

**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.**

## **Table of Contents**

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions .....	1
2.0	Eligibility Requirements .....	1
2.1	Provisions.....	1
2.1.1	General.....	1
2.1.2	Specific .....	2
2.1.3	Regular Medicaid.....	2
2.1.4	Medicaid for Pregnant Women.....	2
2.1.5	Undocumented Aliens.....	2
2.1.6	Presumptive Eligibility .....	2
2.1.7	Retroactive Eligibility.....	2
2.2	Special Provisions.....	3
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age .....	3
3.0	When the Procedure, Product, or Service Is Covered.....	4
3.1	General Criteria Covered .....	4
3.1.1	Telehealth Services.....	4
3.2	Specific Criteria Covered.....	4
3.2.1	Specific criteria covered by Medicaid .....	4
3.2.2	Medicaid Additional Criteria Covered.....	4
3.3	Package Services.....	6
4.0	When the Procedure, Product, or Service Is Not Covered.....	6
4.1	General Criteria Not Covered .....	6
4.2	Specific Criteria Not Covered.....	6
4.2.1	Specific Criteria Not Covered by Medicaid.....	6
4.2.2	Medicaid Additional Criteria Not Covered.....	6
5.0	Requirements for and Limitations on Coverage .....	6
5.1	Prior Approval .....	6
5.2	Ultrasounds .....	6
5.3	Program Requirements .....	7
5.3.1	Pregnancy Risk Screening .....	7
6.0	Providers Eligible to Bill for the Procedure, Product, or Service .....	7
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	7
6.2	Provider Certifications.....	8
7.0	Additional Requirements .....	8
7.1	Compliance .....	8

8.0 Policy Implementation/Revision Information..... 9

Attachment A: Claims-Related Information..... 14

- A. Claim Type ..... 14
- B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) ..... 14
- C. Code(s)..... 14
- D. Modifiers..... 15
- E. Billing Units..... 15
- F. Place of Service ..... 15
- G. Reimbursement ..... 15

Attachment B: Risk Factors Related to High-Risk Pregnancy ..... 17

Attachment C: Requirements for Pregnancy Management Program Providers..... 18

Attachment D: OB Ultrasound Codes Exempt from Prior Approval (PA) for Pregnancy Management Program Providers ..... 19

### Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1E-5 *Obstetrical Services*

1E-7, *Family Planning Services*

1E-4, *Fetal Surveillance*

1-H, *Telehealth, Virtual Patient Communications, and Remote Patient Monitoring*

## 1.0 Description of the Procedure, Product, or Service

The Pregnancy Management Program (PMP) (formerly Pregnancy Medical Home - PMH) is a care program with a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing health care costs. The PMP encourages adoption of the best prenatal, pregnancy, and perinatal care for Medicaid beneficiaries. Unlike the PMH program, there is no enrollment requirement for the PMP. All providers eligible to bill NC Medicaid (Medicaid) for obstetric services are considered participating PMP providers.

A key feature of the PMP is the continued use of the standardized screening form to identify and refer women at risk for an adverse birth outcome to the Care Management for High-Risk Pregnancies (CMHRP) program, a more intense set of care management services that is coordinated and provided by Local Health Departments (LHDs). Together, these two programs work to improve the overall health of women and newborns across the state.

All PMP providers shall be required to ensure appropriate coordination with LHD care managers for the sub-set of their practice population who receive CMHRP services.

To allow the PMP to stay abreast of PMP beneficiary medical needs, LHD care managers shall provide the PMP alerts, including: emergency department (ED) visits, visits to a specialist, and missed appointments.

### 1.1 Definitions

#### a. High-Risk Pregnancy Definition

A pregnancy that threatens the health or life of the beneficiary or fetus, often requiring specialized care.

**Note:** Refer to **Subsection 3.2. b(e)** Risk Factors Related to High-Risk Pregnancy

**Note:** The qualified PMP provider shall adhere to documented guidelines in clinical coverage policy 1E-5 *Obstetrical Services*, at <https://medicaid.ncdhhs.gov/>.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid policies)*

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*)
- b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

### 2.1.2 Specific

(*The term "Specific" found throughout this policy only applies to this policy*)

- a. **Medicaid**  
None Apply.

### 2.1.3 Regular Medicaid

Refer to clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>.

### 2.1.4 Medicaid for Pregnant Women

Refer to clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>.

### 2.1.5 Undocumented Aliens

Refer to clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>.

### 2.1.6 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.

The pregnant beneficiary shall apply for Medicaid no later than the last day of the month following the month she is determined presumptively eligible. If the pregnant beneficiary 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 beneficiary 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 beneficiary 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.

### 2.1.7 Retroactive Eligibility

Refer to *NCTracks Provider Claims and Billing Assistance Guide*: <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

#### b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*  
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

### 3.0 When the Procedure, Product, or Service Is Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

#### 3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or 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 beneficiary, the beneficiary's caretaker, or the provider.

##### 3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.

#### 3.2 Specific Criteria Covered

##### 3.2.1 Specific criteria covered by Medicaid

None Apply.

##### 3.2.2 Medicaid Additional Criteria Covered

###### 3.2.2.1 Antepartum Care

Antepartum care shall be covered according to clinical coverage policy #1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>.

###### 3.2.2.2 Individual Antepartum Services

Refer to clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/> for additional information on coverage of Evaluation and Management (E/M) services and individual antepartum care.

###### 3.2.2.3 Counseling

Refer to clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>, for information on counseling services.

#### 3.2.2.4 Fetal Surveillance Testing

Refer to clinical coverage policy 1E-4 *Fetal Surveillance* at <https://medicaid.ncdhhs.gov/>, for information on fetal surveillance services.

#### 3.2.2.5 Risk Factors Related to High-Risk Pregnancy

The PMP model designates certain pregnancy risk factors as “priority” risk factors for the purposes of ensuring the beneficiary with these risk factors is assessed by a care manager. Refer to **Attachment B** for a list of current risk factors. This list does not represent a comprehensive list of indications for which a beneficiary would receive case management, nor is it the complete list of the risk screening for which PMP’s are responsible.

#### 3.2.2.6 Pregnancy Risk Screen and Care Management

The Pregnancy Management Program provider shall complete risk screening on all pregnant Medicaid beneficiaries participating in a PMP. The screening must be completed by a physician, nurse practitioner, certified nurse midwife, physician assistant or registered nurse. All pregnant Medicaid beneficiaries determined to be high-risk after screening shall receive case management in proportion to the level of their identified need as determined through assessment by a pregnancy care manager in the Care Management for High-Risk Pregnancy Program (CMHRP).

#### 3.2.2.7 Pregnancy Care Management Services

- a. Pregnancy care management services must begin with the initial assessment and continue as long as the need exists during the pregnancy. Pregnancy care management services shall end on the last day of the month in which the 60th postpartum day occurs.
- b. Pregnancy care management services may begin in the postpartum period if not identified during the antepartum period. Pregnancy care management services shall end on the last day of the month in which the 60th postpartum day occurs.
- c. If the beneficiary is receiving case management services at the time of the referral, the new pregnancy care manager and the current care manager shall determine who shall be the lead care manager with the beneficiary during the pregnancy.
- d. Pregnancy care managers shall work in partnership with PMP providers to ensure proper care of the beneficiary during the pregnancy.
- e. The pregnancy care manager shall refer a MPW beneficiary at the end of their postpartum Medicaid eligibility period to the Family Planning (FP) program.
- f. For a beneficiary with full Medicaid benefits, the pregnancy care manager shall ensure that the beneficiary is referred to their original provider of care prior to the pregnancy. If the beneficiary does not

have a health care provider, the pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of her choice.

- g. The pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of their choice for any future care management service's needs.

**Note:** Refer <https://medicaid.ncdhhs.gov/>, for information on other Medicaid services.

### **3.3 Package Services**

Refer to clinical coverage policy 1E-5, *Obstetrical Services* at, for information on antepartum package, global obstetrics, and postpartum package services.

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

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid shall not cover the procedure, product, or service related to this policy when:

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

### **4.2 Specific Criteria Not Covered**

#### **4.2.1 Specific Criteria Not Covered by Medicaid**

None Apply.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

## **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **5.1 Prior Approval**

Medicaid shall not require prior approval for the Pregnancy Management Program.

### **5.2 Ultrasounds**

PMP providers are not required to obtain prior approval for any obstetrical ultrasound. Refer to **Attachment D** for a list of exempt ultrasound procedure codes.

Certain ultrasound procedures require medical necessity indication, such as a known or suspected fetal anatomic or genetic abnormality and can only be performed by specific providers. Refer to **Attachment A, G “Reimbursement.”**

### 5.3 Program Requirements

#### 5.3.1 Pregnancy Risk Screening

- a. The standardized pregnancy risk screening form must be used to identify a pregnant beneficiary in need of pregnancy care management services.
- b. Providers shall complete the pregnancy risk screening form at the beneficiary’s initial visit and follow-up screening any time there is a maternal or fetal change in condition necessitating a new risk assessment. It is recommended that the Pregnancy Risk Screening Form be completed at the visits closest to 28 weeks gestation and 36 weeks gestation.
- c. A Medicaid beneficiary with a priority risk factor present on the pregnancy risk screening form shall be referred for pregnancy care management assessment. A copy of the pregnancy risk screening form must be provided to the high-risk case management agency.
- d. A beneficiary shall be eligible to receive pregnancy care management services at any time during pregnancy or the postpartum period which ends on the last day of the month during which the 60<sup>th</sup> day post-delivery occurs.

**Note:** The Pregnancy Risk Screening Form can be found on the following web site:

<https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp>

**Note:** Refer to **Attachment C** for a complete list of requirements for PMP Providers.

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

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

#### 6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Individual physicians or physician groups, nurse practitioners, certified nurse midwives, and physician assistants enrolled with Medicaid and providing obstetrical services in one of the following:

- a. General Medicine;
- b. Family Medicine;
- c. Obstetrics and Gynecology;
- d. Multi-specialty;

- e. Federally Qualified Health Clinics (FQHC);
- f. Rural Health Clinics (RHC); or
- g. Local Health Departments (LHD).

## 6.2 Provider Certifications

None Apply.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s)

## 8.0 Policy Implementation/Revision Information

Original Effective Date: March 1, 2011

### Revision Information:

Date	Section Revised	Change
03/1/11	Throughout	Initial promulgation of new policy for Pregnancy Medical Home
03/9/11	Subsection 6.0.b.4	Removed reference to local health departments
03/9/11	Attachment A: H	Removed reference to local health departments
10/15/11	Subsection 3.2.6	Specified “registered” nurse
10/15/11	Attachment A	Deleted Institutional Claim in Attachment A: Claim Type
10/15/11	Attachment E	Updated Risk Screening Tools
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
3/1/12	Subsection 6.1.1	Added Physician Assistants
8/15/12	Throughout	Updated template language
8/15/12	Subsection 5.3.1	Deleted Pregnancy Risk Screening Tool from the policy. Added links to the website to access the revised Pregnancy Risk Screening Tool
8/15/12	Throughout	Replaced “recipient” with “beneficiary.”
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
01/01/2016	Subsection 3.2.2, 5.2	Policy amended to correlate with changes to the 1K-7, <i>Prior Approval for Imaging Services</i> policy.
01/01/2016	Attachment D	Added ultrasound code exempt from prior approval (PA) for Pregnancy Medical Home providers.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
12/31/2019	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
12/31/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.

Date	Section Revised	Change
12/01/2020	Related Coverage Policies	Added 1E-7, <i>Family Planning Services</i> , 1E-4 <i>Fetal Surveillance</i> , and 1-H, <i>Telehealth, Virtual Patient Communications, and Remote Patient Monitoring</i> .
	Section 1.0	Changed plural reference of “beneficiaries” to singular “beneficiary” in this section and throughout policy where appropriate.
12/01/2020	Subsection 1.1	Updated definition of high-risk pregnancy to align with that of 1E-5 Obstetrics policy to read “A pregnancy that threatens the health or life of the beneficiary or fetus, often requiring specialized care. Changed language from “ <b>Note:</b> Refer to <b>Subsection 3.2.5 Risk Factors Related to High-Risk Pregnancy</b> ” to “ <b>Note:</b> Refer to <b>Subsection 3.2.2(e) Risk Factors Related to High-Risk Pregnancy.</b> ”
12/01/2020	Added Subsection 3.1.1	As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: <i>Telehealth, Virtual Patient Communications, and Remote Patient Monitoring</i> .
12/01/2020	Subsection 3.2.2(f)(1)(E)	Removed the word “Waiver” from “Family Planning Waiver” and removed “W” from “FPW”
12/01/2020	Subsection 5.3.1(b)	Removed the requirement for follow up pregnancy risk rescreen by the 28 <sup>th</sup> week of pregnancy and updated to read “follow-up screening any time there is a maternal or fetal change in condition necessitating a new risk assessment.
12/01/2020	Subsection 5.3.1(d)	Updated link to Pregnancy Risk Screen form for DHB website and removed CCNC link.
12/01/2020	Section 6.1(c)(4)	Added the word “Certified” to Nurse Midwives.
12/01/2020	Attachment A, Letter C	Added columns to pregnancy medical home codes indicating if the services were eligible for telehealth along with the following language: Note: Telehealth eligible services may be provided to new and established patients by the eligible providers listed within this policy
12/01/2020	Attachment A, Letter D	Added the following language for telehealth services: <b>Telehealth Claims:</b> Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This

Date	Section Revised	Change
		modifier is not appropriate for virtual patient communications or remote patient monitoring
12/01/2020	Attachment A, Letter F	Added language indicating telehealth codes should be filed with the provider's usual place of service code(s)
12/01/2020	Attachment B	Added overweight and obesity, and young or old maternal age to list of Risk Factors Related to High-Risk Pregnancy.
12/01/2020	Attachment A, Letter H	Added the following language for providers billing S0280 and S0281: PMH providers shall bill the pregnancy risk screen and the postpartum plan maintenance incentives if the initial prenatal visit and postpartum visit was conducted in person or via telehealth.
12/01/2020	Added beginning of Policy	Added the language "This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect."
04/01/2022	Policy Title	Changed title of policy from 1E-6: Pregnancy Medical Home to 1E-6: Pregnancy Management Program. Changed title of 1E-5, Obstetrics to 1E-5, Obstetrical Services.
04/01/2022	Related Clinical Coverage Policies	Removed Clinical Coverage Policy 1K-7, Prior Approval for Imaging Procedures as Prior Approval no longer applicable.
04/01/2022	Section 1.0	Updated Description for program change from Pregnancy Medical Home (PMH) to Pregnancy Management Program (PMP) including that there is no longer an "opt in" enrollment process.
04/01/2022	All Sections and Attachments	Changed Pregnancy Medical Home to Pregnancy Management Program and changed the abbreviation PMH to PMP where necessary throughout policy. Specified policy applicable to Medicaid Direct beneficiaries where necessary. Changed title of 1E-5, Obstetrics to 1E-5, Obstetrical Services throughout.
04/01/2022	Subsection 2.1.4	Removed the text and link for prior approval for a MPW beneficiary.
04/01/2022	Subsection 3.2.2.4	Removed reference to Clinical Coverage Policy 1K-7, Prior Approval for Imaging Procedures as Prior Approval no longer applicable.
04/01/2022	Subsection 3.2.2.6	Added Pregnancy Risk Screen to section heading.

Date	Section Revised	Change
04/01/2022	Section 5.3.1	Added Reference to Attachment C for Requirements for Pregnancy Management Program providers.
04/01/2022	Subsection 5.2 (a)	Removed section as Prior Approval no longer applicable.
04/01/2022	Subsection 5.2 (b)	Changed Reference for Attachment A from section H to section G for Reimbursement.
04/01/2022	Subsection 5.2. (c)	Removed section as Prior Approval no longer applicable.
04/01/2022	Attachment A, Letter G	Removed the following sentence:-HCPCS code S0281 will not be reimbursed for miscarriage, spontaneous abortion, and terminations.
04/01/2022	Attachment C	Updated program requirements to match those of Pregnancy Management Program in the current May 12, 2021, Program Guide for Management of High-Risk Pregnancies and At-Risk Children in Managed Care.
04/01/2022	Attachment D	Updated Pregnancy Medical Home language to Pregnancy Management Program.
04/01/2022		Policy has an effective date of July 1, 2021 with an amended date of April 1, 2022
02/01/2023	All Sections and throughout	With the exception of subsection 2.1.6. Presumptive Eligibility, “pregnant woman” was changed to “pregnant beneficiary” and “her/she/hers” was changed to non-gender pronouns. Changed the word “tool” to “form” throughout.
02/01/2023	Section 1.0	Changed the name of the screen tool to Care Management for High-Risk Pregnancies (CMHRP)
02/01/2023	Subsection 3.2.2.7 a. and b.	Added text to clarify that pregnancy care management services shall end on the last day of the month in which the 60 <sup>th</sup> postpartum day occurs.
02/01/2023	Subsection 3.2.2.7.g.	Added text that “the pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of their choice for any futures management service’s needs.”
02/01/2023	Subsection 5.3.1.b.	Added the text “It is recommended that the Pregnancy Risk Screening Form also be performed at the visits closest to 28 weeks gestation and 36 weeks gestation.”
02/01/2023	Subsection 5.3.1.d.	Added text to clarify that pregnancy care management services shall end on the last day of the month in which the 60 <sup>th</sup> post delivery day occurs. Updated the website link to the

Date	Section Revised	Change
		Pregnancy Risk Screening Form. Added this text in the sentence: for a complete list of
02/01/2023	Attachment A, Letter G.	Added the text “and at the visits closest to 28 weeks gestation and 36 weeks gestation” and text, “a maximum of three times” to sentences to clarify.
02/01/2023	Attachment B. e.	Deleted the text overweight.
02/01/2023	Attachment B. f.	Added text “35 years or older”
02/01/2023	Attachment B. g	Changed homelessness, inadequate housing to home insecurity. Changed family to domestic violence.
02/01/2023	Attachment B. h	Added disorders.
02/01/2023	Attachment B. k.	Changed inappropriate to Increased. Removed / between Emergency Department and Labor and Delivery.
02/01/2023	Attachment C. d.	Added the text “Screen all pregnant beneficiaries” and added “and offer a management plan based on their individual risk factors”. Deleted text that referenced 17p intramuscular injection.
02/01/2023	Attachment C e.	Added text “It is recommended that the Pregnancy Risk Screening Form also be performed at the visits closest to 28 weeks gestation and 36 weeks gestation.”
02/01/2023	Attachment C. f.	Added the text “pregnant beneficiaries” and added a website link.
4/15/2023	All Sections, All Attachment(s)	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.
12/15/2023		Fixed minor formatting issue posting and amended date not changed.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

### A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

### B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Refer to **Section B** of **Attachment A: Claims-Related Information** of clinical coverage policy 1E-5, *Obstetrical Services*, at <https://medicaid.ncdhhs.gov/>, for covered ICD-10-CM diagnosis code information.

### C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The following table contains codes for the billing of the PMP Pregnancy Risk Screening Form and the PMP Postpartum plan maintenance:

HCPCS Code(s)	Guidelines	Telehealth Eligible Services
S0280	Providers shall bill this code after the pregnancy risk screening tool has been completed.	Yes
S0281	Providers shall bill this code after the postpartum visit is completed.	Yes

**Note:** Telehealth eligible services may be provided to new and established patients by the eligible providers listed within this policy.

Refer to **Section C of Attachment A:** Codes, of clinical coverage policy 1E-5, *Obstetrical Services*, at <https://medicaid.ncdhhs.gov/> for additional information on covered CPT codes.

Refer to **Attachment B:** Billing for Obstetrical Services, of clinical coverage policy 1E-5, *Obstetrical Services* at <https://medicaid.ncdhhs.gov/>, for additional information on covered Evaluation and Management Services codes.

#### **D. Modifiers**

Non-Telehealth Claims: Providers shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

#### **E. Billing Units**

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

Refer to **Section E of Attachment A:** Codes, of clinical coverage policy 1E-5, *Obstetrical Services*, at <https://medicaid.ncdhhs.gov/>, for additional information on billing for multiple births.

#### **F. Place of Service**

Inpatient hospital, Outpatient hospital, Office.

Telehealth claims must be filed with the provider's usual place of service code(s).

Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

#### **G. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

Any provider who bills global, package or individual pregnancy procedures within their scope of practice is considered a PMP provider and must follow the PMP program requirements outlined in **Attachment C**.

PMP providers shall bill for prenatal risk screening incentives when the screen is performed at the initial prenatal visit, and at the visits closest to 28 weeks gestation and 36 weeks gestation, or at any point when the beneficiary's biopsychosocial circumstances change.

The PMP provider can only bill HCPCS codes S0280 a maximum of three times, and S0281 one time during the gestational period even if there are multiple births. Once billed, no other provider can bill these codes in the same gestational period.

The PMP practice is reimbursed for S0280 and S0281 and not the individual physician with the exception of a sole proprietor.

The provider billing S0281 must be the same provider that bills the postpartum visit.

PMP providers shall bill the pregnancy risk screen and postpartum incentives if the risk screen and postpartum visits are conducted in person or via telehealth.

CPT Procedure codes 76811 and 76812 require medical necessity indication, such as a known or suspected fetal anatomic or genetic abnormality and can only be performed by specific providers. The PMP may refer a beneficiary to another provider or may perform these codes in office only if they meet the following:

- a. OB ultrasound providers certified with the American Institute of Ultrasound in Medicine (AIUM) or an American College of Radiology (ACR) accredited practice; or
- b. Providers with sub-specialty in Maternal Fetal Medicine (Perinatology) or Radiology.

With the exception of FQHC's and RHC's, one of the following procedure codes must be billed before code S0281 is reimbursed: 59400, 59410, 59430, 59510, or 59515.

Refer to **Section C of Attachment A:** Codes, of clinical coverage policy 1E-5, *Obstetrical Services*, at <https://medicaid.ncdhhs.gov/>, for information on obstetrical codes and instructions for **physicians** and **FQHC/RHC** provider billing for PMP.

## Attachment B: Risk Factors Related to High-Risk Pregnancy

Risk factors related to high-risk pregnancy can include any of the following:

- a. History of preterm birth (less than 37 weeks);
- b. History of low birth weight (less than 2500grams);
- c. Multiple gestation;
- d. Fetal complications;
- e. Chronic condition complicating pregnancy (diabetes, hypertension, Human Immunodeficiency Virus (HIV), Systemic Lupus Erythematosus (SLE), sickle cell, asthma, seizure disorder, renal disease, substance abuse diagnosis, mental illness);
- f. Obesity;
- g. Adolescents or elderly gravidas 35 years or older;
- h. Unsafe living environment (e.g., homelessness, inadequate housing, domestic violence, sexual abuse, coercion, community violence);
- i. Substance use disorders;
- j. Nicotine use such as tobacco and electronic cigarette use;
- k. Missing two or more prenatal appointments without rescheduling; or
- l. Increased hospital utilization (Emergency Department or Labor & Delivery triage visit by a pregnant beneficiary with no prenatal care provider, antepartum hospitalization, two or more Emergency Department or Labor and Delivery triage visits by a beneficiary with a prenatal care provider).

**Note:** This list does not represent a comprehensive list of indications for which a beneficiary would receive case management, nor is it the complete list of the risk screening for which PMPs are responsible.

## Attachment C: Requirements for Pregnancy Management Program Providers

The Pregnancy Management Program provider shall agree to all of the following:

- a. Integrate the beneficiary's plan of care with local CMHRP staff, which is inclusive of collaboration and communication, ensuring access to HIPAA compliant space for adequate patient and CMHRP staff engagement, access to patients' Electronic Medical Record (EMR) and to foster the embedded care management model;
- b. Allow Health Plan or Health Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
- c. Maintain or lower the rate of elective deliveries prior to (39) weeks gestation;
- d. Screen all pregnant beneficiaries for the prevention of preterm birth and offer a management plan based on their individual risk factors;
- e. Complete the standardized Pregnancy Risk Screening Form at the initial prenatal visit and at any point when the beneficiary's biopsychosocial circumstances change. It is recommended that the standardized Pregnancy Risk Screening Form be performed at the visits closest to 28 weeks gestation and 36 weeks gestation;
- f. Decrease the cesarean section rate among nulliparous pregnant beneficiaries  
<https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp> ;
- g. Decrease the primary cesarean section delivery rate if the rate is over the Department's designated cesarean rate; (Note: NC Medicaid sets the rate annually, which is at or below twenty percent (20 percent)); and
- h. Ensure comprehensive postpartum visits occur within (56) days of delivery.

### Attachment D: OB Ultrasound Codes Exempt from Prior Approval (PA) for Pregnancy Management Program Providers

Procedure Code	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a 76801
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
93325	Doppler echocardiography color flow velocity mapping