Delivering Healthcare Professional (DHCP) Webinar- June 9, 2021

Attendee	Topic	Question	Agency's Response
J. Davis	Billing	What is Medicaid rule for a patient that delivers prior to enrolling with the care coordinators (ACHNs)? Will her delivery be paid/approved?	Recipients that are not assigned to an ACHN on the date of service will not require a DHCP referral for reimbursement. If the recipient is assigned to an ACHN on the date of service but refuses service from the ACHN, the recipient must be made aware that she may be responsible for the payment of the services provided. This notification must be documented in the recipient's medical record.
T. Baker	Billing	If patient doesn't enroll (with the ACHN), will the patient be responsible for the visit?	If the recipient is assigned to an ACHN on the date of service but refuses service from the ACHN, the recipient must be made aware she may be responsible for the payment of the visit and any services provided during the visit. This notification must be documented in the medical record.
B. Shephard	Billing	We are having check ups denied because within global del days, will they pay with 24 modifier?	The provider needs to contact provider representative at Gainwell for assistance. The Provider Assistance Center's toll free phone number is 1-800-688-7989.
J. Pridmore	Billing	If a patient transfers care and we only see pt 3 times how do we bill the drs E&M codes?	The provider should bill with the E&M office visit codes
E. Brooks	Billing	We have a lot of patients that are on emergency medicaid that the providers are billing the first trimester. The claims are denied because it is a non emergency. This is for the H1000 cpt code.	Emergency Medicaid covers delivery only.
M. Wilson	Billing	How can we get paid if a patient drops in and delivers and not enrolled in ACHN?	If the delivery is deemed an emergency on the claim by the physician, a DHCP referral from the ACHN will not be required for reimbursement. If the delivery is not an emergency, the provider may contact the ACHN to obtain a DHCP referral.
D. Robertson	Billing	Do you want any bililng during the pregnancy or just the delivery and bonuses?	Ultrasounds can be billed during the pregnancy. When a physician provides 8 or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code in billing. Providers should bill 59425 for 4-6 visits and 59426 for 7 or more visits. When less than 4 visits are provided, the provider should bill the applicable E&M office visit codes. The provider must bill the bonuses (H1000 and G9357) on separate claims.
A. Garcia	Billing	Can we circle back to being able to bill the patients? If they do not enroll with the ACHN, the care coordinator will get us a delivery referral . . . I thought we were unable to bill patients unless it was a non-covered service or they were out of physician visits for the year?	If the recipient is assigned to an ACHN on the date of service but refuses service from the ACHN, the recipient must be made aware she may be responsible for the visit. This notification must be documented in the medical record.
J. Graves	Billing	Are the office visit consider global?	No. If the patient has less than 4 visits for antepartum care, the provider should use the applicable E&M office visit codes. The E&M office visit codes will count towards the annual 14 limit for office vists.
T. Austin	Billing	Is the first prental visit billable like we do with private health ins? I mean is the first visit in the clinic with the provider billable for initating care? Then follow with global? Does that make sense?	Antepartum care includes all usual prenatal services such as the initial office visit at which time the pregnancy is diagnosed, initial and subsequent history, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc. therefore, additional claims for routine services shall not be filed. Antepatrum care also includes routine lab work. Billing for antepartum care services in additional to global care is not permissable (refer to Chapter 40 of the Provider Billing manual). For specific billing related questions, contact your Gainwell Provider Rep at 1-800-688-7989.
S. Prentiss	Billing	If a patient tranfers to our office after seeing another OBGYN for first prenatal visit, why can't our office get paid for a first time office visit? It's not the bonus im talking about it is the new patient visit to our office	See above.
T. Austin	Billing	Where is this listed about the 8 visits?	Chapter 28 of the Provider Billing Manual, page 33: *When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code in billing.*
J. Mitchell	Billing	I thought that prenatal visits were not submitted as global but paid per visit.	It varies case by case. Providers should submit the global codes for reimbursement when applicable. Per CPT guidelines, the codes are: 59425 for 4-6 visits and 59426 for 7 or more visits. NOTE: The E&M office visit codes will count towards the annual 14 limit for office vists.
TMT1604	Billing	We have a patient that just signed up at 37 weeks and can't get 8 visits, how would we bill?	Identify the applicable procedure code(s) and submit for reimbursement. NOTE: Providers should bill 59425 for 4-6 visits and 59426 for 7 or more visits. When there are less than 4 visits, the provider should bill the applicable E&M office visit codes.

J. Mitchell	Billing	Are prenatal visits no longer paid per visit ? When did they revert back to global billing?	To justify billing for global antepartum care services, physicians must utilize the CPT-4 antepartum care global codes (either 4-6 visits or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's limit of 14 office visits per year. Physicians who provide less than four (4) visits for antepartum care must utilize CPT-4 codes under the office medical services section when billing for these services. These office visit codes will be counted against the recipient's limit of 14 physician visits a calendar year.
C. Wren	Billing	I thought is was only 4 antepartum or more visits to bill 59400, etc.	When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code (59400) in billing.
J. Graves	Billing	We have talked about vaginal visit what about c/s (c-section)?	Same rules apply. When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code (59400) in billing.
E. Jane	Billing	As a rural health clinic we are required to bill per visit and delivery only per the manual. What codes can we use to prevent using all a patients visits?	Rural Health Clinics (RHCs) should be billing for itemized services delivered to Medicaid recipients during their medical visit. The RHC program area is not aware of any procedure codes utilized to prevent using patients visits, more information is needed. Please contact the RHC program area at 334-242-5455.
J. Mitchell	Billing	Are FQHCs still paid via PPS rates using 99 code	Federally Qualified Health Centers (FQHCs) are reimbursed utilizing the Prospective Payment System (PPS) rate. Upon enrollment, the FQHC submits a budgeted cost report to establish an interim PPS rate. A final cost report is submitted and the permanent PPS rate is established. The FQHC program area is not certain of the 99 code mentioned, more information is needed. Please contact the FQHC program area at 334-242-5455.
M. Schaller	Billing	Please verify- is it 7 or 8 visits to bill global?	Per Alabama Medicaid Agency policy: When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code in billing.
C. Smyth	Bonus Payments	Can they get both (DHCP bonus payments)? You just stated they only can have 1 bonus payment.	Yes. If a provider sees the recipient within the specified time periods, the provider may be eligible to receive both (prenatal and postpartum) bonus payments within a pregnancy.
C. Sansaricq	Bonus Payments	I understand that the H1000 can only be billed once within a pregnancy. If they transfer to our office can we bill the first visit that they have with us because they are "new" to us?	Only one prenatal and one postpartum bonus payment will be paid per recipient per pregnancy.
G. Holloway	Eligiblity	Does emergency Medicaid pay for patients blood work?	No. Emergency Medicaid only covers the delivery.
G. Holloway	Eligiblity	Will emergency Medicaid pay for bilateral tubal ligation for patients that have a vaginal delivery in the hospital?	No. Emergency Medicaid only covers the delivery.
B. Shephard	Eligiblity	So are tubals covered for emergency Medicaid patients?	No. Emergency Medicaid only covers the delivery.
C. Stanley	Family Planning	Why is there a waitng period for tubal ligation but not the hysterectomy form in a patient who is fertile? Doesn't seem consistent.	Reimbursement to providers who perform tubal ligations is federally mandated by CMS. This procedure is an elective procedure with a 30-day waiting period (per CMS guidelines) to give patients a chance to change their minds as this will be a permanent procedure. Chapter #28, page 51, of the Physician Manual states: Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are not covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program. The hysterectomy consent form was revised to include a section for unusual circumstances documentation.
T. Austin	Family Planning	What about months that have an extra day, to make 30 days?	30 calendar days from the date the recipient signs the consent form unless there is an extenuating circumstance (see Form 193).
R. Patterson	Family Planning	Some people only print and cannot write in cursive. I have sent in copies of legal ID to prove this and still been denied.	Recipient signatures should be affixed by the person who is being sterilized in such a manner as he/she usually signs in his/her hand writing during the regular and daily course of business, i.e., their driver's license, legal document, etc. In addition, the Family Planning Provider Manual Appendix C states: Consent forms submitted to Gainwell with missing and/or invalid information in non-correctable fields (recipient's signature and date recipient signed, signature of the person obtaining consent and date person obtaining consent signed, and interpreter's signature and date interpreter signed, if an interpreter is used) of the consent form will be denied by Gainwell and not returned to the provider.

J. Kelley	Family Planning	Some patients do not use cursive and print only.	Recipient signatures should be affixed by the person who is being sterilized in such a manner as he/she usually signs in his/her hand writing during the regular and daily course of business, i.e., their driver's license, legal document, etc. In addition, the Family Planning Provider Manual Appendix C states: Consent forms submitted to Gainwell with missing and/or invalid information in non-correctable fields (recipient's signature and date recipient signed, signature of the person obtaining consent and date person obtaining consent signed, and interpreter's signature and date interpreter signed, if an interpreter is used) of the consent form will be denied by Gainwell and not returned to the provider.
C. Stanley	Family Planning	Was on phone with Gainwell rep yesterday for 30 mins and they were not very useful.	Please contact the Program area regarding this issue.
T. Austin	Family Planning	So if I had one (consent form) to reject with the extra day in the month, who do I call?	The provider needs to contact Gainwell's Provider Assistance Center for assistance. The Provider Assistance Center's toll free phone number is 1-800-688-7989.
Yrenta	Family Planning	If provider completes sterilization form and another provider from same office does procedure will it be covered?	When it is not known in advance which specific physician will perform the procedure, it is acceptable to list a generic description of the physician, i.e. "staff physician, on-call physician, OB/GYN physician". When using a generic description and not a specific physician's name, the patient is to be informed that the physician on call or on duty will perform the procedure. The name of the provider facility (hospital, surgical center, etc.) or provider physician's group must also be entered in the same blank containing the generic physician description when the generic physician description is used. The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery and signs the "Physician's Statement". The physician's statement must be signed by the physician who is performing the sterilization procedure. Rubber stamped signatures are not permissible in this field. The physician must date the certification on the same date he or she signs it.
S. Stewart	Family Planning	Does anyone have a good contact for the Family Planning process at the State level I could call?	For claims and payment related inquiries, please contact your provider representative at Gainwell Technologies. The Provider Assistance Center's toll free phone number is 1-800-688-7989. For policy related inquiries, please call 334-353-5533.
J. Sheffield	Family Planning	Is the emergency indicator valid to use on a sterilization claim for Emergency Medicaid?	No. Emergency Medicaid only covers the delivery.
C. Stanley	Family Planning	Can you send me a formal response as to why there is not a 30 day waiting period for hysterectomy in a fertile patient? Thanks	Reimbursement to providers who perform tubal ligations is federally mandated by CMS. This procedure is an elective procedure with a 30-day waiting period (per CMS guidelines) to give patients a chance to change their minds as this will be a permanent procedure. Chapter #28, page 51, of the Physician Manual states: Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are not covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program. The hysterectomy consent form was revised to include a section for unusual circumstances documentation.
M. Schaller	General	Will the slides be printable?	Yes. The slides can be found here: https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx
L. Thaler	General	Will this be recorded so my staff can listen to it?	Yes. The recording can be found here: https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx
T. Baker	General	Will the slides be available?	Yes. The slides can be found here: https://medicaid.alabama.gov/content/5.0_Managed_Care/5.1_ACHN/5.1.3_ACHN_Providers.aspx
R. Patterson	Referrals	I have had to have a referral for the last year to get claims paid.	Please submit the ICN for the denied claims to ACHN@medicaid.alabama.gov
T. Baker	Referrals	We already have claim denying for no DHCP.	Please submit the ICN for the denied claims to ACHN@medicaid.alabama.gov
C. Smyth	Referrals	We have claims that denied for no ACHN referral.	Please submit the ICN for the denied claims to ACHN@medicaid.alabama.gov
A. Griffith	Referrals	Is a DHCP referral still required to obtain both of the bonus payments?	Yes.
N. Mcferrin	Referrals	Are yall going to stop the one time referrals and only use the permanent referrals.	Most of the referrals are for the pregnancy but if the pregnant female chooses to change their DHCP, which is there choice and required by Federal rules, the ACHN will issue a new referral to the new DHCP. There may also be times when a one time or temporary DHCP referral is issued by the ACHN. For example, a referral for consultation by a MFM may be needed.
C. Wren	Referrals	If a patient has Medicare and full Medicaid, do they need an ACHN referral?	No. Dual eligible Medicare/Medicaid recipients are not eligible for ACHN enrollment.

T. Clay	Referrals	Is the ACHN limited on when they can give a referral for the delivery for a patient that did not enroll?	No, the ACHN will issue a referral when they are able to enroll the recipient into care coordination. For specific issues or questions about referrals, the Agency encourages the provider to discuss it with the ACHN that the provider has signed a DHCP Agreement with.
M. Hawkins	Referrals	If we received one time referral from ACHN. Can we use during the completed visit/delivery?	It depends on why you received a one-time referral from your ACHN. If the referral was for the delivery only, then that would be ok. For specific questions about referrals, the Agency encourages you the provider to discuss it with the ACHN that you the provider has have signed a DHCP Agreement with.