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

Presenters from Managed Care Operations:
Travis Houser, Associate Director, Network Provider Assistance
Linda White, Program Consultant, Maternity, Family Planning/Plan First
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**

**STATEMENT OF PERSON OBTAINING CONSENT**

<table>
<thead>
<tr>
<th>Field 14</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the recipient</td>
<td></td>
</tr>
<tr>
<td>Field 15</td>
<td>Description</td>
</tr>
<tr>
<td>Benefit type of operation</td>
<td></td>
</tr>
<tr>
<td>Field 16</td>
<td>Description</td>
</tr>
<tr>
<td>Fact that it is intended to be final and irreversible procedure and the discomfort, risks and benefits associated with it</td>
<td></td>
</tr>
<tr>
<td>Field 17</td>
<td>Description</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Field 18</td>
<td>Description</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Field 19</td>
<td>Description</td>
</tr>
<tr>
<td>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 consequences of the procedure.</td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN’S STATEMENT**

<table>
<thead>
<tr>
<th>Field 20</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortly before I performed a sterilization operation upon</td>
<td></td>
</tr>
<tr>
<td>Field 21</td>
<td>Description</td>
</tr>
<tr>
<td>Name of the recipient</td>
<td></td>
</tr>
<tr>
<td>Field 22</td>
<td>Description</td>
</tr>
<tr>
<td>Date of sterilization</td>
<td></td>
</tr>
<tr>
<td>Field 23</td>
<td>Description</td>
</tr>
<tr>
<td>Name of the physician</td>
<td></td>
</tr>
<tr>
<td>Field 24</td>
<td>Description</td>
</tr>
<tr>
<td>The fact that it is intended to be final and irreversible procedure and the discomfort, risks and benefits associated with it</td>
<td></td>
</tr>
<tr>
<td>Field 25</td>
<td>Description</td>
</tr>
<tr>
<td>I informed 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.</td>
<td></td>
</tr>
<tr>
<td>Field 26</td>
<td>Description</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Field 27</td>
<td>Description</td>
</tr>
<tr>
<td>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 consequences of the procedure.</td>
<td></td>
</tr>
</tbody>
</table>

**INTERPRETER’S STATEMENT**

<table>
<thead>
<tr>
<th>Field 28</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 the consent form in the recipient’s language and explained its contents to him/her. To the best of my knowledge and belief, I have understood this explanation.</td>
<td></td>
</tr>
</tbody>
</table>

**INTERPRETER’S SIGNATURE**

<table>
<thead>
<tr>
<th>Field 29</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter’s Signature</td>
<td></td>
</tr>
</tbody>
</table>

**Date**

<table>
<thead>
<tr>
<th>Field 30</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

**FORM 193 (REV 9/26/2016)**
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.

Recipient’s Signature

Date

Type/Print Recipient’s Name

Recipient’s Medicaid Number

[Image of a driver's license from Alabama]
## Top Reasons For Returns

<table>
<thead>
<tr>
<th>Most frequent causes of claims having to be returned for correction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recipient’s date of birth not the same on the claim and consent form.</td>
</tr>
<tr>
<td>2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.</td>
</tr>
<tr>
<td>3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.</td>
</tr>
<tr>
<td>4. All blanks not appropriately completed.</td>
</tr>
<tr>
<td>5. Physician’s signature is missing.</td>
</tr>
<tr>
<td>6. Date of sterilization not the same on the claim and on the consent form.</td>
</tr>
<tr>
<td>7. Legibility of dates and signatures.</td>
</tr>
<tr>
<td>8. Facility name not on the consent form.</td>
</tr>
</tbody>
</table>
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.
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

- 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

<table>
<thead>
<tr>
<th>Pregnancy and Delivery Bonus Procedure Code Description</th>
<th>Procedure Code</th>
<th>Total Bonus Paid for FY20 Services (as of 05/18/2021)</th>
<th>Number of Recipients</th>
<th>Total Deliveries during FY20 (as of 05/01/2021 data)</th>
<th>Percent Paid Procedure Codes</th>
<th>Number Of Recipients With No Bonus Procedure Codes Reimbursed</th>
<th>Bonus Payments Not Billed By Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Bonus Payment</td>
<td>H1000</td>
<td>$994,012</td>
<td>10,321</td>
<td>29,327</td>
<td>35.19%</td>
<td>19,006</td>
<td>$1,900,600</td>
</tr>
<tr>
<td>Postpartum Bonus Payment</td>
<td>G9357</td>
<td>$1,265,808</td>
<td>13,053</td>
<td>29,327</td>
<td>44.51%</td>
<td>16,274</td>
<td>$1,627,400</td>
</tr>
</tbody>
</table>

| Sum Amount Paid:                                       |                | $2,259,820                                             |                      |                                                      |                               |                                                               | $3,528,000                             |

**Missed Bonus Payment Opportunities**
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:
  o Pamela Moore, Associate Director- Pamela.Moore@medicaid.Alabama.Gov
  o Linda White, Maternity Program Consultant- Linda.White@medicaid.Alabama.Gov
  o Julie Gilliland, Family Planning/Plan First Program Manager- Julie.Gilliland@medicaid.Alabama.Gov

• Network Provider Assistance:
  o Travis Houser, Associate Director- Travis.Houser@medicaid.Alabama.Gov
  o Patricia Toston, Program Manager- Patricia.Toston@medicaid.Alabama.Gov
  o Jessica Brooks, Program Manager- Jessica.Brooks@medicaid.Alabama.Gov
Questions

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