Maternity Case Management Billing Guide for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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Resources

This guide is a quick reference for information about Maternity Case Management (MCM) billing by an FQHC or an RHC. For additional information about program requirements, definitions, forms, and billable services, please see the following resources.

- DMAP Home Page
  http://www.oregon.gov/DHS/healthplan/index.shtml

- DMAP Provider Services: 1-800-336-6016 or
  dmap.providerservices@state.or.us. Provider website with many resources:
  http://www.oregon.gov/OHA/healthplan/tools_prov/main.shtml

- Oregon Administrative Rules 410-130-0595 (Maternity Case Management)
  http://arcweb.sos.state.or.us/rules/OARS_400/OAR_410/410_130.html
  See section 410-130-0595. This website also contains a link to the MCM forms.

- Medical-Surgical Services Rulebook
  http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html
  Contains the MCM Forms.

- Oregon Administrative Rules 410-147-0200 (Maternity Case Management for Federally Qualified Health Centers and Rural Health Clinics)
  http://arcweb.sos.state.or.us/rules/OARS_400/OAR_410/410_147.html
  See section 410-147-0200.

- Federally Qualified Health Centers and Rural Health Clinics Rulebook & FQHC/RHC Program Supplemental Information
  http://www.dhs.state.or.us/policy/healthplan/guides/fqhc-rhc/main.html
  See section 410-147-0200.
  Under the "Supplemental Information" heading on this website, see the "Federally Qualified Health Centers and Rural Health Clinics Supplemental Information" link.

- MCM forms and training documents
  http://public.health.oregon.gov/HealthyPeopleFamilies/Women/Pregnancy/MaternityCaseManagement/Pages/forms.aspx

- Benefit RN Hotline (at DMAP): 1-800-393-9855 or 503-945-5939
  Help with determining if a condition is covered under the Oregon Health Plan (OHP).

Maternity Case Management Reimbursement for FQHCs and RHCs

Maternity Case Management procedure codes identify DMAP-reimbursable services. These include:

- G9001–Initial Assessment
- S9470–Nutritional Assessment
- G9012–Case Management Home Visit
- G9011–Case Management Visit Outside the Home
- G9006–Home/Environmental Assessment
- G9005–High Risk Case Management

DMAP reimburses FQHCs and RHCs for MCM services. The FQHC or RHC bills DMAP the PPS (Prospective Payment System) encounter rate for each date of service. Typically, only one MCM procedure code is reimbursable per date of service. If an FQHC or RHC bills more than one reimbursable MCM procedure code for a single date of service, each claim may receive a "PAID" status in the MMIS, but all except one will pay out at $0 ("zero pay"). An exception to this rule is an Initial Assessment and a Nutritional Assessment. The Initial Assessment and Nutritional Assessment are both reimbursable for the same date of service. (Note: only a medical prenatal visit and an MCM Initial Assessment are also reimbursable for the same date of service. No other prenatal visits and case management visits are reimbursable on the same date of service.)

Only one provider at a time may provide MCM services to the client. The provider must coordinate care to ensure that duplicate claims for MCM services are not submitted to the Division. Before providing services to a client enrolled in a prepaid health plan, see OAR 410-147-0200(a) & (b) and OAR 410-130-0595(4).

The following key questions determine service level and appropriate billing codes.

Navigating Billing: The 3 Ds	
Diagnosis	Was the pregnancy risk status normal or high risk?
Duration	Was the service period for 3 months or longer?
Delivery	Was the client service plan carried through the date of delivery?

The tables for Normal Pregnancy and High-Risk Pregnancy (below) summarize typical combinations of procedure codes that FQHC and RHC service providers bill. For more complete information and service limitations, see Section 410-147-0200 of the Oregon Administrative Rules for Federally Qualified Health Centers: http://www.dhs.state.or.us/policy/healthplan/guides/fqhc-rhc/main.html

Normal Pregnancy Case Management for FQHCs and RHCs

Procedure Codes	Billing Frequency/Timing
G9001 **Initial Assessment**	• Perform the Initial Assessment (https://apps.state.or.us/Forms/Served/oe2470.pdf) before providing any other MCM services. • The Initial Assessment must be completed prenatally, at least one day prior to delivery. No other MCM service can be performed or billed until the Initial Assessment has been completed. • Develop a Client Service Plan (CSP) that addresses identified needs. • Communicate with the prenatal care provider and other providers. • Bill once per pregnancy.
G9006 **Home/Environmental Assessment**	• Complete an entire Home/Environmental Assessment and document it. This is an MCM program option, but is not a requirement. (See OAR 410-130-0595(16), Table 130-0595-1 Environmental Assessment.) • Bill once per pregnancy, except if the situation requires a repeat Home/Environmental Assessment. Submit documentation with the faxed paper claim stating the reason for repeat assessments or follow-up assessments. • If the client moved, simply write “moved” on the documentation and note the client’s new address.
G9012 **Case Management Home Visit**	• Services must be delivered in the home. • Must include an evaluation and/or revision of objectives and activities addressed in the CSP, and also include training, information, and education on at least two topics. (See the training and education topics in OAR 410-130-0595(17), Table 130-0595-2.) • Up to four (4) G9012-Case Management Home Visits may be billed prenatally. (Visits outside the home and telephone visits are included in this total). Some of these visits may occur up to two months postpartum. • A postpartum visit is not required.

Procedure Codes	Billing Frequency/Timing
G9011 **Case Management Visit Outside the Home**	• Bill when services are not delivered in the client's home. • Must include an evaluation and/or revision of objectives and activities addressed in the CSP, and also include training, information, and education on at least two topics. (See the training and education topics in OAR 410-130-0595(17), Table 130-0595-2.) • Counts as one MCM visit in the total 4 allowable visits. • Must meet all requirements of a Case Management Visit. Performed when a face-to-face Case Management Visit is not possible or practical. • A case management telephone visit is billed as a Case Management Visit Outside the Home. Document the reason why a telephone call was substituted for face-to-face contact.

High-Risk Case Management for FQHCs and RHCs

See Oregon Administrative Rule 410-130-0595(5)(e) for the definition of a high-risk client.

Procedure Codes	Billing Frequency/Timing
G9001 **Initial Assessment**	• Perform the Initial Assessment (https://apps.state.or.us/Forms/Served/oe2470.pdf) before providing any other MCM services. • The Initial Assessment must be completed prenatally, at least one day prior to delivery. No other MCM service can be performed or billed until the Initial Assessment has been completed. • Develop a Client Service Plan (CSP) that addresses identified needs. • Communicate with the prenatal care provider and other providers. • Bill once per pregnancy.
S9470 **Nutritional Counseling**	• Service provider is a licensed and registered dietician (R.D. and L.D.), as outlined in OAR 410-130-0595 (7). • Not required for MCM. Client must meet criteria as defined in OAR 410-130-0595(12)(a)(A-I). • May be billed once per pregnancy if the client meets the criteria and the service was provided by a qualified provider.
G9006 **Home/Environmental Assessment**	• Complete an entire Home/Environmental Assessment and document it. This is an MCM program option, but is not a requirement. (See OAR 410-130-0595(16), Table 130-0595-1 Environmental Assessment.) • Bill once per pregnancy, except if the situation requires a repeat Home/Environmental Assessment. Submit documentation with the faxed paper claim stating the reason for repeat assessments or follow-up assessments. • If the client moved, simply write “moved” on the documentation and note the client’s new address.
G9012 **Case Management Home Visit**	• Use when services are delivered in the home. • Must include an evaluation and/or revision of objectives and activities addressed in the CSP, and also include training, information, and education on at least two topics. (See the training and education topics in OAR 410-130-0595(17), Table 130-0595-2.) • Up to 10 total visits may be billed for a high-risk case. (Case Management Visits Outside the Home, which includes visits by telephone, are included in this total). • Up to four (4) G9012-Case Management Home Visits may be billed prenatally. Some of these visits may occur up to two months postpartum. • Up to six (6) additional G9012-Case Management Home Visits may be billed after delivery for a high-risk pregnancy. The visits may occur before or after delivery, up to two months postpartum. • The MMIS will not pay for any visits beyond the fourth one until a high-risk case code has processed successfully. A high-risk diagnosis code must be used on any claim for high-risk case management. • A postpartum visit is not required.

Procedure Codes	Billing Frequency/Timing
G9011 **Case Management Visit Outside the Home**	• Bill when services are not delivered in the client's home. • Must include an evaluation and/or revision of objectives and activities addressed in the CSP, and also include training, information, and education on at least two topics. (See the training and education topics in OAR 410-130-0595(17), Table 130-0595-2.) • Counts as one MCM visit in the total 10 allowable visits in a high-risk case. • Must meet all requirements of a Case Management Visit. Performed when a face-to-face Case Management Visit is not possible or practical. • A case management telephone visit is billed as a Case Management Visit Outside the Home. Document the reason why a telephone call was substituted for face-to-face contact.
G9005 **High-Risk Case Management**	• Bill once per pregnancy. • Bill after delivery. • Client or pregnancy must meet the high-risk criteria in OAR 410-130-0595(5)(e). • Client received services for 3 months or longer, and services were carried through the date of delivery. • A postpartum visit is not required. • After delivery, bill the additional visits done for the high-risk client. Claims for up to 6 additional visits may be submitted with or after you have submitted a claim for G9005-High Risk Case Management. • The MMIS will not pay for any visits beyond the fourth one until a high-risk case code has processed successfully. A high-risk diagnosis code is required on the claim for high-risk case management.

Number of Allowable MCM Reimbursables for FQHCs and RHCs

— Normal Pregnancy —

Bill prenatally <u>or</u> after delivery . . .	**Bill <u>only</u> after delivery . . .**
• One (1) Initial Assessment. Required before any other services may be billed. • Up to four (4) case management visits per normal pregnancy. Telephone visits count toward this total. • One (1) Home/Environmental Assessment. An additional Home/Environmental Assessment may be billed with documentation of problems that necessitate follow-up or when a client moves.	• Any of the four (4) allowable case management visits that may have occurred during the two-month postpartum period. Four (4) case management visits are allowed per normal pregnancy. • Any Home/Environmental Assessment that may have occurred during the postpartum period.

— High-Risk Pregnancy —

Bill prenatally <u>or</u> after delivery . . .	**Bill <u>only</u> after delivery . . .**
• One (1) Initial Assessment. Required before any other services may be billed. • One (1) Nutritional Assessment. Client must meet criteria in OAR 410-130-0595(12)(a)(A-I). • Up to 4 (four) case management visits. Telephone visits count toward this total. • One (1) Home/Environmental Assessment. Additional Home/Environmental Assessments may be billed with documentation of problems that necessitate follow-up or when a client moves.	• One (1) High-Risk Case Management procedure code. Bill the 5th visit using G9005-High Risk Case Management (instead of G9012 or G9011). Or, bill G9005-High Risk Case Management and the 5th visit (G9012 or G9011) on the same date of service. Bill only when services were initiated prenatally, provided for at least 3 months, and carried through the date of delivery. • Up to six (6) additional case management visits for high-risk clients only. Bill G9012-Case Management Home Visit or G9011-Case Management Visit Outside the Home. These additional visits for high-risk clients may occur before or after delivery. They are billed, however, only after delivery. The G9005-High-Risk Case Management procedure code must process before these visits.

MCM Diagnosis Codes (V-Codes)

Diagnosis codes or V-Codes are the classifications for factors that influence health status and contact with health services. They show the reason for services.

The MCM diagnosis codes are drawn from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

A diagnosis code must be submitted on every reimbursement claim. If you are billing on paper or through an electronic submitter, the diagnosis code appears on the claim without the decimal point. See the left column of the table below.

Diagnosis Code	Description
V220	V22.0 – Supervision of normal first pregnancy
V221	V22.1 – Supervision of other normal pregnancy
V233	V23.3 – Grand multiparity
V2341	V23.41 – Pregnancy with history of preterm labor
V2349	V23.49 – Pregnancy with other poor obstetric history
V2381	V23.81 – Elderly primigravida
V2382	V23.82 – Elderly multigravida
V2383	V23.83 – Young primigravida
V2384	V23.84 – Young multigravida
V239	V23.9 – Unspecified high-risk pregnancy
V241	V24.1 – Lactating mother
V242	V24.2 – Routine postpartum follow-up
V2509	V25.09 – Other family planning advice

Optional MCM Billing Worksheet for FQHCs/RHCs

This optional worksheet can help you track billing claims for a client.

Client Name	Date of Birth	Medicaid Number

Procedure Code		Date of Service
G9001–Initial Assessment (required, bill first)		
S9470–Nutritional Assessment (if client meets criteria and provider is a licensed, registered dietician)		
G9012–Case Management Home Visit or G9011–Case Management Visit Outside the Home	Visit 1	
	Visit 2	
	Visit 3	
	Visit 4	
G9006–Home/Environmental Assessment		
G9005–High Risk Case Management (high-risk clients only)		Bill only after delivery
(high-risk clients only) G9012–Case Management Home Visit or G9011–Case Management Visit Outside the Home	Visit 5	Bill only after delivery
	Visit 6	Bill only after delivery
	Visit 7	Bill only after delivery
	Visit 8	Bill only after delivery
	Visit 9	Bill only after delivery
	Visit 10	Bill only after delivery
Reason(s) for high-risk status:		

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FQHC/RHC Sample Billing Flowchart

This sample flowchart represents when billing occurs, not when services are delivered. Many combinations of case management visits that occur before and after delivery are possible. Different combinations of case management visits inside and outside the home are also possible.