



Delivering Healthcare Professionals (DHCPs) Billing Overview & Program Updates

June 9, 2021

- The webinar will begin at 12:00 p.m.
- Record your attendance by typing your name/organization in the Chat Box
- Please keep your microphone muted throughout the presentation
- A recording of today's presentation will be posted at www.Medicaid.Alabama.gov



Delivering Healthcare Professionals (DHCPs) Billing Overview & Program Updates

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Objectives



Objectives:

- DHCP Selection Referral Requirement Update
- Sterilization Claims & Consent Form Review
- Billing Of Maternity Services Education
- Patient-centered Medical Home Attestation Reminder (For Applicable Providers)

DHCP Selection Referral Requirement



Reinstatement of the DHCP Selection Referral Requirement

- ALL maternity claims with dates of service July 1, 2021 and beyond will require a DHCP selection referral from the ACHN
- Ensures collaborative communication between the DHCP and the ACHN for quality health outcomes

Reinstatement of the DHCP Selection Referral Requirement

- Maternity claims with dates of service March 16, 2020 – June 30, 2021, will not require a DHCP selection referral
- Contact the recipient's assigned ACHN for a DHCP selection referral form

DHCP Selection Referral Requirement

Sample ACHN DHCP Referral Form

Alabama Coordinated Health Network

Delivering Healthcare Professional Selection Referral Form

ACHN's Name: _____ ACHN's NPI Number: _____

Date: _____

Type of Referral: Initial Change of DHCP High-Risk/Specialty Other _____

Medicaid Eligible Individual (EI) Information

Name:

Last _____ First _____ MI _____

Medicaid Number: _____ DOB: _____

Address: _____

Telephone Number (with area code): _____

Sterilization Consent Forms



Code of Federal Regulations (CFR)

- Alabama Medicaid Agency must adhere to the guidelines outlined in 42 CFR Part 50 (42CFR50) when accepting sterilization consent forms
- Consent form must be signed and dated by all of the following:
 - Individual to be sterilized
 - Interpreter, if one is provided
 - Person who obtains the consent
 - Physician who will perform the sterilization procedure

Non-Correctable Fields

- Non-Correctable Field- A field that cannot be changed, edited, or revised once sterilization consent form has been submitted to Gainwell
- Recipient signatures are non-correctable
- Recipient's signature must match or resemble the signature on the recipient's verification documentation, when requested

ALABAMA MEDICAID AGENCY STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

Field 1
Physician or Clinio

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

Field 2
Specify Type of Operation

The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Field 3
Month/Day/Year

I, _____
Field 4
Name of the Recipient

hereby consent of my own free will to be sterilized by

Field 5
Physician or Clinio

by the method called _____
Field 6
Specify Type of Operation

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about this operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

X _____ X _____
Field 7 Field 8
Recipient's Signature Date

Field 9
Type/Print Recipient's Name

Field 10
Recipient's Medicaid Number

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the recipient to be sterilized: I have translated the information and advice presented orally to the recipient to be sterilized by the person obtaining the consent. I have also read him/her the consent form in _____
Field 11
language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

Field 12 Field 13
Interpreter's Signature Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____
Field 14

Name of the Recipient

signed the consent form, I explained to him/her the nature of the sterilization operation _____
Field 15

Specify Type of Operation

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the recipient to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the recipient to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

X _____ X _____
Field 16 Field 17
Signature of Person Obtaining Consent Date

Field 18
Type or Print Name

Field 19
Facility

Field 20
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

Field 21 on X _____
Name of the Recipient Date of Sterilization

I explained to him/her the nature of the sterilization operation

Field 23
Specify Type of Operation

the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the recipient to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the recipient to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the recipient's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

- (1) At least thirty days have passed between the date of the recipient's signature on the consent form and the date the sterilization was performed.
- (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the recipient's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
 - Premature delivery
Recipient's expected date of delivery: _____
Field 24
 - Emergency abdominal surgery (describe circumstances in an attachment)

X _____ X _____
Field 25 Field 26
Physician's Signature Date

Type/Print Name _____
Field 27

NPI Number _____
Field 28

Non-Acceptable Signature Comparison Example

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about this operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

x *Heidi Sample* *5.5.21*
Recipient's Signature Date

Type/Print Recipient's Name

Recipient's Medical Number



Top Reasons For Returns

Most frequent causes of claims having to be returned for correction:

1. Recipient's date of birth not the same on the claim and consent form.
2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.
3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.
4. All blanks not appropriately completed.
5. Physician's signature is missing.
6. Date of sterilization not the same on the claim and on the consent form.
7. Legibility of dates and signatures.
8. Facility name not on the consent form.

Top Reasons For Denials

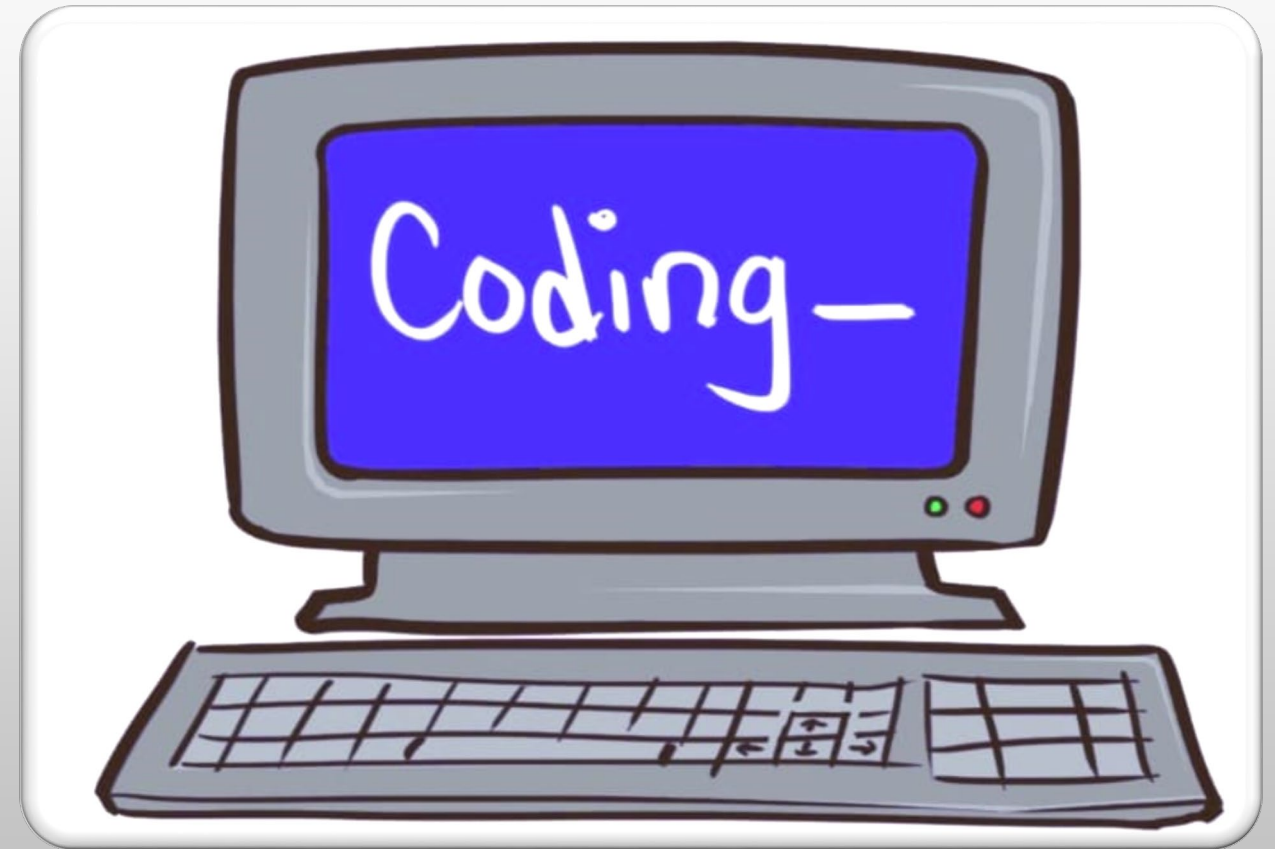
Reasons consent forms and associated claims will be denied:

1. Missing recipient signature.
2. Missing or invalid date of recipient signature, including less than 30 days prior to procedure.
3. Recipient under age 21 on date consent form was signed.
4. Missing signature of person obtaining consent.
5. Missing or invalid date of person obtaining consent, including date of procedure, or any later date.
6. Missing interpreter signature (if one was used).
7. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used).
8. Sterilization performed less than 72 hours after the date of the recipient signature on the consent form in cases of premature delivery and emergency abdominal surgery.

Where to Get Help with the Sterilization Consent Form 193

- Appendix C - Provider Billing Manual (updated quarterly)
 - Detailed instructions on how to complete the sterilization consent form:
https://medicaid.alabama.gov/content/7.0_providers/7.6_manuals.aspx
- Gainwell Provider Representatives: (855) 523-9170 or 334-215-0111

Maternity Billing



Global Maternity Codes

Global Maternity Codes

- Applies to delivery codes
- Includes prenatal, delivery and/or postpartum services
- Mid-level practitioners reimbursed at 80%
- Physicians reimbursed at 100%

Global Code Unbundle

Global Maternity Code

- Unbundle when appropriate
 - Mid-level practitioners can only be reimbursed for qualifying delivery related procedure codes
 - Mid-level practitioners reimbursed at 80%
 - Physicians reimbursed at 100%
- Delivery claim(s) should support actual services rendered and the rendering provider

DHCP Bonus Payments



Bonus Payment Opportunities

- Prenatal Bonus Payment
 - Visit within 90 days of the last menstrual period
 - Pc- H1000
 - Exceptions can be overridden, if applicable
 - Miscarriages
 - \$100 per bonus payment

Bonus Payment Opportunities

- Postpartum Bonus Payment
 - Visit between 21 & 56 days of delivery
 - Pc- G9357
 - A paid delivery claim must be on file
 - Exceptions can be overridden if applicable
 - Out of hospital/state deliveries
 - \$100 per bonus payment

Bonus Payment Opportunities

- DHCP Bonus Payments must be billed on a separate claim
 - Will deny if on same 1500 claim
- Only one prenatal and/or postpartum DHCP Bonus Payment will be paid per recipient per pregnancy
 - Exceptions can be overridden, if applicable
- Contact your Gainwell provider representative for billing assistance

DHCP Bonus Payments

FY 20 Unpaid Bonuses Per Delivery

Pregnancy and Delivery Bonus Procedure Code Description	Procedure Code	Total Bonus Paid for FY20 Services (as of 05/18/2021)	Number of Recipients	Total Deliveries during FY20 (as of 05/01/2021 data)	Percent Paid Procedure Codes	Number Of Recipients With No Bonus Procedure Codes Reimbursed	Bonus Payments Not Billed By Providers
Prenatal Bonus Payment	H1000	\$994,012	10,321	29,327	35.19%	19,006	\$1,900,600
Postpartum Bonus Payment	G9357	\$1,265,808	13,053	29,327	44.51%	16,274	\$1,627,400
	Sum Amount Paid:	\$2,259,820					\$3,528,000



**Patient-centered
Medical Home
(PCMH)
Attestation**



Patient-Centered Medical Home

For interested eligible OB/GYN PCP provider groups:

- PCMH attestation for FY 2022 is due no later than October 1, 2021
- Begin your PCMH recognition now to avoid potential delays

Patient-Centered Medical Home

For interested eligible OB/GYN PCP provider groups:

- Attestation is required to be eligible for the 5% PCMH bonus payment
- Attestation form is available on the Medicaid website:
https://medicaid.alabama.gov/content/9.0_resources/9.4_forms_library/9.4.19_achn_pcp_forms.aspx
- Contact ACHN@medicaid.alabama.gov for further assistance

Program Contacts

- Maternity, Family Planning, & Plan First:
 - Pamela Moore, Associate Director- Pamela.Moore@medicaid.Alabama.Gov
 - Linda White, Maternity Program Consultant- Linda.White@medicaid.Alabama.Gov
 - Julie Gilliland, Family Planning/Plan First Program Manager- Julie.Gilliland@medicaid.Alabama.Gov
- Network Provider Assistance:
 - Travis Houser, Associate Director- Travis.Houser@medicaid.Alabama.Gov
 - Patricia Toston, Program Manager- Patricia.Toston@medicaid.Alabama.Gov
 - Jessica Brooks, Program Manager- Jessica.Brooks@medicaid.Alabama.Gov

Questions



Submit questions for official response to:
ACHN@medicaid.alabama.gov