Maternity Care Billing

Question:

How do I bill when the maternity care spans over multiple MCOs?

Answer:

Providers can use as a reference the KMAP professional manual section 8400 pg 8-21. In instances when a patient's pregnancy is not covered by a single MCO, the provider will split bill previous/current MCO in accordance with the guidelines below:

Obstetrical and Gynecological billing guidelines:

- The following procedures are content of service of total obstetrical (OB) care:
  - Office visits (nine months before and six weeks after delivery)
  - Urinalysis
  - Internal fetal monitor
- Total OB care generally consists of 13 office visits, delivery (vaginal or cesarean), and postpartum care. The provider of total OB care should bill codes 59400 or 59510 whichever applies. If an ARNP or PA provides part of the prenatal care but does not deliver the baby, the physician may bill the global fee without indicating the PA or ARNP as the performing provider.
- If the ARNP or PA provides part of the prenatal care and delivers the baby, the services must be broken out and the PA or ARNP indicated as the performing provider. Providers should **not** bill for OB services until care is completed (for example, the beneficiary delivers or the beneficiary is no longer a patient).
- When a provider does not complete total OB care, and only partial antepartum care has been provided, the following guidelines apply when billing services:
  - **One to three prenatal visits only** - Bill using E&M office visit codes.
  - **Four to six prenatal visits only** - Bill using code 59425. This code must NOT be billed by the same provider in conjunction with one to three office visits, or in conjunction with code 59426.
  - **Complete antepartum care without delivery** - Bill using code 59426. Complete antepartum care is limited to one beneficiary pregnancy per provider.
  - **Delivery only** (no antepartum care provided) - Bill using code 59409 or 59514.
  - **Delivery and postpartum care only** - Bill using code 59410 or 59515.
- **Codes 59425 and 59426** may be billed only once per provider, per beneficiary pregnancy. These codes must not be billed together by the same provider for the same beneficiary, during the same pregnancy.
- Pregnancy-related (E&M) office visits must not be billed in conjunction with code 59425 or 59426 by the same provider for the same beneficiary, during the same pregnancy.
- Fetal oxytocin stress testing (initial or subsequent) is not covered in place of service 21 (inpatient).
- Fetal nonstress test (electronic, external fetal monitor applied) is not covered in place of service 21 (inpatient).
- Code 59426 is limited to one per pregnancy, per provider.