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1.0 Description of the Procedure, Product, or Service

Obstetrics is a branch of medical science that deals with maternity care, including antepartum care, labor and delivery, and postpartum care. Standards of care are published by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and the American College of Nurse Midwifery (ACNM) for the perinatal care of the mother.

Information on services provided in DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home (PMH)* can be found on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.1 Regular Medicaid

Female recipients in this eligibility category are eligible for antepartum, labor and delivery, and postpartum care.

2.1.2 Medicaid for Pregnant Women

Female recipients of all ages with Medicaid for Pregnant Women (MPW) coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that—in the judgment of their physician—may complicate pregnancy. Conditions that may complicate the pregnancy can be further defined as any condition that may be problematic or detrimental to the well-being or health of the mother or the unborn fetus such as undiagnosed syncope, excessive nausea and vomiting, anemia, and dental abscesses (This list is not all-inclusive.). The eligibility period for MPW coverage ends on the last day of the month in which the 60th postpartum day occurs [42 CFR 447.53(b)(2)].

Refer to **Subsection 5.1** for information on referring MPW recipients for non-obstetrical pregnancy-related treatment services.

2.1.3 Undocumented Aliens

Undocumented aliens are eligible only for emergency medical services[42 CFR 440.255(c)], which includes labor and vaginal or cesarean section (C-section) delivery as defined in 10A NCAC 21B .0302. Services are authorized only for actual dates that the emergency services were provided.

Note: The local department of social services in the county where the alien resides determines eligibility coverage dates when the emergency service is for labor and delivery (vaginal or C-section delivery). The Division of Medical Assistance (DMA) determines eligibility coverage for all other emergency services, including miscarriages and other pregnancy terminations.

2.1.4 Presumptive Eligibility

Section 1920(b) of the Social Security Act allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined. Ambulatory Antepartum Care can be defined as the level of prenatal care typically provided in primary-level facilities that covers assessment of the normal progress of pregnancy. This includes physical examinations; routine laboratory assessments; appropriate screening tests including basic fetal ultrasound (s), AFP tests, glucola tests, and etc.; and prenatal information and education.

The pregnant woman shall apply for Medicaid no later than the last day of the month following the month she is determined presumptively eligible. If the pregnant woman fails to apply for Medicaid within this time period, she is eligible only through the last calendar day of the month following the month she is determined presumptively eligible. If the pregnant woman applies for Medicaid within this time frame, she remains presumptively eligible for Medicaid until the local department of social services makes a determination on her application.

In the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination, the presumptive eligibility period ends.

Note: Presumptive eligibility is limited to one presumptive eligibility period per pregnancy.

2.1.5 Retroactive Eligibility

Refer to the *Basic Medicaid Billing Guide* Retroactive Eligibility, Section 2 at Web site: <http://www.ncdhhs.gov/dma/basicmed/>.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or

other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the pregnancy under treatment, and not in excess of the recipient's needs;

- b. the level of service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Antepartum Care

The initial and subsequent antepartum visits include the history, physical examination; and recording of weight, blood pressure, fetal heart tones, and laboratory tests including urinalysis and urine hemoglobin analysis performed at the time of the visit.

3.2.1 Antepartum Visits

The frequency and number of antepartum visits are determined by the needs of the recipient. A recipient with an uncomplicated pregnancy is generally seen on the following schedule:

- a. Every 4 weeks for the first 28 weeks of gestation
- b. Every 2 to 3 weeks until the 36th week of gestation
- c. Weekly from the 36th week of gestation until delivery

Note: the recipient may be seen more frequently if her condition warrants.

3.2.2 Individual Antepartum Services

Individual antepartum services (use of Evaluation and Management codes) are covered if

- a. a pregnancy is high risk and requires more than the normal amount of services for a routine pregnancy; or
- b. antepartum care is initiated less than three months prior to delivery; or
- c. the recipient is seen by a provider between one (1) and three (3) office visits as specified in **Attachment B: Billing for Obstetrical Services**.

DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home* (on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>), provides information on the definition of high-risk pregnancy and risk factors.

Note: Hospital-Based Entities as defined by 42 CFR 413.65 shall bill individual antepartum services without the restrictions of **Subsection 3.2.2**.

Note: Local Health Departments (LHDs) who provide high-risk antepartum care will bill appropriate Evaluation and Management (E/M) codes for individual antepartum services as specified in **Subsection 3.2.2**.

3.2.3 Counseling

Refer to DMA's Clinical Coverage Policy 1M-3, *Health and Behavioral Intervention* (on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>), for information on counseling services for behavioral intervention.

Refer to Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*, 8B, *Inpatient Behavioral Health Services*, 8C, *Outpatient*

Behavioral Health Services Provided by Direct-Enrolled Providers, and 8L, Mental Health/Substance Abuse Targeted Case Management (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on behavioral health treatment.

Refer to Clinical Coverage Policy 1-I, *Dietary Evaluation and Counseling* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on dietary counseling services.

3.2.4 Fetal Surveillance Testing

Medicaid covers medically necessary fetal surveillance testing. Refer to Clinical Coverage Policy 1E-4, *Fetal Surveillance* and 1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information.

3.2.5 Case Management

Case management services for pregnant women is covered through DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home* for recipients assessed as high-risk and Clinical Coverage Policy 12B, *Human Immunodeficiency Virus (HIV) Case Management* policy. Refer to DMA's Website at <http://www.ncdhhs.gov/dma/mp/> for additional information on case management services for PMH and HIV case management services.

3.3 Package Services

3.3.1 Antepartum Package Services

Antepartum package services are covered when the attending provider rendering the antepartum care does not perform the delivery. The attending provider or group provider shall have seen the recipient for at least three consecutive months during her pregnancy.

Note: Individual antepartum visits are not covered in conjunction with antepartum package services. Refer to **Attachment A, Claims-Related Information**, for billing instructions.

3.3.2 Global Obstetrics Services

Antepartum care, labor and delivery, and postpartum care are covered as an all-inclusive service (CPT codes 59400 or 59510) when

- a. antepartum care was initiated at least three months prior to the delivery and
- b. the same provider who renders the antepartum care performs the delivery and postpartum care.

3.3.3 Postpartum Package Services

Postpartum package services are covered when the attending provider

- a. has not provided any antepartum care, but performs the delivery and provides postpartum care (CPT codes 59410 or 59515); or
- b. has not provided any antepartum care and did not perform the delivery, but performs all postpartum care (CPT code 59430); or

- c. bills individual visits for antepartum care due to a high-risk condition (CPT codes 59410, 59430, or 59515).

3.4 Consultations

Inpatient and outpatient consultations are covered when medical records substantiate that the services are medically necessary.

Refer to Clinical Coverage Policy 1M-6, *Maternal Care Skilled Nurse Home Visit and Home Visit for Postnatal Assessment and Follow-up Care* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on these services. These services require a physician's referral.

3.5 Labor and Delivery

Vaginal delivery includes episiotomy, the delivery of the placenta, external cephalic version, and special services associated with delivery.

Note: When there are extenuating circumstances and a certified or licensed provider other than the attending provider or provider group performs the episiotomy, it may be covered as a separate procedure. When a provider other than the attending physician or physician group performs the delivery of the placenta, it may be covered as a separate procedure. Refer to **Section 5.0, Requirements for and Limitations on Coverage**, for additional information.

3.5.1 Anesthesia

Anesthesia services are covered separately. Refer to Clinical Coverage Policy #1L-1, *Anesthesia* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for information on anesthesia and obstetrics.

3.5.2 Complications Related to Delivery

Medicaid covers complications related to delivery when the diagnosis substantiates medical necessity.

3.5.3 Multiple Births

If the recipient delivers multiple babies, vaginally or by C-section, the appropriate modifiers and diagnosis codes shall be used for reimbursement. Refer to **Attachment A, Claims-Related Information**.

3.5.4 Stand-by Services

Anesthesia stand-by is defined as the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) standing by until it is determined whether services are required to administer and/or monitor anesthesia.

Physician stand-by service is covered for anesthesia services. This service is available only for physician stand-by services at high-risk deliveries. Only stand-by services related to the mother can be billed. The service shall be requested by a physician, and a diagnosis substantiating the high risk shall be documented on the claim (A list of these diagnosis codes can be found in **Attachment A**, letter B "Diagnosis Codes"). Medical records documenting the high-risk delivery and the need for stand-by services are not required with the claim submission, but shall be available for DMA or its agents upon request.

Medicaid covers physician stand-by services for

- a. Care provided to the mother during a high-risk delivery [refer to **Attachment A**, letter B (Diagnosis Codes)]; and
- b. Attendance at delivery and initial stabilization of the newborn during a high-risk delivery [refer to **Attachment A**, letter C (Procedure Codes)].

3.6 Postpartum Care

Postpartum services encompass management of the mother after delivery and during the postnatal period. Components of this service may include postpartum examination and contraceptive counseling. Medicaid covers medically approved family planning methods such as Nuva Ring, Birth Control Pills, Depo-Provera, IUD's (Paraguard and Mirena), Ortho Evra, sterilizations including the Essure procedure, Implanon, emergency contraceptive counseling, contraceptive management procedures, and pharmaceuticals to prevent conception. This includes services for recipients with MPW coverage during their postpartum eligibility period.

Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs.

Note: For continued services after the 60th day, refer MPW recipients to the Department of Social Services for continuing eligibility determination.

3.6.1 Vaccinations

Medicaid covers vaccinations for measles, mumps, rubella (MMR)/rubella component for women who do not have evidence of immunity and other vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Center for Disease Control (CDC). The vaccine is provided upon completion or termination of pregnancy and before discharge from the health-care facility.

The ACIP recommendations for varicella vaccination indicate that women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy, according to ACIP protocol, and before discharge from the health care facility. The second dose should be administered between 4 and 8 weeks after the first dose. Medicaid covers the varicella vaccine series when provided according to this schedule and if the recipient is eligible for Medicaid on the day the service is provided.

Rhogam is a medication that is given to prevent Rhesus (Rh) hemolytic disease of the newborn (HDN). HDN is a serious, often fatal disease caused by incompatibility between an Rh-negative mother and her Rh-positive fetus. Medicaid covers rebatable NDCs for Rho D immune globulin in the postpartum period. This includes recipients with MPW coverage.

Medicaid covers inpatient and outpatient immunizations for Tetanus toxoid, Diphtheria toxoid, and Acellular Pertussis (Tdap) for recipients during the postpartum period. ACIP recommends that adults who have or who anticipate having close contact with an infant less than 12 months of age and who previously have not received Tdap should receive a single dose of Tdap to protect against pertussis and reduce the likelihood of transmission. Tdap can be administered regardless of interval since the last tetanus- or diphtheria-toxoid

containing vaccine. After receipt of Tdap, persons should continue to receive Td for routine booster immunization against tetanus and diphtheria, according to immunization guidelines.

Refer to **Attachment A, Claims-Related Information**, for a list of covered procedures.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Emergency Services for Undocumented Aliens

The following antepartum and postpartum services are not covered for undocumented aliens for emergency services.

ICD-9-CM Procedure Code	Description
66.21	Bilateral endoscopic ligation and crushing of fallopian tubes
66.22	Bilateral endoscopic ligation and division of fallopian tubes
66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes
66.31	Other bilateral ligation and crushing of fallopian tubes
66.32	Other bilateral ligation and division of fallopian tubes
66.39	Other bilateral destruction or occlusion of fallopian tubes

CPT Code	Description
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

CPT Code	Description
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure)(List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4–6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only; including postpartum care

The following CPT procedure codes will be considered for coverage only in an emergency situation such as an ectopic pregnancy:

CPT Code	Description
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Sterilization procedures are not included in the definition of emergency services and therefore are not covered for undocumented aliens. Refer to **Subsection 2.1.3, Undocumented Aliens.**

4.3 Stand-by Services

- a. Medicaid does not cover stand-by services for pre-anesthesia evaluations.
- b. Medicaid does not cover stand-by services for the mother and for the newborn when provided by the same provider.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

5.1 Prior Approval for MPW Recipients

Prior approval is required for MPW recipients when the physician determines that any of the services listed below are needed for the treatment of a medical illness, injury, or trauma that may complicate the pregnancy.

- a. Podiatry;
- b. Chiropractic;
- c. Optometric and optical services;
- d. Home health;
- e. Personal care services;
- f. Hospice;
- g. Private duty nursing;
- h. Home infusion therapy; or
- i. Durable medical equipment.

Refer to the specific clinical coverage policies on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/> for specific requirements for prior approval for MPW recipients.

Clinical Coverage Policy 4A, *Dental Services* (<http://www.ncdhhs.gov/dma/mp/>), describes dental services available to recipients with MPW. These services require the same prior approval as dental services to any other recipient with full Medicaid coverage and are covered through the day of delivery.

5.2 Limitations

The following limitations apply to obstetric care services.

- a. Individual delivery procedures (vaginal delivery and delivery of placenta) are not covered more than once in a 225-day period.
Note: When there is more than one pregnancy within 225 days and both pregnancies result in separate deliveries on different dates of service within 225 days, the service is covered.
- b. Antepartum care package services are covered once during the recipient's pregnancy. In special circumstances (for example when the recipient moves), up to 3 different providers can bill for 59425 (Antepartum care; 4–6 visits). This does not apply to different providers in the same group.

- c. Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs. Refer to **Subsection 3.6, Postpartum Care**.
- d. Stand-by services related to the mother for a high-risk delivery are limited to two hours per day.
- e. Performance of an episiotomy or delivery of a placenta by a provider other than the attending physician is covered only through the adjustment process.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws; regulations; and agreements, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Update Information

Original Effective Date: October 1, 1985

Revision Information:

Date	Section Revised	Change
8/1/09	Throughout	Updated language to DMA's current standard.
8/1/09	Section 7.0	Deleted previous paragraphs on Federal & State Requirements and Records Retention and substituted Compliance.
8/1/09	Subsection 3.5.4, Att. A	Added diagnosis codes allowable for billing anesthesia stand-by for high-risk deliveries related to the mother.

Date	Section Revised	Change
8/1/09	Attachment A	Clarified billing practices for multiple births.
8/1/09	Attachment B	Added E/M codes 99217 through 99239 to the "Evaluation and Management Services" section; they cannot be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430, 59510, or 59515.
9/1/11	1.0, added 2.1.5, 3.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, 3.3.3, 3.4, 3.6, 3.6.1, Attachment A-Sections C and E.	Added PMH reference in Section 1.0. Added Subsection 2.1.5. Revised wording in Subsections 3.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, and 3.3.3. Added information about policy 1M-6. Added family planning information in Subsection 3.6 and added rhogam and Tdap information in Subsection 3.6.1. Revised the information for FQHC and RHC billing for codes T1015, 59409, 59410, 59430, 59514, and 59515 in Attachment A, Section C. Clarified billing for multiple births in Attachment A, Section E.
9/1/11	Section 1.0	Added reference to PMH.
9/1/11	Subsection 2.1.2 and 2.1.4	Clarified conditions that complicate the pregnancy. Added definition of Ambulatory Antepartum Care and clarified Presumptive Eligibility coverage.
9/1/11	Subsection 2.1.5	Added this section to the policy.
9/1/11	Subsections 3.2, 3.2.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, and 3.3.3	Referenced PMH and added information about Hospital-Based Entities in Subsection 3.2.2. Referenced LHDs in Subsection 3.2.2. and added letter "c". Revised wording to remove Maternity Care Coordination section and to add information about Health and Behavioral Intervention, Enhanced Mental Health and Substance Abuse, Inpatient Behavioral Health Services, and Mental Health/Substance Abuse Targeted Case Management to Subsection 3.2.3. Added reference to the Prior Approval for Imaging Procedures policy to Subsection 3.2.4. Revised information for case management and removed information about the Baby Love Program. Removed statement "...with the intention of performing the delivery." from Subsection 3.3.1. Added CPT codes to match the service in Subsections 3.3.2 and 3.3.3. Added letter "c" in 3.3.3.
9/1/11	Subsection 3.4	Added reference to the Maternal Care Skilled Nurse Home Visit and Postnatal Assessment and Follow-up Care policies. Deleted Prior Approval note.
9/1/11	Subsection 3.5.4	Removed statement regarding anesthesia stand-by services related to the mother.
9/1/11	Subsection 3.6	Added family planning information.
9/1/11	Subsection 3.6.1	Added rhogam information and Tdap information.
9/1/11	Attachment A-Section B	Added numbers and changed title of the table.

Date	Section Revised	Change
9/1/11	Attachment A- Section C	Added information about PMH, Indian Health Services and PMH procedure codes. Added information regarding LHD billing. Moved information regarding Birthing Center billing from CPT code 59410 to CPT code 59409.
9/1/11	Attachment A- Section E	Added new table to depict billing for multiple gestations.
9/1/11	Attachment A- Section E	Clarified billing for multiple births. Removed the word "Consecutive" and added the word "Additional" in the table title.
9/1/11	Attachment B	Added Billing information for 1-3 visits using E/M codes.
9/1/11	Throughout	Updated language to DMA's current standard

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity and that most accurately describes the state of pregnancy and outcome of the delivery.

Diagnosis Codes that Substantiate High-Risk Deliveries for Maternal Stand-by Service

ICD-9-CM Code	Description
286.0	Congenital factor VIII disorder
286.1	Congenital factor IX disorder
286.2	Congenital factor XI deficiency
286.3	Congenital deficiency of other clotting factors
286.4	von Willebrand's disease
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants (effective until 9/30/2011)
286.52	Acquired hemophilia (effective 10/1/2011)
286.53	Antiphospholipid antibody with hemorrhagic disorder (effective 10/1/2011)
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors (effective 10/1/2011)
286.6	Defibrination syndrome
286.7	Acquired coagulation factor deficiency
286.9	Other and unspecified coagulation defects
428.0	Congestive heart failure, unspecified
641.13	Hemorrhage from placenta previa, antepartum condition or complication
641.23	Premature separation of placenta, antepartum condition or complication
641.33	Antepartum hemorrhage associated with coagulation defects, antepartum condition or complication
641.83	Other antepartum hemorrhage, antepartum condition or complication
641.93	Unspecified antepartum hemorrhage, antepartum condition or complication
642.03	Benign essential hypertension complicating pregnancy, childbirth, and the puerperium, antepartum condition or complication
642.13	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, antepartum condition or complication
642.23	Other pre-existing hypertension complicating pregnancy, childbirth, and the puerperium, antepartum condition or complication
642.33	Transient hypertension of pregnancy
642.43	Mild or unspecified pre-eclampsia, antepartum condition or complication
642.53	Severe pre-eclampsia, antepartum condition or complication

ICD-9-CM Code	Description
642.63	Eclampsia, antepartum condition or complication
642.73	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, antepartum condition or complication
642.93	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
646.23	Unspecified renal disease in pregnancy, without mention of hypertension, antepartum condition or complication
646.73	Liver disorders in pregnancy, antepartum condition or complication
648.03	Diabetes mellitus, antepartum condition or complication
648.13	Thyroid dysfunction, antepartum condition or complication
648.33	Drug dependence, antepartum condition or complication
648.43	Mental disorders, antepartum condition or complication
648.53	Congenital cardiovascular disorders, antepartum condition or complication
648.63	Other cardiovascular diseases, antepartum condition or complication
649.23	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
649.33	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
649.43	Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
658.43	Infection of amniotic cavity, antepartum condition or complication
659.23	Maternal pyrexia during labor, unspecified, antepartum condition or complication
659.33	Generalized infection during labor, antepartum condition or complication
665.03	Rupture of uterus before the onset of labor, antepartum condition or complication
665.10	Rupture of uterus during labor, unspecified as to episode of care or not applicable
668.03	Complications of the administration of anesthetic or other sedation in labor and delivery; pulmonary complications, antepartum condition or complication
668.13	Complications of the administration of anesthetic or other sedation in labor and delivery; cardiac complications, antepartum condition or complication
668.23	Complications of the administration of anesthetic or other sedation in labor and delivery; central nervous system complications, antepartum condition or complication
668.83	Complications of the administration of anesthetic or other sedation in labor and delivery; other complications of anesthesia or other sedation in labor and delivery, antepartum condition or complication
669.03	Other complications of labor and delivery, not elsewhere classified; maternal distress, antepartum condition or complication
669.13	Other complications of labor and delivery, not elsewhere classified; shock during or following labor and delivery, antepartum condition or complication
669.23	Other complications of labor and delivery, not elsewhere classified; maternal hypotension syndrome, antepartum condition or complication
671.33	Venous complications in pregnancy and the puerperium; deep phlebothrombosis, antepartum, antepartum condition or complication

ICD-9-CM Code	Description
673.03	Obstetrical pulmonary embolism; obstetrical air embolism, antepartum condition or complication
673.13	Obstetrical pulmonary embolism; amniotic fluid embolism, antepartum condition or complication
673.23	Obstetrical pulmonary embolism; obstetrical blood-clot embolism, antepartum condition or complication
673.33	Obstetrical pulmonary embolism; obstetrical pyemic and septic embolism, antepartum condition or complication
673.83	Obstetrical pulmonary embolism; other pulmonary embolism, antepartum condition or complication
674.03	Other and unspecified complications of the puerperium, not elsewhere classified; cerebrovascular disorders in the puerperium, antepartum condition or complication

C. Procedure Codes

The following table combines obstetrical codes and instructions for **physicians** and **FQHC/RHC providers**. Information for **anesthesia providers** follows in a separate table.

Information for reimbursement of PMH procedure codes (S0280 *Medical home program, comprehensive care coordination and planning, initial plan* and S0281 *Medical home program, comprehensive care coordination and planning, maintenance of plan*) will be found in DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home* (on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>). PMH providers shall bill according to the specifications in the table below. Indian Health Service PMH providers will bill RC 510, S0280, and S0281 for reimbursement for PMH services.

- Local Health Departments (LHDs) who provide only antepartum and postpartum care for pregnancy services shall bill CPT codes 59425, 59426, and 59430 for antepartum and postpartum care.
- LHDs who provide high-risk antepartum care shall bill appropriate Evaluation and Management (E/M) codes for individual antepartum services as specified in **Subsection 3.2.2**.
- LHDs who provide complete antepartum, labor and delivery, and postpartum care by employing or contracting with obstetric providers shall bill 59400, 59409, 59410, 59425, 59426, 59430, 59510, 59514, or 59515.

Routine Obstetrical Procedure Codes				
HCPCS Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
T1015	Individual	Clinic visit/ encounter, all-inclusive	N/A	Rendering antepartum and postpartum care is a core service. ★ Use the "A" suffix provider number.

Routine Obstetrical Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
59400	Global	Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	<p>The provider billing for OB care shall have rendered at least 3 months of consecutive antepartum care to the recipient.</p> <p>✦</p> <p>The date the provider first saw the recipient for antepartum care shall be entered in block 15 of the CMS-1500 form.</p> <p>✦</p> <p>The date of service on the claim for the OB care shall be the date of delivery.</p> <p>✦</p> <p>This code cannot be billed in addition to other OB global codes.</p>	N/A
59409	Individual	Vaginal delivery only (with or without episiotomy and/or forceps)	<p>This code is limited to one unit within 225 days when billed by the same or different provider except as described in E below.</p> <p>✦</p> <p>If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code.</p> <p>✦</p> <p>This code cannot be billed in addition to global OB codes.</p> <p>✦</p> <p>Birthing Centers use this code for reimbursement.</p>	<p>This code is limited to one unit within 225 days when billed by the same or different provider.</p> <p>✦</p> <p>Postpartum care services are not included in this code.</p> <p>✦</p> <p>✦</p> <p>Use the "C" suffix provider number.</p>

Routine Obstetrical Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
59410	Package	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	<p>This code is limited to one unit within 225 days when billed by the same or different provider.</p> <p>✦</p> <p>If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code.</p> <p>✦</p> <p>This code cannot be billed in addition to global OB codes.</p> <p>✦</p>	N/A
59412	Individual	External cephalic version, with or without tocolysis	Use 59412 in addition to code(s) for delivery.	<p>Use 59412 in addition to code(s) for delivery.</p> <p>✦</p> <p>Use the "C" suffix provider number.</p>
59414	Individual	Delivery of placenta (separate procedure)	<p>This code cannot be billed in conjunction with another delivery code.</p> <p>✦</p> <p>This code is limited to one unit within 225 days when billed by the same or different provider.</p>	<p>This code cannot be billed in conjunction with another delivery code.</p> <p>✦</p> <p>This code is limited to one unit within 225 days when billed by the same or different provider.</p> <p>✦</p> <p>Use the "C" suffix provider number.</p>

Routine Obstetrical Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
59425	Package	Antepartum care only; 4-6 visits	<p>The date the provider first saw the recipient for antepartum care shall be entered in block 15 of the CMS-1500 form.</p> <p style="text-align: center;">✦</p> <p>The date of service on the claim shall be the date of the last visit if the date of delivery is not known.</p> <p style="text-align: center;">✦</p> <p>This code cannot be billed in addition to other OB global codes.</p> <p style="text-align: center;">✦</p> <p>This code can be billed only once during the pregnancy with one unit by the same provider. (Refer to Subsection 5.2, letter b.)</p> <p style="text-align: center;">✦</p> <p>If delivery and postpartum care are also performed by the same provider, do not bill this code. Select a global code that includes all services provided.</p>	N/A

Routine Obstetrical Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
59426	Package	Antepartum care only; 7 or more visits	<p>The date the provider first saw the recipient for antepartum care shall be entered in block 15 of the CMS-1500 form.</p> <p>✦</p> <p>The date of service on the claim shall be the date of delivery.</p> <p>✦</p> <p>This code cannot be billed in addition to other OB global codes.</p> <p>✦</p> <p>This code can be billed only once during the pregnancy with one unit.</p> <p>✦</p> <p>If delivery and postpartum care are also performed by the same provider, do not bill this code. Select a global code that includes all services provided.</p>	N/A
59430	Individual	Postpartum care only (separate procedure)	<p>This code cannot be billed in addition to other OB global codes.</p> <p>✦</p> <p>This code includes 60 days postpartum.</p> <p>✦</p> <p>Do not use this code if delivery and antepartum care were performed by the same provider. Select a global code that includes all services provided.</p>	N/A

Routine Obstetrical Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
59510	Global	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	<p>The provider billing for OB care shall have rendered at least 3 consecutive months of antepartum care to the recipient.</p> <p>✦</p> <p>The date the provider first saw the recipient for antepartum care shall be entered in block 15 of the CMS-1500 form.</p> <p>✦</p> <p>The date of service on the claim for the OB care shall be the date of delivery.</p> <p>✦</p> <p>This code cannot be billed in addition to other OB global codes.</p>	N/A
59514	Individual	Cesarean delivery only	<p>This code is limited to one unit within 225 days when billed by the same or different provider except as described in E below.</p> <p>✦</p> <p>This code cannot be billed in addition to global OB codes.</p> <p>✦</p> <p>If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code.</p>	<p>This code is limited to one unit within 225 days when billed by the same or different provider.</p> <p>✦</p> <p>Use the "C" suffix provider number.</p>
59515	Package	Cesarean delivery only; including postpartum care	<p>This code is limited to one unit within 225 days when billed by the same or different provider.</p> <p>✦</p> <p>If antepartum care is performed by the same provider, bill the appropriate global code.</p>	N/A

Additional Obstetrical Services Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	<p>Use this code with high-risk deliveries. ✦</p> <p>Use this code when services are related only to the mother. ✦</p> <p>Services shall be requested by a physician, and this request shall be documented in the medical record. ✦</p> <p>Diagnosis substantiating the high risk shall be listed on the claim form. ✦</p> <p>This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦</p> <p>This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦</p> <p>Refer to the CPT book for the descriptions and indications for physician standby services. ✦</p> <p>This code is limited to 2 hours per day.</p>	<p>Use this code with high-risk deliveries. ✦</p> <p>Use this code when services are related only to the mother. ✦</p> <p>Services shall be requested by a physician, and this request shall be documented in the medical record. ✦</p> <p>Diagnosis substantiating the high risk shall be listed on the claim form. ✦</p> <p>This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦</p> <p>This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦</p> <p>Refer to the CPT book for the descriptions and indications for physician standby services. ✦</p> <p>This code is limited to 2 hours per day. ✦</p> <p>Use the "C" suffix provider number.</p>

Additional Obstetrical Services Procedure Codes				
CPT Code	Type	Description	Physician Services Guidelines	FQHC/RHC Guidelines
99464	Individual	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	<p>This code cannot be billed in conjunction with newborn resuscitation (99465).</p> <p>✦</p> <p>This code cannot be billed on the same date of service as code 99360 by the same provider.</p>	<p>This code cannot be billed in conjunction with newborn resuscitation (99465).</p> <p>✦</p> <p>This code cannot be billed on the same date of service as code 99360 by the same provider.</p> <p>✦</p> <p>Use the "C" suffix provider number.</p>

Stand-by Services for Anesthesia Providers			
HCPCS Code	Type	Description	Anesthesia Guidelines
99360	Individual	Physician standby service, requiring prolonged physician attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	<p>Use this code with high-risk deliveries.</p> <p>✦</p> <p>Use this code when services are related only to the mother.</p> <p>✦</p> <p>Services shall be requested by a physician, and this request shall be documented in the medical record.</p> <p>✦</p> <p>Diagnosis substantiating the high risk shall be listed on the claim form.</p> <p>✦</p> <p>This code cannot be billed on the same date of service as, or in conjunction with, code 99464.</p> <p>✦</p> <p>This code cannot be billed on the same date of service as CPT codes 99354 through 99357.</p> <p>✦</p> <p>This code cannot be billed on the same date of service as any other anesthesia codes.</p> <p>✦</p> <p>Refer to the CPT book for the descriptions and indications for physician standby services.</p> <p>✦</p> <p>This code is limited to 1 hour (2 units) per day.</p>

Postpartum Vaccinations	
CPT Code	Description
90396	Varicella-zoster immune globulin, human, for intramuscular use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90716	Varicella virus vaccine, live, for subcutaneous use

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing for Multiple Births

The appropriate multiple gestation diagnosis code shall be on the claim for reimbursement.

Gestation	ICD-9-CM Code	Description	Additional Units to Be Billed
Twin	651.01	Twin pregnancy, delivered, with or without mention of antepartum condition	1
Triplet	651.11	Triplet pregnancy, delivered, with or without mention of antepartum condition	2
Quadruplet	651.21	Quadruplet pregnancy, delivered, with or without mention of antepartum condition	3

In addition to the multiple gestation diagnosis code, the correct delivery codes are also required.

Type of delivery	CPT Code for First Birth No Modifier	Effective with DOS on and after 8/01/2009 CPT code and modifier for Consecutive Births	Effective with DOS 3/31/11 CPT code and modifier for Consecutive Births
All vaginal	59400 or 59409 or 59410	59409- 51 (one line for each additional birth)	59409-51, 59 (one line with one unit for each additional birth)
All cesarean	59510 or 59514 or 59515	59514- 51 (one line for each additional birth)	59514-51, 59 (one line with one unit for each additional birth)
Mixed—vaginal first	59400 or 59409 or 59410	59409- 51 (one line for each vaginal additional birth) or	59409-51, 59 (one line with one unit for each additional birth)

Type of delivery	CPT Code for First Birth No Modifier	Effective with DOS on and after 8/01/2009 CPT code and modifier for Consecutive Births	Effective with DOS 3/31/11 CPT code and modifier for Consecutive Births
		59514- 51 ,59 (one line for each additional cesarean birth)	or 59514- 51 , 59 (one line with one unit for each additional birth)

Note: For multiple births of more than four infants, submit the first claim electronically. It will deny with a request for operative notes. Submit the second claim as an adjustment with operative notes attached.

F. Place of Service

Inpatient hospital
Outpatient hospital
Office

G. Co-Payments

Co-payments are not required for obstetrics.

H. Reimbursement

Providers shall bill their usual and customary charges.

Attachment B: Billing for Obstetrical Services

The CPT procedure codes listed below may not be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430, 59510, or 59515 by the same billing provider.

CPT Code	Description
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel (Calcium, total)
80050	General health panel
80051	Electrolyte panel
80055	Obstetric panel
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
82731	Fetal fibronectin, cervicovaginal secretions, semiquantitative
83020	Hemoglobin fractionation and quantitation; electrophoresis (e.g., A2, S, C, and/or F)
83021	Hemoglobin fractionation and quantitation; chromatography (e.g., A2, S, C, and/or F)
83026	Hemoglobin; by copper sulfate method, non-automated
83030	Hemoglobin; F (fetal), chemical
83036	Hemoglobin; glycosylated (A1C)
83045	Hemoglobin; methemoglobin, qualitative
83050	Hemoglobin; methemoglobin, quantitative
83051	Hemoglobin; plasma
83055	Hemoglobin; sulfhemoglobin, qualitative
83060	Hemoglobin; sulfhemoglobin, quantitative
83065	Hemoglobin; thermolabile
83068	Hemoglobin; unstable, screen
83069	Hemoglobin; urine
85046	Blood count; automated differential WBC count; reticulocytes, automated, including one or more cellular parameters (e.g., reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [MRV], RNA content), direct measurement

(continues)

CPT Code	Description (Evaluation and Management)
99201 through 99215	Office or other outpatient services
99217	Observation care discharge day management
99218 through 99220	Initial observation care
99221 through 99239	Hospital inpatient services
99241 through 99245	Office or other outpatient consultations
99251 through 99255	Inpatient consultation

Billing Individual Evaluation and Management Codes for 1-3 Visits

When an obstetrical patient is seen by the obstetric provider between one (1) and three (3) visits, the visits would be coded as an E/M service, according to the services that were provided. If the patient is new to the physician, codes 99201-99205 shall be reported for the new patient initial visit. E/M codes 99211-99215 for an established patient shall be reported for the next two visits.