

## OBNAF & OBSTETRICAL CARE BILLING GUIDE

### Obstetrical Needs Assessment Form (OBNAF) – NEW OBNAF EFFECTIVE FEBRUARY 1, 2012

- Effective February 1, 2012, please use the new DPW statewide OBNAF for all *NEW* pregnancies. Any old ONAF forms received for *NEW* pregnancies will be returned to the Provider for re-submission using the new OBNAF form.
- The first visit with an obstetrical patient is considered the intake visit, or if a patient becomes a Gateway Health Plan® member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit.
- At the intake visit, an OBNAF must be completed. For easy access and completion an editable PDF version of the form is available to our OB provider network. Just go to **FORMS** within the **Medicaid PROVIDER** page at [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com); click on the PDF, update and print a copy for submission and the patient's medical record.
- Completed OBNAFs must be submitted to Gateway's **MOM Matters®** program within 30 days of the intake visit. A copy of the OBNAF may be submitted via Gateway's secure email address. Simply go to this **OBNAF & Obstetrical Care Billing Guide** under **FORMS** within the **Medicaid PROVIDER** page at [www.GatewayHealthPlan.com](http://www.GatewayHealthPlan.com). To ensure confidentiality OBNAFs may only be emailed to Gateway via our secure email portal. Providers still have the option to fax completed OBNAFs. The fax numbers are (412) 255-5639 or 1-888-225-2360.
- The OBNAF is not a claim; however, the OBNAF must be received by Gateway in order to process the claim for the intake visit. Submit claims on a CMS-1500 within 180 days to receive payment for the intake package.

### Outreach Bonus

- **As of July 1, 2008** Gateway began reimbursing providers a bonus payment of \$200 plus your contracted percentage increase for initial prenatal visits rendered within the first trimester. Please bill as indicated below to receive the bonus payment.
- The initial prenatal visit **MUST** be rendered within the first trimester and the DPW statewide **Obstetrical Needs Assessment Form (OBNAF)** must be completed during the visit and faxed or emailed to Gateway's MOM Matters® Department within 30 days of the intake visit.
- Procedure codes 99429-HD (First Trimester Outreach) and T1001-U9 (Initial Risk Assessment) must be reported together on the same claim form to allow the bonus payment.

- **The bonus payment will NOT be paid if both codes/modifiers referenced above are not reported on the same claim.** The OBNAF is not a claim form; however, the OBNAF must be received by Gateway and documented in our claims system prior to receipt of the claim to allow the appropriate bonus and intake visit payment.
- If the member's first prenatal visit doesn't occur within the first trimester then code 99429-HD should not be billed. However, the first visit with an obstetrical patient is considered to be the intake visit. If a patient becomes a Gateway member during the course of her pregnancy, her first visit as a Gateway member is considered to be her intake visit. At the intake visit, an OBNAF must be completed and a claim submitted with code T1001-U9 for reimbursement.

## **Obstetrics Billing**

- **Prenatal visits are reimbursed on a per visit basis.** All prenatal visits and dates of service must be included on the HCFA 1500 form and identified with Evaluation and Management code (99201 – 99215) **ONLY**. The **U9 pricing modifier** must follow the code in the first position on the claim form. Please do not use the State's pricing or informational modifiers or any other Healthy Beginning codes for submission to Gateway Health Plan<sup>®</sup>. Delivery charges must be identified with CPT codes.
- All charges for newborns that become enrolled in Gateway, other than hospital bills covering the confinement for both Mom and baby, are processed under the newborn name and newborn Gateway ID number.
- In directing a member's care, a referral to a hospital for diagnostic services or ER care may be instituted by the OB/GYN. Referrals may be issued either on a paper form or via the DIVA Telephone Referral System.
- If an OB/GYN provider determines that assessment or treatment by another specialist is necessary, the OB/GYN is required to contact the member's PCP to request a referral to a specialist. The OB/GYN cannot refer a member directly to another specialist. **(See exceptions below.)**
- Referrals are **NOT** needed to a participating perinatologist or for lab work completed at a member's designated lab. The designated lab is noted on the member's Gateway ID card.

## **Family Planning Billing**

- When billing for family planning services use the national standard codes on MA Bulletin #08-05-09. The FP modifier must follow the code in the first position on the claim form. If a claim is submitted using the MA Local code, the claim will be denied (D5, Invalid Procedure Code). You will need to resubmit on paper a "corrected claim" within 120 days from the date of the initial denial to our claims office in Harrisburg.
- When billing for contraceptives and family planning drugs for Gateway members use the appropriate J code. When a valid J code is not available bill with an unspecified J code along with the NDC code and the number of units administered.