Obstetrics

The MCO shall require that all prenatal outpatient visit evaluation and management (E&M) procedure codes be modified with TH. The TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

The MCO shall cover two initial prenatal visits per pregnancy (270 days). These two visits may not be performed by the same attending provider.

The MCO shall consider the enrollee a 'new patient' for each pregnancy whether or not the enrollee is a new or established patient to the provider/practice. The MCO shall require that the appropriate level E&M CPT procedure code be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, which must be modified with TH, shall include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier.

Follow-Up Prenatal Visits

The MCO shall require the provider to submit the appropriate level E&M CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The E&M CPT code for each of these visits must be modified with the TH modifier.

The reimbursement for this service shall include, but is not limited to:

- The obstetrical (OB) examination;
- Routine fetal monitoring (excluding fetal non-stress testing);
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy; and
- Routine dipstick urinalysis.

Delivery Codes

The MCO's policy for coding deliveries shall include the following:

- The most appropriate "delivery only" CPT code shall be submitted. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered except in cases related to third party liability.
- Modifier -22 for unusual circumstances is to be used with the most appropriate CPT code for a vaginal or cesarean section delivery when the method of delivery is the same for all births.
- If the multiple gestation results in a cesarean section delivery and a vaginal delivery, the provider must use the most appropriate "delivery only" CPT code for the cesarean section delivery and also bill the most appropriate vaginal "delivery only" procedure code with modifier -51 appended.
- When a long-acting reversible contraceptive (LARC) is inserted immediately postpartum and prior to discharge, reimbursement shall be made separately for the insertion procedure and the LARC.

Global Maternity Care for Third Party Liability

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care. Other antepartum services are not considered part of global maternity services—they are reimbursed separately. An initial visit, confirming the pregnancy, is not a part of global maternity care services.

The MCO shall accept global maternity procedure codes for claims billed for secondary payment. Global maternity codes shall be recognized and considered for reimbursement only when billed to the MCO as secondary payer. The MCO shall deny claims billed to the MCO as primary payer. Refer to the Professional Services Fee Schedule for the global maternity procedure codes and rates.

The MCO shall calculate reimbursement based upon LDH TPL payment policy as defined in the Contract or this Manual.

LDH, or is contracted actuary, will consider maternity global codes in rate development. Global maternity codes shall only be payable when billed to the MCO as secondary payer; therefore, these codes will not be included in encounter kick payment logic.

The provider should bill prenatal, delivery, and/or postpartum services separately when the enrollee's coverage terminates prior to delivery.

Add-on codes for maternity-related anesthesia will not apply. The MCO should bypass add-on rates when modifiers 47 and 52 are reported.

Interest applies when a payable clean claim remains unpaid beyond the 30 day claims processing deadline. Refer to the Contract for detailed information.

Maternity claims where the enrollee's primary carrier does not cover maternity services should be billed to the MCO as primary payer. The MCO should accept global maternity procedure codes for claims billed only as secondary payer.

Postpartum Care Visit

The postpartum care CPT code (which is not modified with –TH) shall be reimbursed for the postpartum care visit when performed. Reimbursement is allowed for one postpartum visit per 270 days.

The reimbursement for the postpartum care visit includes, but is not limited to:

- Physical examination;
- Body mass index (BMI) assessment and blood pressure check;
- Routine dipstick urinalysis;
- Follow up plan for women with gestational diabetes;
- Family planning counseling;
- Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed;
- Screening for postpartum depression and intimate partner violence; and
- Other counseling and or services associated with releasing a patient from obstetrical care.

Prenatal Laboratory and Ultrasound Services

Prenatal Lab Panels

The MCO shall cover the obstetric panel test as defined by CPT only once per pregnancy.

The MCO shall cover a complete urinalysis only once per pregnancy (270 days) per billing provider, or more when medically necessary, for example, to diagnose a disease or infection of the genitourinary tract.

Non-Invasive Prenatal Testing

Non-Invasive Prenatal Testing (NIPT) is a genetic test which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is completed during the pre-natal period of pregnancy to screen for the presence of some common fetal chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

- Trisomy 21 (Down syndrome);
- Trisomy 18 (Edwards syndrome); and
- Trisomy 13 (Patau syndrome).

The MCO shall cover NIPT when medically necessary and without the requirement of prior authorization.

NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:

- Abnormal first trimester screen, quad screen or integrated screen;
- Abnormal fetal ultrasound scan indicating increased risk of aneuploidy;
- Prior family history of aneuploidy in first (1st) degree relative[1] for either parent;
- Previous history of pregnancy with aneuploidy; and
- Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

The MCO shall not cover NIPT for women with multiple gestations.

[1] 1st degree relative is defined as a person's parent, child, or sibling.

Ultrasounds

A minimum of ~~two~~ three obstetric ultrasounds shall be reimbursed per pregnancy (270 days) without the requirement of prior authorization or medical review when performed by providers other than maternal fetal medicine specialists:

- ~~-~~When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall only be counted as one obstetric ultrasound; and
- Obstetric ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count.

For maternal fetal medicine specialists, there shall be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

17-Alpha Hydroxyprogesterone Caproate

The MCO shall cover 17-alpha hydroxyprogesterone caproate (17P) without the requirement of prior authorization when substantiated by an appropriate diagnosis and all of the following criteria are met:

- Current pregnancy with a history of pre-term delivery before 37 weeks gestation;
- No symptoms of pre-term in the current pregnancy;
- Current singleton pregnancy; and
- Treatment initiation between 16 weeks 0 days and 23 weeks 6 days gestation.

Fetal Non-Stress Test

The MCO shall cover fetal non-stress tests when medically necessary as determined by meeting one of the following criteria:

- The pregnancy is post-date/post-maturity (after 41 weeks gestation);
- The treating provider suspects potential fetal problems in an otherwise normal pregnancy; or
- The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

Fetal Biophysical Profile

The MCO shall cover fetal biophysical profiles when medically necessary, as determined by meeting at least two of the following criteria:

- Gestation period is at least 28 weeks
- Pregnancy must be high-risk, and if so, the diagnosis should reflect high risk
- Uteroplacental insufficiency must be suspected in a normal pregnancy