



State of New Mexico
 Medical Assistance Program Manual
Supplement



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TO: Birthing Options Program- Licensed Birth Center & Midwife Providers
FROM: Nicole Comeaux, Director, Medical Assistance Division *[Signature]*
THROUGH: Birthing Options Program- Licensed Birth Center & Midwife Providers
SUBJECT: Birthing Options Program-Billing Procedures & Reimbursement

This Supplement supersedes the guidance that was provided in Supplement 17-10, dated October 26, 2017, and standardizes the way in which Birthing Options Program (BOP) midwife providers and Licensed Birth Center claims are billed and paid.

The BOP is an out-of-hospital birthing option for pregnant women enrolled in the Medicaid program who are at low-risk for adverse birth outcomes. BOP services are provided by an eligible midwife that enrolls as a BOP provider with the Human Services Department/Medical Assistance Division (HSD/MAD). Unless specified below, the BOP is specifically for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care that is limited to stabilization of the baby during this transition. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

The BOP out-of-hospital birth locations include a pregnant member’s home or a Licensed Birth Center - provider type 405. Providers should note that coverage of Licensed Birth Centers by state Medicaid programs is required under Section 2301 of the Patient Protection and Affordable Care Act (ACA).

1. Eligible BOP Providers

Eligible providers include certified nurse-midwife (CNM) - provider type 322, and licensed midwife (LM) - provider type 323. A midwife may enroll as a BOP provider by completing the enrollment process that includes submitting notarized MAD 316 and MAD 317 forms to HSD/MAD. BOP may be provided through managed care or Fee-for-service (FFS).

2. Required BOP Forms

The following forms are available on the New Mexico Medicaid Portal in the Provider Section at <https://nmmedicaid.portal.conduent.com/static/index.htm>:

- **MAD 316** – Supplemental Release and Indemnification Agreement
 This form provides release of HSD liability.

- **MAD 317** – Affidavit and Certification of Liability Insurance Coverage
This form is used by the midwife to provide legal judgement for malpractice and liability insurance coverage status.
- **MAD 318** – Confirmation/Release Statement
This form provides release of HSD liability by the Medicaid-enrolled individual.

3. **Billing and Payment for Facility Charges**

The billing facility must use the UB/837I claim format only and include the National Provider Identification (NPI) number of the Licensed Birth Center – provider type 405. HSD/MAD confirms that the “split billing” model is to be used for services that include both a facility charge and a professional charge, as is typical within the national coding systems. The change being implemented for Licensed Birth Centers through this directive will allow the facility charges to be billed and paid on the UB/837I format while the professional services will continue to be billed using the CMS 1500/837P format under the provider types 322 and 323.

The Licensed Birth Center facility claim will contain:

1. Type of Bill 841, which is the appropriate type of claim for a Licensed Birth Center from admission through discharge;
2. Revenue Code 0724, which is the appropriate revenue code for Labor Room delivery at the birth center; or Revenue Code 0729 as indicated below; and
3. The appropriate procedure code, as follows in Section 4 below.

4. **BOP Procedure Codes and Rates**

- **CPT codes 59400 – 59410 Vaginal Delivery:** Comprehensive and Component Services. Use Revenue Code 0724. The Medicaid fee-for-service (FFS) payment rate is \$1,400.00.

Please note that code S8415 - Supplies for Home Delivery – will no longer be used by Licensed Birth Centers.

- **59610 – 59614 Vaginal Delivery:** After Prior Cesarean Section Comprehensive and Components of Care. These codes may be used by Licensed Birth Centers that ensure the availability of support services at all times, including obstetric ultrasonography, laboratory testing, and blood bank supplies. The Licensed Birth Center must also be able to begin an emergency Cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care. Use Revenue Code 0724. The Medicaid FFS payment rate is \$1,400.00.

As noted above, code S8415 will no longer be used by Licensed Birth Centers.

- **S4005 Interim Labor Facility:** Labor Occurring but Not Resulting in Birth. The Medicaid FFS rate is \$70.

As noted above, code S8415 will no longer be used by Licensed Birth Centers.

- In the event, that a labor requires transfer from a Licensed Birth Center to a hospital, the Medicaid program will now pay for both a delivery at the Licensed Birth Center and a delivery at the hospital, on the same date of service or within one day of each other. The Licensed Birth Center

will bill using procedure code **59899 Unlisted Procedure, Maternity Care and Delivery**. Use Revenue Code 0729.

The “patient status” block on the UB format must be completed with one of the following status codes:

- 02 Transferred to short-term hospital
- 66 Transferred to critical access hospital
- 82 Transferred to acute care short-term hospital.

The Medicaid FFS payment rate is \$700.00.

As noted above, code S8415 will no longer be used by Licensed Birth Centers.

5. **Billing and Payment for Midwife Professional Services**

To ensure correct processing of claims, providers billing for professional services provided in a Licensed Birth Center should use the CMS 1500/837P claim format, as follows:

- Include the Licensed Birth Center’s NPI number in Block 32a (Service Facility Location Information) or its 837P equivalent;
- Include the NPI of the individual CNM-provider type 322 or LM-provider type 323 who rendered the service in Block 24j (Rendering Provider ID) or its 837P equivalent; and
- Include the NPI of any business entity or group practice formed by CNMs or LMs as the billing provider in Block 33a or its 837P equivalent.

Midwife billing for home births must be submitted using the CMS 1500/837P format and based on the parameters and guidelines below:

- Payment is made only to the CNM-provider type 322 or LM-provider type 323.
- A CNM is paid at the same level as physician reimbursement. A LM is paid at 77 percent of the level of physician reimbursement.
- To assure safety and protect the best interest of Medicaid members, HSD/MAD and/or the Centennial Care MCOs may deny professional claims for services that are beyond the scope of the BOP as described in the second paragraph of this Supplement.

6. **Births at Home**

A BOP participant may elect to have a home birth when she has a BOP midwife provider who is associated with a Licensed Birth Center. If the delivery takes place at home, the Licensed Birth Center facility charge cannot not be billed nor paid.

7. **Billing for Supplies & Materials**

The procedure code 99070 can be used to bill for supplies and materials on the CMS 1500/837P format. This can be paid to provider type 322 or 323 and is only for a home birth .

Effective Date

The effective date of this guidance is January 1, 2019. FFS claims submitted since January 1, 2019, but not paid according to these parameters, will be readjusted. The Centennial Care MCOs are directed to readjust claims retroactive to January 1, 2019, in accordance with this directive.