the hospital (fee schedule payment). I do understand the TH modifier is new. I am assuming RHC will need to include this modifier - can you confirm?
Answer: Yes, the TH Modifier will be necessary

5. Please note, as an RHC, we use T1015 code on the claim.
Answer: Yes, please use the TH Modifier.

6a. As an RHC clinic, do we not unbundle clinic visits as described in the presentation when commercial insurance is primary? This would lower our reimbursement as RHC reimbursement is cost based.
Answer: Follow your current billing process when the patient has commercial insurance as primary.

6b. What about when commercial insurance is identified after the fact? Assuming we would need to rework all claims and change billing to bundled and submit a correction.
Answer: Correct. First, all claims will need a rework and submit to commercial insurance and then the bundled to Medicaid (MCOs).

7. If bill prime and you stated after delivery does that mean that we count visits and bill? We are reading the question as: Primary Insurance (Commercial)
Answer: There is no change in the current Global Maternity Billing process for Medicaid Secondary Members. **If the question is regarding Medicaid as primary, then** follow the process as stated. Bill at point of service for each visit and track the number in your patient/client's record.

8a. Are referral specialists considered those who also provide OB care such as Maternal Fetal Medicine physicians or is this just for providers outside of obstetrics?
Answer: If the referral is to Maternal Fetal Medicine (MFM) provider, then the MFM would count for the 14. The MFM would use the codes identified and the TH Modifier.

8b. Are these referral visits part of the 14 visits or are these covered by a different mechanism? For example, if a patient is referred to a psychiatrist do these visits deduct from the 14 visits beneficiaries can have for the entire pregnancy/postpartum episode
Answer: If referred to psychiatrist no TH Modifier on the visit and does not count to the 14 visits. The Psychiatrist would be using the codes approved for their services.

9. Do antepartum RN visits count (NSTs, etc.) in the 14 prenatal visits or postpartum RN visits (blood pressure checks, mood checks, etc.) count in the 3 postpartum visits?
Answer: RN codes are not a part of this unbundle process. A NST is billed outside of the unbundle. If the office visit includes the NST, it should be added to the claim. The NST has never been a part of the Bundled program.

10. NST's are not included in the bundled global. Is there a reason the TH modifier will need added to these services in the new unbundled process?
Answer: The TH Modifier identifies the billing is under the unbundled program. When billing the NSTs for the Global Package- do not use the TH Modifier

11. Will there be any changes to reimbursement parity for advanced practice providers with this new process?
Answer: If registered as an Advanced Practice Provider, they are to submit the unbundled codes. The TH modifier needs to be in the 1st position. Then include the 25 identifiers.

12. Will any of these payments have a value-based component or is it just breaking out the previously bundled maternity payments?
Answer: This is not a value-based reimbursement process. This is the Unbundled Program of the Global Package.

13. If a patient called into the OB office with concerns such as cramping or bleeding or dysuria, complaints that don't necessarily need to be a hospital admission, do those visits count as part of the 14 and then would a PA need to be done for the remaining visits?
Answer: If this is just a phone call discussion, it cannot be billed. If the provider has the patient come into the office or changes to a telehealth video call, it is billed and becomes part of the 14. If the patient is sent to Observation in the hospital, follow the hospital description in the billing guide.

14. Could you see the benefits you see for both women and providers with this change?
Answer: All data will be reviewed for both women and providers benefits. We expect to see increase provider reimbursement with the increase office/video telehealth visits. We expect to see improved outcomes for women/infant with additional prenatal/postpartum medical services.

15. What are the financial impacts with this change to our MCO's and Medicaid?
Answer: There is $440,000 appropriation for this change. The Fiscal Analysis has identified the spend is likely to be right at that amount.

16. Will this unbundling affect any Title V billing codes?
Answer: No

17. Does C-section assist 59514/80 and 59514/AS also need TH modifier?
Answer: Yes. This will be added to the Billing guide as well.

18. Are the three PP just for OB/PCP practice or is that inclusive of the referrals to other follow up (ie endocrine, etc.)?
Answer: The three PP are just for OB/PCP practice. The referrals are not inclusive of the three PP visits. Those providers will bill as they do any other Medicaid member for the 12-month postpartum period

19. Does this affect facility billing? Is the TH modifier required on both facility and physician claims for the services indicated in this policy?
Answer: This does affect outpatient services regardless of location for services that are a part of this policy but does not impact Inpatient claims for the facility.

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20. Will an informational letter go about this change?
Answer: No

21. If a provider sees the patient for a non-pregnancy diagnosis but includes pregnancy in the diagnosis list - does it count as a pregnancy visit and does it need the TH modifier?
Answer: If the reason for the visit to a provider is not pregnancy related, it is claimed to Medicaid (MCOs) as per usual. No TH Modifier is needed.

22. Does the requirement continue to only use E&M codes 99203 and 99213. The preference is to have the codes available for reporting based on the documented level of medical decision making.
Answer: Please continue using only the E&M codes 99203 and 99213. We are performing internal review and if anything changes it will be posted.

23. Is there a timeframe for postpartum visits?

Answer: The three individual postpartum visits may be used based on the member's condition. We encourage within each visit to make referrals to other providers (Endocrinology, Behavioral/Mental health providers, Internal Medicine, General Practitioners, etc.,) based on the woman's needs. Each postpartum visit is separated billed.

24. Is the cap for billing postpartum visits at three (3) of how many more postpartum visits the patient is eligible for?

Answer: The cap is three. Please make referrals to other providers based on the woman's condition.

25. Does it matter what position the TH modifier is in on the claim? Does it have to be first listed?

Answer: Each Code identified in the billing guide requires to have the TH modifier. Not just in one location.

26. For patients who obtain emergent coverage for the 3-day window during delivery, can we bill the hospital e/m codes (99222, 99232, 99238) in addition to the delivery?

Answer: If the code description is met, please submit the claim for the member with emergent coverage. Be sure to include the TH Modifier.

27. Do Maternal Fetal Medicine provider consults count as part of the 14 antepartum codes?

Answer: Maternal Fetal Medicine provider consults **DO NOT** count as part of the 14 antepartum codes.