Obstetrics

All prenatal outpatient visit evaluation and management (E&M) procedure codes must be modified with TH. ~~in order to process correctly.The modifier must be placed in the first position after the *Current Procedural Terminology* (CPT) code.~~
The TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

Louisiana Medicaid ~~allows~~ reimburses for up to two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same attending provider.

Louisiana Medicaid considers the ~~recipient~~ beneficiary a 'new patient' for each pregnancy whether or not the ~~recipient~~ beneficiary is a new or established patient to the provider/practice. ~~–~~The appropriate level E&M *Current Procedural Terminology* (CPT) procedure code ~~from the range of codes for new patient "Office or Other Outpatient Services"~~ shall 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~~s~~, 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 ~~can~~ may only be ~~billed~~submitted ~~at~~ with the appropriate level E&M ~~service~~ without the TH modifier.

Follow-Up Prenatal Visits

The appropriate level E&M CPT code from the range of procedure codes used for an established patient ~~in the "Office or Other Outpatient Services"~~ may be ~~billed~~ submitted 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~~s~~, 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.

~~Treatment for conditions such as minor vaginal problems and routine primary care issues, including infections, sinusitis, etc., is~~ are ~~considered an essential part of maternal care during pregnancy.~~

Delivery Codes

The most appropriate "delivery only" CPT code ~~should~~ shall be ~~billed~~submitted. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered except in cases related to third party liability.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth and delivery records ~~should~~ must be attached. A Modifier~~A~~-22 ~~modifier~~ for unusual circumstances ~~should~~ is to be used with the most appropriate CPT code for a vaginal or Cesarean section (C-section) delivery when the method of delivery is the same for all births.

If the multiple gestation results in a C-section delivery and a vaginal delivery, the provider ~~should~~ must ~~bill~~use the most appropriate "delivery only" CPT code for the C-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.

Postpartum Care Visit

The postpartum care CPT code (which ~~should NOT be~~ is not modified with –TH) ~~should~~ may be billed 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 obstetric panel test as defined by CPT shall only be reimbursed once per pregnancy.

A complete urinalysis is reimbursable only once per pregnancy (270 days) per billing provider unless medically necessary, for example, to diagnose a disease or infection of the genitourinary tract.

~~One laboratory "Obstetric Panel" is reimbursable per pregnancy. See current CPT manual for the appropriate procedure code for the "Obstetric Panel".~~

~~A complete urinalysis is reimbursable only once per pregnancy (270 days) per billing provider unless medically necessary and the primary diagnosis for the additional urinalysis supports a disease or infection of the genitourinary (GU) 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).

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 for either parent;
- Previous history of pregnancy with aneuploidy; and
- Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

Note: 1st degree relative is defined as a person's parent, children, or sibling.

NIPT is NOT covered for women with multiple gestations.

Ultrasounds

Two ~~medically necessary~~ obstetric ultrasounds shall be ~~allowed~~ reimbursed per pregnancy (270 days) when medically necessary and ~~. This includes OB ultrasounds performed by all providers regardless of place of treatment when~~ performed by providers other than maternal fetal medicine specialists. For most beneficiaries, this will be one ultrasound for the determination of gestational age and one for the survey of fetal anatomy, both performed by the end of the second trimester.

Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. Documentation –must include evidence of an existing condition or indicate that the ultrasound is necessary to rule out a suspected abnormality.

If more than two ultrasounds must be performed due to multiple pregnancies (failed or completed) within 270 days, providers must submit a hardcopy claim and attach documentation with each submission for these subsequent ultrasounds indicating a previous pregnancy within 270 days.

When a beneficiary is sent to an outpatient facility for the ultrasound, the obstetrical provider must forward the information supporting the medical need for additional ultrasounds to the radiologist.

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.
~~Obstetrical providers shall utilize the obstetrical ultrasound section of CPT.~~
~~Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists.~~ ~~Louisiana Medicaid anticipates that two medically necessary ultrasounds will have been performed by the end of the second trimester of the pregnancy, one for determination of gestational age and one for survey of fetal anatomy. Providers are cautioned not to maximize reimbursement by performing more than the medically necessary number of ultrasounds per pregnancy. Abuse of the ultrasound limit to maximize reimbursement is subject to review and possible recoupment and/or sanctions.~~

~~Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. Documentation should include evidence of an existing condition or documentation to rule out an expected abnormality.~~

~~If the two ultrasound limit has been exceeded due to multiple pregnancies (failed or completed) within 270 days, providers must submit a hardcopy claim and attach documentation with each submission for these subsequent ultrasounds indicating a previous pregnancy within 270 days.~~

~~The recipient's obstetrical provider should forward the information supporting the medical need for additional ultrasounds to the radiologist when recipients are sent to an outpatient facility for the ultrasound.~~

~~Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists.~~ ~~(These are not included in the two per pregnancy limit described previously for the attending OB provider.)~~

17 Alpha Hydroxyprogesterone Caproate (17-P)~~Injections~~

~~Refer to the "Injectable Physician Administered Medications" section for more information on 17 Alpha Hydroxyprogesterone Caproate (17-P) and the billing of other injectable medications~~ Medicaid covers 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:

- Pregnant woman 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 Testing

~~**Fetal Oxytocin Stress Test**~~

~~A fetal oxytocin stress test is payable in an office setting to those professionals who have provided written verification to the fiscal intermediary's Provider Enrollment Unit of their the capacity to perform the procedure in their office.~~

- ~~The full service is payable to physicians only when the service is performed in the office setting. The full service is not payable to physicians if the place of service is in an inpatient or outpatient hospital.~~
- ~~The "professional component only" aspect of this code is payable to all physicians, regardless of the place of service.~~

Fetal Non-Sstress Test

Fetal non-stress tests are covered and considered medically necessary when one of the following is met: ~~is payable only in the following instances:~~

- The pregnancy is ~~P~~post-date/post-maturity ~~pregnancies~~ (after 41 weeks gestation);~~.~~

- The treating ~~physician~~ provider ~~has reason to~~ suspect~~s~~ ~~potential~~ fetal problems in an otherwise ~~"normal"~~normal pregnancy; or~~. If so, the diagnosis should reflect this.~~

- The pregnancy is high risk, ~~High risk pregnancies,~~ including but not limited to diabet~~es mellitus, ic patient, toxemia,~~ pre-eclampsia, eclampsia, multiple gestation~~s~~, and previous intrauterine fetal death.~~. The diagnosis should reflect high risk.~~

~~In addition, if the place of service is either in an inpatient or outpatient hospital, or the billing physician is rendering the "interpretation only" in his/her office, only the professional component (modifier 26) should be used.~~

~~**NOTE:** See the Medical Review section for additional information.~~

Fetal Biophysical Profile

Fetal biophysical profiles are covered and considered medically necessary ~~reimbursable~~when~~, ~~, but claims must be substantiated by~~ at least two of the ~~three criteria listed below:~~following are met:

- Gestation period is at least 28 weeks~~,~~; and/or

- Pregnancy must be high~~-~~ risk, as determined by the provider; and/or~~and if so, the diagnosis should reflect high risk, or~~

- Uteroplacental insufficiency ~~must be suspected~~is suspected in a normal pregnancy.

~~Hospital Observation Care~~

~~Louisiana Medicaid considers "Initial Observation Care" a part of the E&M services provided to recipients designated as "observation status" in a hospital. The key components of the codes used to report physician encounter(s) are defined in CPT's "Evaluation and Management Services Guidelines". These guidelines indicate that professional services include those face-to-face and/or bedside services rendered by the physician and reported by the appropriate CPT code. In order to submit claims to the Louisiana Medicaid program for hospital observation care, the service provided by the physician must include face-to-face and/or bedside care.~~