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Topic: Billing and Payment for Midwife First Assistant Services

Topic

Billing

Billing for cesarean: https://www.aapc.com/memberarea/forums/36692-coding-modifier-usage-assisted-cesarean-delivery.html

Payment Policies

Centers for Medicare and Medicaid – APRN Payment (2016):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf

Centers for Medicare and Medicaid – Payment for Certified Nurse-Midwives (2011):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7005.pdf

Harvard Pilgrim Payment Policy (2017):
https://www.harvardpilgrim.org/pls/portal/docs/PAGE/PROVIDERS/MANUALS/PAYMENT%20POLICIES/H-1%20CNM%20CM%20NP%20PA_031517.PDF

Kaiser Payment Policy (2014):
https://provider.ghc.org/open/billingAndClaims/claimsProcedures/assistant-surgeon.pdf

Unisys Payment Policy (2014):
http://www.lamedicaid.com/provweb1/ProviderTraining/Packets/2010ProvTrain/PT90_Assistant_Surgery.pdf

United Healthcare Oxford Payment Policy (2017):
https://www.oxhp.com/secure/policy/assistant_surgeon_policy.pdf

Modifiers

Moda Health First Assistant Modifier Policy (2016):
https://www.modahealth.com/pdfs/reimburse/RPM013.pdf

Priority Health Modifier Guidance (2016):
http://www.priorityhealth.com/provider/manual/billing-and-payment/modifiers/80-and-82

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Background and Notes

Each midwifery practice should bill for all professional services provided by appropriately licensed midwives (such as CNMs/CMs). Assistant surgeon fees may require an appropriate modifier for eligible providers using *non-global cesarean CPT codes* (59514, 59620) to be eligible to be reimbursed.

Generally, the surgeon or the first assistant must compete paperwork - such as a completing a check box in the EHR, a billing sheet, or naming of the FA in the op note - to trigger billing for FA services.

Most practices bill for professional services using the individual practitioner's National Provider Identification (NPI) number, which can be used to track who actually provided the services. This is critical to capturing the fiscal value of midwifery services, and assuring transparency in health care services and billing. The NPI number is commonly *assigned* to the practice so the revenue goes to the practice not the provider of record.

It's important to verify that all bills for services provided by midwives are billed using the midwife's NPI number as that ensures that midwifery services are accurately captured and reflected in data about utilization of services. On occasion, some insurers may have alternate policies that require billing using the physician's NPI number, so familiarity with each insurers payment policy is necessary.

All billable clinical midwifery services (and clearly first assistant services are included) should ideally be billed using the midwife's NPI number; all midwifery services are thus captured through the practice or facility billing service. The importance of using the CNM's NPI number (even when it is "assigned" to the practice) is so the facility can track exactly who performs what procedures - even when it is not attached to midwife compensation – as well as the insurers. This allows accurate representation of services provided by each type of professional.

Often the midwife will have to become credentialed with the commercial insurer in order for bills to be processed for reimbursement. This may include submitting copies of the same documentation submitted to the Medical Staff office when FA privileges were extended, plus a copy of your delineation of privileges. The practice's contractual agreements with the health care insurers may need to be renegotiated and updated to reflect this expansion of your practice and to determine which modifier is the appropriate one to use when billing.

However, many health insurance companies require the CNM/CM to be credentialed with the company for the service before they will recognize it as a covered service. This way it is clear to the insurance company staff which midwives are paid for which services. This is especially important when there is staff turnover.

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Key factors to address with insurers are that CNMs are advanced practice nurses, and then determine whether the practice's contract with the insurers require that you are credentialed with them for this service.

If the insurers pay some CNMs/CMs in your state, then you can find out how your billing practices differ. If insurers continue to refuse to pay, it is worth following up with your affiliate to see what other avenues can be approached as an affiliate – there is greater negotiating power when all of the CNMs in the affiliate are pursuing the same objective. While the reimbursement received from the insurer may be less than that of a physician, this is midwifery-specific revenue, which can positively affect the practice (or facility) bottom line, and ultimately the perceived and actual value of the midwives (and their salaries).

Also, it can be helpful to review state insurance laws to support requests for changes to health care insurer payment policies - for example in Maine it is mandated through insurance regulation that NP and CNM services are paid by commercial insurance companies. This does not include Medicaid - so that is still an issue. However, you are encouraged to keep submitting bills, calling at regular and frequent intervals (for example, weekly), and request information about why non-payment is occurring (so you can identify the issue and initiate corrective action) when non-payment occurs for any payor. Persistence can pay off, provided you do your homework first, and remain polite and professional at all times.

If there is a persistent denial of payment for FA services for which the midwife is privileged and qualified to perform, then it's work working with the local ACNM Affiliate to see if this is occurring for others, and if so, then to address the issue through the Affiliate. Often the OBs (and perhaps the local ACOG chapter) will support efforts for appropriate insurance reimbursement.

Also, when newly privileged as a first assistant, all midwives should reach out to their liability insurance carriers and notify them of the expansion of practice to include the first assistant role. While there may or may not be a change in cost, they always want to know what clinical activities each CNM/CM is privileged to perform, and it is the midwife's responsibility to keep them apprised of changes in practice.

In terms of midwife compensation for FA services, it's reasonable to have an increase in salary or a bonus per case in recognition of the added skill set, convenience, and enhanced patient safety that results from having the midwives as first assistants. A salary increase eliminates any potential for bias toward cesarean that a bonus or productivity system may inadvertently cause.

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In the military, service members are paid by rank and years of experience rather than by job title. Therefore, pay is unrelated to the number of vaginal births or cesareans the midwife attends.

Sometimes an outside practice will pay a per case bonus as an incentive to be available (usually instances where the midwife is on call and must come in for the case).

A pay continuum (or range) based on level of skills (clinician), responsibilities (patient), and availability (system) is a good place to start when renegotiating salary. Midwives can highlight the ready access of a skilled assistant, increased patient safety and continuity of care (satisfaction), and the ability to provide team-based maternity care as you begin your negotiations.

The nice thing about productivity is that it captures all of the clinical services provided and rewards those who work hard. And the challenge with productivity models is that they can lead to increased interventions by incentivizing this type of practice. It is important that spontaneous birth is accurately reflected in productivity models as the care is labor intensive (no pun intended!) and real skill is needed to maximize safe vaginal birth rates.

When midwives provide midwifery support postpartum, these are *Midwifery Rounds* – when seeing women following a cesarean midwives talk about the labor and birth, infant care and feeding, self care and maternal adaptation - and should documented even if the midwife can't bill for them. Many midwives, when they are the first assistant for a midwifery client, provide individual or team-based post-op rounds to support continuity of care, decrease confusion and continue the collegial relationship with the surgeon.

The value of a midwifery service is not limited to fiscal revenue it can also include physician convenience (easier to hire and keep OBs), patient safety and satisfaction, and marketing maternity care services.