

**Covered Families & Children (CFC) Program  
Delivery Payment Reporting  
Procedures For ODJFS Managed Care Plans**

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To receive payment for deliveries from the Ohio Department of Job and Family Services (ODJFS), managed care plans (MCPs) must submit claims using the following codes:

**Delivery Payment Codes for dates of service prior to January 1, 2010**

**UB-92**

<b>ICD-9 Procedure Codes</b>	
72.x	Forceps, vacuum, and breech delivery
73.51	Manual assisted delivery – manual rotation of fetal head
73.59	Manually assisted delivery – other manually assisted delivery
74.0	Cesarean section and removal of fetus; Classical cesarean section
74.1	Cesarean section and removal of fetus; Low cervical cesarean section
74.2	Cesarean section and removal of fetus; Extraperitoneal cesarean section
74.4	Cesarean section and removal of fetus; Cesarean section of other specified

**UB-92 and HCFA 1500**

<b>ICD-9 Diagnosis Codes:</b>	
<b>V27.x</b>	Outcome of Delivery (must be used in conjunction with one of the ICD-9 codes and/or CPT codes listed below)
Except for code 650, the following codes must have a 5th digit equal to 1 or 2 to qualify for the delivery payment:	
<b>640-648</b>	Complications mainly related to pregnancy
<b>650-659</b>	Normal delivery and other indications for care in pregnancy, labor and delivery
<b>660-669</b>	Complications occurring mainly during the course of labor and delivery
<b>670-676</b>	Complications of the puerperium
<b>CPT Codes:</b>	
<b>59409</b>	Vaginal delivery (with or without episiotomy and/or forceps)
<b>59514</b>	Cesarean delivery only
<b>59612</b>	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps)
<b>59620</b>	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

To qualify for reimbursement, the encounter must contain one of the preceding diagnosis or procedure codes and the provider type of the “pay\_to” provider (**the provider submitted on professional encounters should be the rendering provider, when known**) must be one of the following:

Provider Type	Provider Type Description
01	General Hospital
15	Birthing Center
71	Nurse, Midwife

**OR**

A Provider Type of 20 (Physician, Individual), 21(Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) must have a specialty of one of the following:

Provider Specialty	Provider Specialty Description
01	General Practice
15	Internal Medicine
16	Pediatrics
51	General Surgery
53	Obstetrics & Gynecology
60	Emergency Medicine
71	Obstetrics & Gynecology (Osteopaths)

## Delivery Payment Codes for dates of service beginning January 1, 2010

### UB-92

ICD-9 Procedure Codes	
72.x	Forceps, vacuum, and breech delivery
73.09	Other artificial rupture of membranes at the time of delivery
73.22	Internal and combined version with extraction
73.51	Manual assisted delivery – manual rotation of fetal head
73.59	Manually assisted delivery – other manually assisted delivery
73.8	Operations on fetus to facilitate delivery
73.9	Other operations assisting delivery
74.x	Cesarean section and removal of fetus

### UB-92 and HCFA 1500

ICD-9 Diagnosis Codes:	
<b>V24.0</b>	Postpartum care and examination immediately after delivery
Except for code 650, the following codes must have a 5th digit equal to 1 or 2 to qualify for the delivery payment:	
<b>640-649</b>	Complications mainly related to pregnancy

<b>650-659</b>	Normal delivery and other indications for care in pregnancy, labor and delivery
<b>660-669</b>	Complications occurring mainly during the course of labor and delivery
<b>670-676</b>	Complications of the puerperium
<b>CPT Codes:</b>	
<b>59400-59410</b>	Vaginal Delivery, Antepartum and Postpartum Care
<b>59510-59515</b>	Cesarean Delivery
<b>59610-59622</b>	Delivery After Previous Cesarean Delivery

To qualify for reimbursement, the encounter must contain one of the preceding diagnosis or procedure codes and the provider type of the “pay\_to” provider (**the provider submitted on professional encounters should be the rendering provider, when known**) must be one of the following:

<b>Provider Type</b>	<b>Provider Type Description</b>
01	General Hospital
15	Birthing Center
71	Nurse, Midwife
82	Ambulance
83	Ambulette

**OR**

A Provider Type of 20 (Physician, Individual), 21(Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) must have a specialty of one of the following:

<b>Provider Specialty</b>	<b>Provider Specialty Description</b>
01	General Practice
15	Internal Medicine
16	Pediatrics
51	General Surgery
53	Obstetrics & Gynecology
60	Emergency Medicine
71	Obstetrics & Gynecology (Osteopaths)

## Identification of a Delivery Encounter

To identify a delivery encounter, ODJFS searches every encounter submitted for codes specified as 'Delivery Payment Codes' (above) with the date of service on or after the effective date associated with that code. The following Record/Type locations in the UB-92 & NSF Specification documents are searched for delivery payment codes as specified:

### UB-92 (institutional)

#### ➤ In-patient encounters

Record Type 70, principal procedure code & date, and other procedure codes & dates  
See *Delivery Payment Codes*

--- or ---

Record Type 70, principal diagnosis code, and other diagnosis codes.  
Record Type 20, statement covers period thru date.  
See *Delivery Payment Codes*

#### ➤ Out-patient encounters

Record Type 61, HCPCS procedure code & date of service  
See *Delivery Payment Codes*

--- or ---

Record Type 70, principal diagnosis code, and other diagnosis codes.  
Record Type 20, statement covers period thru date.  
See *Delivery Payment Codes*

### NSF (non-institutional)

· Record Type FA0, HCPCS procedure, & service from date.  
See *Delivery Payment Codes*

— or —

➤ Record Type EA0, diagnosis code w/FA0 service from date.  
See *Delivery Payment Codes*

Submission of multiple delivery encounters indicating the same delivery event is expected (e.g., one encounter from the physician delivering and another from the hospital). The first encounter identifying a delivery event will trigger payment. The recipient's ID, and the date of service of this triggering encounter will be reported to the MCP on the delivery payment remittance advice. Subsequent delivery encounters for the same delivery event will be considered supporting encounters as long as the MCP MMIS provider number and recipient ID are the same and the date of service is within 180 days of the triggering encounter. If a subsequent delivery encounter has a different MMIS provider number or a different recipient ID or the date of service is outside the 180 day range, it will be considered a separate delivery and will trigger a separate delivery payment. The date of service of the triggering and supporting encounters are important when considering a take back of payment after an update or a delete of any of the encounters indicating the same delivery event.

## Delivery Payments

MCPs will be paid monthly for deliveries that are identified in the submitted encounters. For example, payment for a delivery encounter submitted by March 5, 2009 will be reimbursed in May. This payment will be a part of a weekly update that is in place currently. The third weekly update of the month will include the delivery payment. The delivery remittance advice will be in the same format as the capitation remittance advice. A delivery payment will be indicated by the codes 'C100D – C800D' in the 'Proc-Mod / Revenue-Proc / Drug Code' field where 1-8 represents the region. All other information on the remittance advice will be the same as the capitation remittance advice. The date of service on the remittance advice associated with a payment is the date of service of the triggering encounter. This date is important when evaluating a payment for take back when any of the encounters indicating the same delivery event are updated or deleted

### Updating Delivery Encounters

To update a delivery encounter, the MCP resubmits the encounter and ODJFS overwrites the past submission. This is the same method as is currently used for all other encounters. Both versions of the encounter, old and new, are re-evaluated to determine the appropriate action regarding the handling of the delivery payment.

### Deleting Delivery Encounters

To delete a delivery encounter, the MCP resubmits the encounter with a special delete code, 'T', signifying that ODJFS should delete the claim, and "take back" its payment. Deletion of "delivery claims" without "take back" is not allowed. Claims flagged "delete w/take back" are physically deleted from the encounter master file as part of the monthly updating process. The following are the specifications for deleting delivery encounters:

To delete w/take back payment for a "delivery" claim:

UB-92 format, record/field 20-7, "Sex"

Code value T = Delete w/Take Back Payment, Encounter "Delivery" Claim Only

NSF format, record/field CA0-31.0a, "Delete Encounter Claim Flag"

Code value T = Delete w/Take Back Payment, Encounter "Delivery" Claim Only

To delete "non-delivery" claims:

UB-92 format, record/field 20-7, "Sex"

Code value D = Delete Encounter "Non-delivery" Claim

NSF format, record/field CA0-31.0a, "Delete Encounter Claim Flag"

Code value D = Delete Encounter "Non-delivery" Claim

**Mass delete w/take back of delivery claims is not supported.** Each MCP will be permitted to "delete w/take back" a limited number of claims monthly to handle error correction (see table below). **The number of allowable "delete w/take backs" is 100 delivery encounters. Delete w/take back beyond the threshold will be rejected at the time the master file is updated, and not when the data is initially processed. A new report of these rejections will be sent to the MCP.**

### Take back of delivery payments

The first delivery encounter identifying a delivery event triggers a delivery payment. Subsequent encounters identifying the same delivery event (same MCP region-specific provider number and same

recipient) are recognized as supporting the triggering encounter as long as the date of service is within 180 days of the date of service of the triggering encounter. This means that supporting encounters have either the same or different dates of service as the encounter that triggered the delivery payment.

With every update (change from delivery to non-delivery) or delete of a delivery encounter, the initial payment must be evaluated for take back. A take back of payment depends on the date of service of the remaining supporting encounters compared to the date of service of the triggering encounter (the date of service of the triggering encounter is reported to the MCP on the delivery payment remittance advice). Take back of payment is made when the triggering encounter and all of the supporting encounters with the same date of service as the triggering encounter are updated (changed from delivery to non-delivery) or deleted. If there are supporting encounters remaining after an update or a delete with a different date of service as the triggering encounter, then, in order to change the date of service associated with payment, there will be an initial take back of payment followed by a re-issuance of payment with a new date of service which will be taken from one of the remaining supporting encounters. The new date of service will be reported to the MCP on the delivery payment remittance advice with the re-issuance of payment. Although it is the goal of ODJFS to reissue payment within the same payment cycle so that the re-issuance of payment will offset the take back, it cannot be guaranteed to be within the same payment cycle because re-issuance of payment involves a manual step.

Take backs are effected through an automatic credit being taken on the next delivery payment run, or, in some circumstances, the next capitation payment run. When the dollar amount of the take backs exceeds the dollar amount of delivery payments, all delivery payments and take backs will be held until the regular monthly capitation payment is executed and enough positive dollars are created to offset the negative balance created by the take backs.

### Examples of Updating and Deleting Delivery Encounters

The following examples show the effects of updating and deleting encounters that trigger the delivery payment and supporting encounters in various combinations.

For the following examples, assume three encounters were submitted to and accepted by ODJFS and a delivery payment was made to the MCPs. The encounter that triggered the payment varies, depending on the example.

Institutional encounter #1:	dated	01/1/2000	code ICD9 Procedure Code 73.51
Noninstitutional encounter #2:	dated	01/2/2000	code CPT 59400
Noninstitutional encounter #3:	dated	01/2/2000	code ICD9 Diagnosis 65101

#### Example 1: Delivery never actually occurred or later it was determined that it was not covered

##### MCP Intended Result: Return Payment

For the MCP to return payment to ODJFS the MCP must update (change from delivery to non-delivery) or delete all three encounters. If any one of the three encounters remain the payment will ultimately stand. The process by which the payment will stand depends on the date of service of the remaining encounter(s) in comparison to the date of service of the encounter that triggered the payment. If one of these encounters remain indicating the delivery, one of the following two scenarios will play out:

**Scenario 1:** The delivery payment was made *based on the encounter #1 with the date of service of 1/1/2000.*

If the MCP resubmits encounter #1 with a “delete w/take back” instruction, then payment is initially taken back. However, to avoid having a payment reissued in support of the remaining encounters with the 1/2/2000 service dates, the two non-institutional claims with 1/2/2000 service dates must also be corrected to no longer reflect a delivery.

**Scenario 2:** The delivery payment was made *based on encounter #2 with the date of service of 1/2/2000*.

If the MCP only resubmits encounter #1 with the 1/1/2000 date of service with a “delete w/take back” instruction, ODJFS would not take back payment because it has a different date of service than the encounter that triggered payment. If the MCP only resubmits encounters #2 and #3 with a “delete w/take back” instruction, the result would be an initial take back of payment followed by a re-issuance of payment in support of the remaining encounter with the 1/1/2000 date of service. The reissued payment would have 1/1/2000 as the new date of service on the remittance advice. As emphasized above, to realize the take back of payment, all three encounters must be updated (changed from delivery to non-delivery) or deleted.

## **Example 2: Encounter #1 was submitted with the incorrect date of service**

### **MCP Intended Result: Correct the date of service on encounter #1**

As in the above example, the date of service of the encounter triggering the initial payment determines how the correction of the date of service on encounter #1 is processed. Although the outcome is same (payment for delivery), the scenarios below illustrate the two possible processes that occur in the evaluation of the initial payment for take back.

**Scenario 1:** Assume the existing delivery *payment was made based on the 1/2/2000 service date*. If the MCP resubmitted encounter #1 with the correct date of service of 1/2/2000, then the payment would stand because the date of service matches that of the encounter which triggered payment.

**Scenario 2:** Assume the existing delivery *payment was made based on the 1/1/2000 service date*. If the MCP resubmitted encounter #1 with the correct date of service of 1/2/2000, then payment would be taken back because there are no other supporting encounters with the same date of service as the triggering encounter and be reissued with the corrected date of service. The remittance advice would show the new date of service (1/2/2000) with the reissued payment. Although it is the goal of ODJFS to reissue payment within the same payment cycle so that the re-issuance of payment will offset the take back, it cannot be guaranteed to be within the same payment cycle because re-issuance of payment involves a manual step.

## **Example 3: The incorrect recipient was identified on all three encounters**

### **MCP Intended Result: Return payment for the incorrect recipient Issue delivery payment for correct recipient**

To achieve the desired results, two steps are required. First, encounters #1, #2, #3 must be deleted. This will result in a take back of payment. Second, delivery encounters for the correct recipient and the correct dates of service must be submitted *with new encounter identification numbers*. This will result in payment for a delivery by the correct recipient.

## **Reporting Guidelines**

A hospital claim and a physician claim should be reported for each delivery. Hospital claims should also be reported for each live newborn. The provider number reported on the hospital claim should be the hospital's provider number. The provider number reported on a physician claim should be the physician group or individual physician number.

Encounter claims must comply with the 'Medicaid Provider Types by Claim Form' specifications. Delivery payment methodology limits delivery payments to certain provider type and specialty codes (noted above) as specified on the Medicaid Provider Master File (PMF). Individual physicians and physician groups should have the appropriate 'Provider Type' and 'Provider Specialty Code' designated on the PMF, as applicable. For example, a physician group composed entirely of physicians with an OB/GYN specialty should be assigned specialty code '53' on the PMF. Please note that physician groups which are composed of more than one type of specialist will not be assigned a specialty code on the PMF. Currently, only one provider number is reported on the encounter claim. Therefore, if the rendering physician is a member of a multi-specialty group, the delivery claim should be submitted with the individual physician's provider number instead of the group number, in order to be eligible for payment. The individual provider number should have the appropriate primary specialty code (i.e., General Practice, Internal Medicine, Pediatrics, General Surgery, OB/GYN, Emergency Medicine) noted on the PMF.

The PMF is available for review in each MCP's SFTP pickup folder and updated on a monthly basis. MCPs should contact their contract administrator in the Bureau of Managed Health Care regarding any necessary corrections/updates on the PMF of specialty codes for providers on their panel.

### **Submission Timelines**

It has been the policy of the Ohio Department of Job and Family Services (ODJFS) that managed health care plans (MCPs) should submit claims thirty-five days after the end of the month in which they were paid by the MCP. For example, claims paid by the MCP in June, 2008 are due August 5, 2008.

MCPs are required to submit all delivery encounters **no later than 460 days after the last date of service (pending ODJFS IT capacity)**. Delivery encounters which are submitted after this time will be denied payment.

Prior to the implementation of the 460 day criteria, delivery encounters which are submitted later than 365 days after the last date of service will be denied payment. MCPs will receive notice of the payment denial on the remittance advice.

#### References:

HEDIS 2008

ICD-9-CM (for hospitals) 2007

CPT 2008