

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Roberts</i>	DATE <i>9-5-13</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000096</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Lynch</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>9-16-13</i>
<i>cleared 10/2/13, letter attached</i>	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Jennifer Lynch

From: Peters, Hal <HalPeters@gov.sc.gov>
Sent: Wednesday, September 04, 2013 11:19 AM
To: Jennifer Lynch
Subject: Correspondence
Attachments: 326939.PDF; 326736.PDF; 327190.PDF

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SEP 05 2013

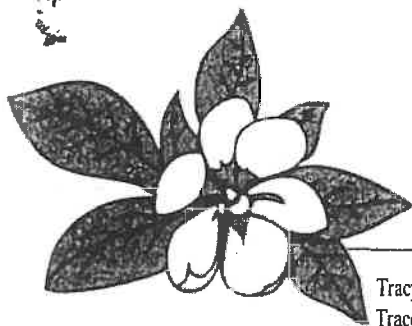
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Jenny-

Attached you will find 3 pieces of correspondence that I am referring to HHS. If you could please respond, I would greatly appreciate it. Thanks and have a great day!

Hal Peters
Policy Analyst
Office of Governor Nikki R. Haley
P 803.734.4062
E halpeters@gov.sc.gov

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Magnolia OB/GYN, LLC OF MYRTLE BEACH

Tracy D. Nelson, M.D., F.A.C.O.G.
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Karyn C. Markley, M.D., F.A.C.O.G.
Norah A. Nutter, MSN, WHNP
Linda Bubaris, APRN

August 14, 2013

Audrey Lutts, RN
South Carolina Department of Health & Human Services
Division of Program Integrity
PO Box 100210
Columbia SC 29202-2210

Provider #: GP2574
Case #: P9354

Dear Ms. Lutts:

This letter is in response to your later dated August 7, 2013 regarding billing of inpatient hospital visit and discharge services following routine vaginal deliveries and cesarean section deliveries. According to your findings, you cited the following potential billing errors:

- 1) The billing of inpatient hospital admission codes 99221-99223, in conjunction with a routine vaginal delivery (code 59409, 59612) or cesarean section (59514 and 59620). This pattern constitutes unbundling of the surgical package when the beneficiary also had prenatal care by the same provider group.
- 2) The billing evaluation and management (E/M) services unrelated to routine postpartum care without a -24 modifier. The inappropriate billing resulted in an unnecessary cost to the Medicaid program; therefore the hospital care codes were disallowed.

While we are now aware of the SCDHHS program policies, at the time these services were rendered and billed, they were submitted in accordance with American Medical Association (AMA) Current Procedural Terminology, 4th Edition (CPT-4), National Correct Coding Initiative (NCCI) guidelines, and the American College of Obstetrician & Gynecologist (ACOG) definition of the global maternity package and correct coding/billing guidelines.

Based on the coding directives from the agencies listed above, the following points detail the justification for the billing in question:

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SEP 05 2013

Department of Health & Human Services
OFFICE OF THE DIRECTOR

1. Magnolia OB/GYN did not bill for the admission related to a delivery. The initial hospital admission is considered part of the service for any type of delivery. Services billed were for subsequent hospital visits and discharge services.
2. SCDHHS requires providers to bill services related to maternity care, including routine antepartum visits, the delivery itself, and the postpartum visit, as separate, itemized charges. SCDHHS does not recognize the global maternity package, which includes routine antepartum, delivery, and postpartum care and is coded as 59400 (vaginal) or 59510 (cesarean section). It stands to reason, based on itemized billing, that *all* services would be reported separately.
3. The CPT-4 code descriptions, inclusion notes, and exclusion notes for delivery only services are as follows:
 - a) 59409 Vaginal delivery only (with or without episiotomy and/or forceps);
EXCLUDES: inpatient management after delivery/discharge services (99217-99239 [99224, 99225, 99226])
 - b) 59514 Cesarean delivery only;
INCLUDES: Admission history; admission to hospital; cesarean delivery; management of uncomplicated labor; physical exam
EXCLUDES: Inpatient management after delivery/discharge services (99217-99239 [99224, 99225, 99226]); Medical problems complicating labor and delivery
4. According to *The Essential Guide to Coding in Obstetrics and Gynecology, Fourth Edition* (ACOG, 2009):

“In the past, ACOG stated that the inpatient postpartum services were included in the delivery only codes. However, in 2006 the ACOG Committee on Coding and Nomenclature, reexamined the vignettes for the delivery-only codes and found that the *values assigned to these codes did not include the physician work for inpatient postpartum care*. This reexamination clarifies that the *delivery only codes (59409, 59514, 59612, and 59620) do not include inpatient postpartum care*” [emphasis added].

Thus, the SCDHHS policy and ruling on these charges is in direct contradiction to established industry guidelines for correct coding and billing. Furthermore, according to the National Correct Coding Initiative (NCCI), the global follow up days for maternity care is listed as "MMM" and excluded as such from the traditional global surgical package.

5. The use of modifier -24 is defined as "Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period" (CMS, 2013). This modifier is to be used
 - a) with E/M service codes
 - b) for services unrelated to the surgery/procedure performed
 - c) not used for medical management after surgery

Since the services in question were related to the delivery and were part of the patient's medical management, and due to SCDHHS' policy regarding itemized billing for maternity services, it is our professional opinion that the use of modifier -24 would be inappropriate. Point in fact, it is not required that modifier -24 be appended to the E/M service codes that are billed as part of routine antepartum care.

Magnolia OB/GYN abides by all federal, state, and payer guidelines in all aspects of coding and billing. It is never our intent to deliberately miscode or bill for services in order to obtain reimbursement, but coding and billing are monitored for completeness, accuracy, and submitted in accordance with correct coding initiatives. During the months of March and April 2013, services were submitted for reimbursement based on national correct coding guidelines. When made aware of the policy of the State of South Carolina, we ceased billing for inpatient postpartum management to Medicaid. Based on State policy, the amount of the overpayment is not in dispute, and Magnolia OB/GYN will submit a reimbursement of \$988.97. We ask that this overpayment be recouped as part of future Medicaid payments.

We also ask that SCDHHS review its policies regarding maternity care and establish a policy that is consistent for all services rendered; meaning, if the requirement is to bill services rendered as individual services and not part of the global maternity package, then this requirement should apply to all services rendered, and not exclude the inpatient postpartum management. If it is the State of South Carolina's position that inpatient postpartum services are considered part of the delivery code, then reimbursement should be adjusted to reflect the additional work performed by the physician for the same.

Thank you for your consideration, and we look forward to your reply.

Sincerely,



Cheryl Gach
Office Manager
Magnolia OB/GYN

Sincerely,



Lisa Scott, CPC, COSC
Billing Supervisor
Magnolia OB/GYN

Enc

Cc: Tony Keck, Director, SCDHHS
The Honorable Nikki Haley, Governor, State of South Carolina



August 7, 2013

CERTIFIED MAIL

Magnolia OB GYN LLC of Myrtle Beach
Cheryl Gach, Office Manager
8203 Nigels Drive, Suite 100
Myrtle Beach, SC 29572-4177

**PROVIDER #: GP2574
CASE #: P8354**

Dear Ms. Gach,

The Department of Health and Human Services is mandated by the federal government to provide surveillance and utilization review of the services rendered to Medicaid beneficiaries to safeguard against unnecessary or inappropriate use of Medicaid services. The Division of Program Integrity performs reviews to identify and recover excessive or inaccurate payments to providers, and insure compliance with the applicable Medicaid laws, regulations and policies. Program Integrity policies and operating procedures as well as citations to appropriate State and Federal Regulations can be found in Section 1 of each provider manual.

In a review of your paid claims data during the period of 6/1/2010 through 5/31/2013, we identified one or both of the following potential billing errors.

- 1) The billing of inpatient hospital admission codes 99221-99223, in conjunction with a routine vaginal delivery (code 59409, 59612) or cesarean section (59514 and 59620). This pattern constitutes unbundling of the surgical package when the beneficiary also had prenatal care by the same provider group.
- 2) The billing of evaluation and management (E/M) services unrelated to routine postpartum care without a 24 modifier. The inappropriate billing resulted in an unnecessary cost to the Medicaid program; therefore the hospital care codes were disallowed.

The Physician's Policy Manual states the following:

Uncomplicated (Routine) Deliveries

Both vaginal (59409 and 59612) and Cesarean section (59514 and 59620) deliveries are considered surgical packages. The following are inclusive in the surgical packages:

- Pitocin induction
- Surgical or mechanical induction
- Fetal monitoring (internal or external)
- Amnio infusion
- Episiotomy
- Laceration repair
- Suture removal
- Standby for delivery
- Subsequent routine hospital care
- Hospital discharge
- Any related evaluation/management visits within 30 days following the delivery

- Routine follow-up care (However, one postpartum visit may be billed separately using procedure code 59430. Refer to *Postpartum Care* under the "Obstetrics and Gynecology" heading in this section.)
- Procedure code 59200, Insertion of Cervical Dilator (e.g., laminaria, prostaglandin) is considered included in the surgical package and may not be billed in addition to the CPT code for the delivery. This applies whether being placed the day of delivery, or several days prior to delivery if placed by the delivering physician or physician within the same practicing group.

Hospital Admission for Delivery

The hospital admission codes 99221 – 99223 are not allowed if the delivering physician or group has provided prenatal care to the beneficiary. The appropriate level admission code may be billed with drop-in vaginal and Caesarean section deliveries only.

Emergency Deliveries If the patient gives birth outside the hospital setting and the patient's private physician did not perform the delivery, but later meets the maternal patient at the hospital for post-delivery services, the following procedures apply:

- The private physician should bill procedure code 59414 for delivery of the placenta, if applicable.
- The private physician may also bill for subsequent hospital care and the hospital discharge, if applicable.

If a hospital-based physician actually performs the delivery and the private physician arrives in time to assist the hospital-based physician or arrives shortly after the delivery, the following apply:

- The hospital-based physician would bill for the delivery.
- The private physician would bill for the post-delivery services using procedure code 59414 if the private physician performed the services.

(Refer to the Medicaid Physicians, Laboratories and other Medical Professionals Manual 02/01/05 edition, updated 09/01/10, section 2, page 89-91)

Postpartum Care Routine Postpartum Visit (59430) – The postpartum visit includes an uncomplicated routine GYN examination of the mother following a vaginal or C-section delivery. Only one postpartum exam per delivery is allowed. Reimbursement for all other routine postpartum visits is included in payment for the delivery. Effective July 1, 2005, Family Planning counseling or instruction (99401 and 99402) may not be billed in addition to the postpartum code when Family Planning services are rendered and documented. See "Family Planning" in this section for the code description and more details.

Complication/Other Medical Attention During 30 Days Post Delivery

– If E/M services unrelated to routine postpartum care are necessary during the 30 days post-delivery, bill these services using modifier 24. Documentation in the patient's chart should substantiate that the visit was unrelated to the delivery.

Note: Wound infection is not considered routine postpartum care.

Enclosed is a copy of the Medicaid claim report. When Program Integrity identifies that improper payments have been made, Medicaid requires a refund of the overpayments. Refer to the Medicaid Physicians, Laboratories and other Medical Professionals Manual updated 05/01/10, section 1, page 28.

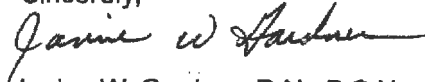
Magnolia OB GYN LLC of Myrtle Beach
August 7, 2013
Page 3 of 3

The amount of the potential overpayment for the errors is: \$988.97.

If we do not hear from you within 10 working days of the receipt of this letter, we will presume that you agree with our findings. If you disagree with our analysis of your claims detail, you must submit documentation to support your claim(s) within 10 days of the date of this letter. The documentation should be sent to ATTN: Audrey Lutts, RN. SCDHHS, Division of Program Integrity, P.O. Box 100210, Columbia, South Carolina 29202-3210. We will review your documentation, make adjustments in the overpayment amount if warranted, and let you know of our determination. At the time you contact us, we may set up an informal conference to discuss the findings.

If you have any questions regarding the findings, please contact Audrey Lutts at (803) 898-0055.

Sincerely,



Janice W. Gardner, R.N., B.S.N.
Department of Medical Service Review

Enclosures

Note: The State authority for this review and recovery of the improper payments can be found at Reg.126.40 et seq., Code of Regulations of South Carolina 1976 as amended; the Federal authority may be found at 42 CFR 433.30 et seq.; See also 42 CFR 431.107; 42 CFR Part 455; and 42 CFR Part 456.

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

(INCLUDES) Fetal heart tones
Hospital/office visits following cesarean section or vaginal delivery
Initial/subsequent history
Physical exams
Recording of weight/blood pressures
Routine chemical urinalysis
Routine prenatal visits:
Each month up to 28 weeks gestation
Every other week from 29 to 36 weeks gestation
Weekly from 36 weeks until delivery

62.30 62.30 FUD MMM

AMA: 2009, Jan, 11-31; 2008, Jan, 10-25

59409 Vaginal delivery only (with or without episiotomy and/or forceps);

(EXCLUDES) Inpatient management after delivery/discharge services (99217-99239 [99224, 99225, 99226])

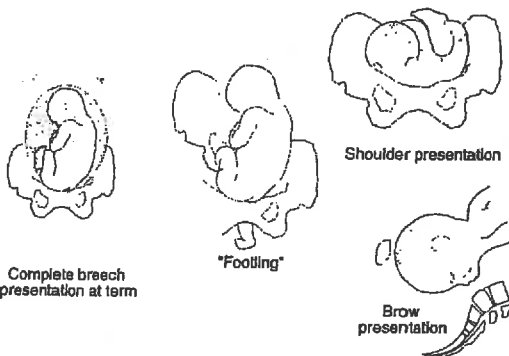
24.50 24.50 FUD MMM

AMA: 2009, Jan, 11-31; 2009, Jun, 10-11; 2008, Jan, 10-25

59410 including postpartum care

(INCLUDES) Hospital/office visits following cesarean section or vaginal delivery

31.14 31.14 FUD MMM

59412-59414 Other Maternity Services

59412 External cephalic version, with or without tocolysis

Code also delivery code(s)
3.12 3.12 FUD MMM

59414 Delivery of placenta (separate procedure)

2.76 2.76 FUD MMM
AMA: 2009, Jan, 11-31; 2008, Jan, 10-25

59425-59430 Prenatal and Postpartum Visits

CMS 100-2,15,20.1 Physician Expense for Surgery, Childbirth, and Treatment for Infertility

CMS 100-2,15,180 Nurse-Midwife (CNM) Services

(INCLUDES) Physician/other qualified health care professional providing all or a portion of antepartum/postpartum care, but no delivery due to:

Referral to another physician for delivery
Termination of pregnancy by abortion

(EXCLUDES) Antepartum care, 1-3 visits (99201-99499 [99224, 99225, 99226])

Medical complications of pregnancy:

Cardiac problems

Diabetes

Hyperemesis

Hypertension

Neurological problems

Premature rupture of membranes

Pre-term labor

Trauma

Toxemia

Newborn circumcision (54150, 54160)

Surgical complications of pregnancy:

Appendectomy

Bartholin cyst

Hernia

Ovarian cyst

59425 Antepartum care only; 4-6 visits

(INCLUDES) Fetal heart tones
Initial/subsequent history
Physical exams
Recording of weight/blood pressures
Routine chemical urinalysis
Routine prenatal visits:
Each month up to 28 weeks gestation
Every other week from 29 to 36 weeks gestation
Weekly from 36 weeks until delivery

10.71 13.63 FUD MMM

AMA: 2009, Jan, 11-31; 2008, Jan, 10-25

59426 7 or more visits

(INCLUDES) Biweekly visits to 36 weeks gestation
Fetal heart tones
Initial/subsequent history
Monthly visits up to 28 weeks gestation
Physical exams
Recording of weight/blood pressures
Routine chemical urinalysis
Weekly visits until delivery

18.89 24.38 FUD MMM

AMA: 2009, Jan, 11-31; 2008, Jan, 10-25

59430 Postpartum care only (separate procedure)

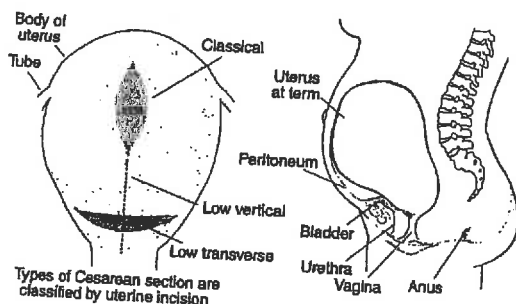
(INCLUDES) Office/other outpatient visits following cesarean section or vaginal delivery

4.21 5.32 FUD MMM

AMA: 2009, Jan, 11-31; 2008, Jan, 10-25

59510-59525 Cesarean Section Delivery: Comprehensive and Components of Care

- INCLUDES** Classic cesarean section
Low cervical cesarean section
- EXCLUDES** Infant standby attendance (99360)
Medical complications of pregnancy:
Cardiac problems
Diabetes
Hyperemesis
Hypertension
Neurological problems
Premature rupture of membranes
Pre-term labor
Trauma
Toxemia
Newborn circumcision (54150, 54160)
Surgical complications of pregnancy:
Appendectomy
Bartholin cyst
Hernia
Ovarian cyst
Vaginal delivery after prior cesarean section (59610-59614)



59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

- INCLUDES** Admission history
Admission to hospital
Cesarean delivery
Fetal heart tones
Hospital/office visits following cesarean section
Initial/subsequent history
Management of uncomplicated labor
Physical exam
Recording of weight/blood pressures
Routine chemical urinalysis
Routine prenatal visits:
Each month up to 28 weeks gestation
Every other week 29 to 36 weeks gestation
Weekly from 36 weeks until delivery
- EXCLUDES** Medical problems complicating labor and delivery
- AMA:** 2009, Jan, 11-31; 2008, Jan, 10-25

59514 Cesarean delivery only:

- INCLUDES** Admission history
Admission to hospital
Cesarean delivery
Management of uncomplicated labor
Physical exam
- EXCLUDES** Inpatient management after delivery/discharge services (99217-99239 [99224, 99225, 99226])
Medical problems complicating labor and delivery
- AMA:** 2009, Jan, 11-31; 2008, Jan, 10-25

- 59515 including postpartum care
INCLUDES Admission history
Admission to hospital
Cesarean delivery
Hospital/office visits following cesarean section or vaginal delivery
Management of uncomplicated labor
Physical exam
- EXCLUDES** Medical problems complicating labor and delivery
- 37.72 37.72 FUD MMM**

59525 Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)

Code first cesarean delivery (59510, 59514, 59515, 59618, 59620, 59622)
14.64 14.64 FUD ZZZ

59610-59614 Vaginal Delivery After Prior Cesarean Section: Comprehensive and Components of Care

CMS 100-2,15,20.1 Physician Expense for Surgery, Childbirth, and Treatment for Infertility
CMS 100-2,15,180 Nurse-Midwife (CNM) Services

- INCLUDES** Admission history
Admission to hospital
Management of uncomplicated labor
Patients with previous cesarean delivery who present with the expectation of a vaginal delivery
Physical exam
Successful vaginal delivery after previous cesarean delivery (VBAC)
Vaginal delivery with or without episiotomy or forceps

- EXCLUDES** Elective cesarean delivery (59510, 59514, 59515)
Medical complications of pregnancy:
Cardiac problems
Diabetes
Hyperemesis
Hypertension
Neurological problems
Premature rupture of membranes
Pre-term labor
Toxemia
Trauma
Medical problems complicating labor and delivery
Newborn circumcision (54150, 54160)
Surgical complications of pregnancy:
Appendectomy
Bartholin cyst
Hernia
Ovarian cyst

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

- INCLUDES** Fetal heart tones
Hospital/office visits following cesarean section or vaginal delivery
Initial/subsequent history
Physical exams
Recording of weight/blood pressures
Routine chemical urinalysis
Routine prenatal visits:
Each month up to 28 weeks gestation
Every other week 29 to 36 weeks gestation
Weekly from 36 weeks until delivery
- 65.46 65.46 FUD MMM**

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps):

- EXCLUDES** Inpatient management after delivery/discharge services (99217-99239 [99224, 99225, 99226])
- 27.57 27.57 FUD MMM**

The *Essential Guide*

to **Coding**

in Obstetrics and Gynecology

Fourth Edition

ACOG

THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

These codes are not used when physicians routinely cover for each other. Coverage situations are addressed in the section on special issues at the end of this chapter.

Antepartum Care Only

Antepartum care may be reported by using E/M codes or the "antepartum care only" codes. If a patient is seen only once, twice, or three times for antepartum care, the appropriate E/M service for each of the visits is reported. The level of service is determined by using the CPT definitions and guidelines for E/M services. The Centers for Medicare and Medicaid Services (CMS) documentation guidelines for E/M services (addressed in Chapter 6) do not apply to routine obstetric care and are not used in these cases. Any laboratory or diagnostic testing or other separately coded services also should be reported.

If a patient is seen for a total of four or more antepartum visits, the visits are coded as follows:

- 59425 (antepartum care only; four to six total visits)
- 59426 (antepartum care only; seven or more total visits)

These codes were designed to represent a range of visits and are reported only once. Some payers, however, require that the appropriate code be reported for each instance of care.

For example, a patient was seen for six antepartum visits. This patient then moved to another state. Another obstetrician saw her for eight additional antepartum visits before she gave birth. The first obstetrician reported code 59425. The second obstetrician reported code 59426 plus the appropriate code for delivery with postpartum care.

Delivery Only and Delivery and Postpartum Care

Sometimes a physician who has provided little or none of the antepartum care performs the delivery. In some instances, one provider manages the patient's prenatal care but asks an obstetrician to perform the delivery because of complications. In other situations, the patient may have received part of her prenatal care in another practice. The CPT book has codes to describe each of these situations. The delivery only and delivery plus postpartum care codes are:

- 59409 Vaginal delivery only (with or without episiotomy and/or forceps);
— 59410 including postpartum care
- 59514 Cesarean delivery only;
— 59515 including postpartum care
- 59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
— 59614 including postpartum care
- 5962 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
— 59622 including postpartum care

In the past, ACOG stated that the inpatient postpartum services were included in the delivery only codes. However, in 2006 the ACOG Committee on Coding and Nomenclature, reexamined the vignettes for the delivery-only codes and found that the values assigned to these codes did not include the physician work for inpatient postpartum care. This reexamination clarifies that the delivery only codes (59409, 59514, 59612 and 59620) do not include inpatient postpartum care.

The delivery with postpartum care codes (59410, 59515, 59614 and 59622) include both inpatient and outpatient postpartum care.



October 2, 2013

CERTIFIED MAIL

Magnolia OB GYN LLC of Myrtle Beach
Cheryl Gach, Office Manager
Lisa Scott, CPC, COSC, Billing Supervisor
8203 Nigels Drive, Suite 100
Myrtle Beach, SC 29572-4177

PROVIDER #: GP2574
CASE #: P8354

Dear Ms. Gach and Ms. Scott,

Thank you for your letter of August 14, 2013 in response to the Program Integrity review findings letter of August 7, 2013. The Program Integrity letter stated that an overpayment of \$988.97 was identified for billing that was not in compliance with the SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL [for] PHYSICIANS, LABORATORIES, AND OTHER MEDICAL PROFESSIONALS, February 1, 2005 edition, updated 05/01/10. Specifically, a portion of the obstetrics policy was not followed.

Your letter stated that the \$988.97 overpayment was not in dispute and raised concerns over the payment policies for obstetrics. It is also my understanding that Ms. Lutts contacted you by telephone on August 15, 2013 to discuss any questions regarding the review and to explain the Program Integrity Division's role in the review process.

The letter will be forwarded to the Program and Contract Administration for review. Once again, thank you for your suggestions.

Sincerely,

Betty Jane Church, Director
Division of Program Integrity