SECTION II -PHYSICIAN/INDEPENDENT LAB/CRNA/RADIATION THERAPY CENTER

CONTENTS

TOC not required

292.671 Method 1 - "Global" or "All-Inclusive" Rate

~~10-1-06~~6-1-20

The global method of billing should be used when one (1) or more physicians in a group see the patient for a prenatal visit and one (1) of the physicians in the group does the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.

No benefits are counted against the beneficiary's physician visit benefit limit if the global method is billed.

A. One (1) charge for total obstetrical care is billed. The single charge includes the following:

1. Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure, and fetal heart tones, routine chemical urinalyses, maternity counseling, and other office or clinic visits directly related to the pregnancy.
2. Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.
3. Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps, or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.
4. Routine postpartum care (sixty (60) days), which includes routine hospital and office visits following vaginal or cesarean section delivery.

B. The global method must be used when the following conditions exist:

1. At least two (2) months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid beneficiary is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis. This beginning date of service must be billed in the "initial treatment date" field on the claim when billing for global obstetric care.
2. The patient was continuously Medicaid eligible for two (2) months or more months before delivery and on the delivery date.

If either of the two (2) conditions is not met, the services will be denied, stating either "monthly billing required" or "beneficiary ineligible for service dates".

C. The correct codes for billing Medicaid for global obstetric care are as follows.

National Codes			
59400	59510	59610	59618

When billing these procedure codes, both the first date of antepartum care after Medicaid eligibility has been established and the date of delivery must be indicated on the claim ~~in the date of service field~~. The delivery date is the date that is to be in the From and To Date

of Service billed on the line with the above codes. The first date of antepartum care is to be billed in the "Initial Treatment Date" field.

For the CMS 1500 claim form, this is field 15 – Other Date Field. Qualifier 454 is required.

For the Provider Portal, the Date Type is "Initial Treatment Date" and the Date of Current is the first date of antepartum care.

If these two (2) dates are not entered and are not at least two (2) months apart, payment will be denied. The 12-month filing deadline is calculated based on the date of delivery.