

Montana Medicaid Hospital Section

Spring Provider Training Presentation

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Presenters:

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Elective Delivery Policy

- “Early elective delivery” means either a non-medically necessary labor induction or cesarean section that is performed prior to 39 weeks and 0/7 days gestation.

Elective Delivery Policy

- Beginning July 1, 2014, all facilities that perform deliveries must have a hard stop policy regarding early elective deliveries and no non-medically necessary cesarean sections at any gestation (medical necessity based on diagnosis).
- Beginning July 1, 2014, the department will begin a “soft rollout” of coding changes.
- Effective October 1, 2014, facilities that perform either an early elective delivery or a non-medically necessary cesarean section will receive a 33% reduction in reimbursement.
- Cost-based hospital claims that do not meet the requirements of the Elective Delivery Policy will not be eligible for final reimbursement through cost settlement.

Elective Delivery Coding Changes

- Facilities can begin using the following coding changes for deliveries on or after July 1, 2014, the changes are required for deliveries on or after October 1, 2014.
- Condition Codes must be used for all inductions and Cesarean Sections.
 - 81- Cesarean Section or induction performed at less than 30 weeks for medical necessity;
 - 82- Cesarean Section or induction performed at less than 39 weeks gestation elective; or
 - 83- Cesarean Section or induction performed at 39 weeks gestation or greater.

ICD Procedure Codes

- As of July 1, 2014, all hospitals must use current ICD procedure codes for both inpatient and outpatient claims, including Medicare crossover claims.
- ICD-10 Updates

Laboratory Billing Changes

- Effective January 1, 2014, CMS made changes to billing requirements for outpatient labs for non-cost based facilities.
- Lab services are considered a bundled service of an outpatient visit if billed on the 013X type of bill.
- Hospitals are to use a 014X type of bill to obtain payment in the following circumstances:
 - Non-patient (referred) specimen;
 - A hospital collects the specimen and furnishes ONLY the outpatient labs on a given date of service; or
 - A hospital conducts outpatient lab tests that are clinically UNRELATED to other hospital outpatient services furnished the same day.

July 1, 2014, Laboratory Billing Changes

- CMS has updated the laboratory billing policy beginning July 1, 2014. Lab only claims as of July 1, 2014, will be billed in the following manner:

*Non-patient (referred) specimen;	Use 014X Type of Bill
*A hospital collects the specimen and furnishes ONLY the outpatient labs on a given date of service; or	Use 013X Type of Bill with modifier
*A hospital conducts outpatient lab tests that are clinically UNRELATED to other hospital outpatient services furnished the same day.	Use 013X Type of Bill with modifier

G0463 Coding

- As of January 1, 2014, CMS changed to a single G0463 code for outpatient clinic visits for OPPS facilities.
- G0463 replaces 99201-99205 and 99211-99215 on facility claims.
- RHCs, FQHCs, IHS, and CAHs will continue to use the 99201-99205 and 99211-99215 codes.

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