ATTENTION HOSPITAL PROVIDERS
IMPORTANT BILLING INFORMATION CONCERNING
BILLING CLAIMS FOR DELIVERIES

As we have implemented new policies related to inpatient stays for deliveries, we have received hospital inquiries concerning claim denials related to diagnosis codes. We want to clarify a billing issue that has come to our attention which is causing these denials.

In order for appropriate claims for deliveries to by-pass the precertification edits and the requirement for a precertification number on the claim, the following information **is required:**

· The admit or primary diagnosis should be a vaginal or c-section delivery diagnosis code.
· The secondary diagnosis or any other diagnosis excluding the admit diagnosis must be the appropriate Outcome of delivery V- Code.
· The surgical procedure code for the vaginal delivery and the date of the procedure must appear on the claim.

The claims processing system allows only five (5) diagnosis codes to be keyed and carried forward on the claim for processing: the admitting diagnosis, the primary diagnosis, and three (3) other diagnoses. The outcome of delivery V-code must be placed in one of the 3 additional diagnosis code fields allowed for processing. If the V-code is entered in any other diagnosis field, the claim will deny since it will not be recognized in the claims processing system.

Please make the necessary changes to your billing process to allow entering the required codes in the appropriate fields on the claim.

Providers with questions should contact Molina Medicaid Solutions Provider Relations at (800) 473-2783 or (225) 924-5040.