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**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
1R-4 Electrocardiography, Echocardiography, and Intravascular Ultrasound  
1K-7, Prior Approval for Imaging Procedures  
1E-6, Pregnancy Medical Home

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

Fetal surveillance testing may be necessary to ensure that the fetus is developing normally. The predominant goal of antepartum fetal testing is to lower perinatal morbidity and mortality rates. Fetal testing should not begin until interventions can be undertaken.

### **1.1 Definitions**

#### **Ultrasound**

Ultrasound is a method of imaging the fetus and the female pelvic organs during pregnancy. A hand-held device is passed over the abdominal surface, recording the echoes of high-frequency sound waves as they are transmitted through tissues with varying density. Ultrasound is used to determine abnormal conditions of pregnancy or other conditions affecting the fetus and future delivery. Doppler ultrasound studies are used to confirm or exclude fetal anemia and help determine timing of delivery.

#### **Fetal Contraction Stress Testing**

Fetal contraction stress testing is a method of assessing fetoplacental respiratory reserve by observing the response of the fetal heart rate to uterine contractions to determine if the fetus is adequately oxygenated.

#### **Fetal Non-stress Testing**

Fetal non-stress testing is a noninvasive method of assessing fetal well-being by observing the response of the fetal heart rate to fetal movement and uterine activity by external means. A uterine monitor is used and the measurements are observed and recorded.

#### **Biophysical Profile**

The biophysical profile (BPP) includes a non-stress test and the following four ultrasonography observations:

- a. Fetal breathing movements
- b. Fetal movement
- c. Fetal tone (one or more episodes of a fetal extremity with return to flexion, or opening or closing of a hand)
- d. Determination of the amniotic fluid volume

#### **Fetal Echocardiography**

Fetal echocardiography is a diagnostic fetal ultrasound test that evaluates the fetus's heart while the fetus is still in the uterus. This testing can diagnose most cardiac defects. Fetal echocardiography is performed using a two-dimensional (2-D) high-resolution ultrasound system.

Color Doppler is used to identify abnormal connections or valve abnormalities, and spectral Doppler is used to assess fetal blood flow velocities and physiology. Additional imaging of the umbilical vessels, hepatic vessels and middle cerebral artery by spectral Doppler are commonly performed as part of a complete fetal echogram.

### **Amniocentesis**

Amniocentesis is an ultrasound-guided procedure used to diagnose various prenatal genetic defects and other fetal conditions. Generally performed at or beyond 14 weeks gestation for genetic testing amniotic fluid is withdrawn from the mother through a needle inserted in the amniotic sac. An ultrasound is usually performed simultaneously to guide the insertion of the needle. The fluid is used to diagnose fetal genetic abnormalities, diagnose intrauterine infection, assess fetal lung maturity, and establish the severity of hemolytic disease in blood group isoimmunization.

### **Chorionic Villus Sampling**

Chorionic villus sampling (CVS) is an ultrasound-guided procedure performed during pregnancy at 10 and 12 weeks to determine congenital chromosome disorders and to detect suspected genetic abnormalities in the fetus. It involves taking samples from the placenta in the early stages of pregnancy to check for the presence of genetic defects in the fetus.

### **Cordocentesis**

Cordocentesis, also call percutaneous umbilical blood sampling (PUBS) is an ultrasound-guided procedure performed to genetic testing or to evaluate severity of fetal anemia. The fetal umbilical cord is visualized with ultrasound while a needle is passed from the surface of the mother's abdomen, through the uterus, into the umbilical cord. A small sample of fetal blood is withdrawn for testing.

### **Fetal Fibronectin**

Fetal fibronectin (fFN) immunoassay is a qualitative test of cervicovaginal secretions for the detection of fFN protein, which anchors the amniotic membranes to the wall of the uterus. When the "anchor" breaks, the fFN leaks into the vagina, and provides a clue that the woman may be going into preterm labor (when the cervix softens or dilates, with or without labor pains, before 37 weeks' gestation). The test therefore predicts preterm delivery.

## **2.0 Eligibility Requirements**

### **2.1 Provisions**

#### **2.1.1 General**

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or

2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

### 2.1.2 Specific

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

a. **Medicaid**

None.

b. **NCHC**

Services included in this policy are not covered for NC Health Choice (NCHC) beneficiaries. NCHC beneficiaries, ages 6 through 18 years of age, who become pregnant, shall be transitioned to another appropriate Medicaid eligibility category that includes coverage for fetal surveillance, if eligible.

## 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: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

**2.3 Gender and Age**

Medicaid beneficiaries from ages 9 through 60 are eligible for the procedure when they meet the medical necessity criteria listed in **Section 3.0**.

**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 and NCHC 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 provide.

### **3.2 Specific Criteria Covered**

#### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

None Apply:

#### **3.2.2 Medicaid Additional Criteria Covered**

##### **Medically Necessary Ultrasound**

Medicaid covers ultrasounds when used as a diagnostic tool for the following conditions:

- a. Abnormality in pregnancy such as, but not limited to:
  - 1. Suspected ectopic pregnancy
  - 2. Suspected hydatidiform mole
  - 3. Threatened or missed abortion
  - 4. Congenital malformations, fetal or maternal
  - 5. Polyhydramnios/oligohydramnios
  - 6. Placenta previa
  - 7. Abrupto placenta
  - 8. Vaginal bleeding
- b. A medical condition threatening the fetus and/or delivery such as, but not limited to:
  - 1. Suspected abnormal presentation
  - 2. Suspected multiple gestation
  - 3. Significant difference between the size of the uterus and the time the fetus has been in the womb
  - 4. Elevated maternal serum alpha-fetoprotein
  - 5. Suspected genetic abnormality due to abnormal maternal serum screening (QUAD Screen) or maternal age greater than 35.
  - 6. Suspected fetal death
  - 7. Suspected anatomical abnormality of the uterus
  - 8. Maternal risk factors such as family history of congenital abnormalities, chronic systemic disease (hypertension, diabetes, sickle cell disease), or substance abuse
  - 9. Suspected fetal growth abnormality, either growth retardation or macrosomia
- c. Confirmation of the estimated date of conception when the clinical history and examination are not certain. In general, a single ultrasound performed prior to 20 weeks' gestation is sufficient for this purpose.

- d. Follow-up ultrasounds may be medically necessary if the study will be used to alter or confirm a treatment plan.
- e. Umbilical artery Doppler velocimetry is considered medically necessary in evaluating pregnancies complicated by intra-uterine growth restriction, oligohydramnios, and/or discordant twins.
- f. Middle cerebral artery Doppler velocimetry is considered medically necessary for evaluation of suspected fetal anemia in conditions such as isoimmunization and parvovirus B-19 infection.

### **Fetal Contraction Stress Testing**

Medicaid covers fetal contraction stress testing only for high-risk pregnancies including, but not limited, to the following:

- a. Anti-phospholipid syndrome
- b. Hyperthyroidism (poorly controlled)
- c. Hemoglobinopathies (hemoglobin SS, SC, or S-thalasemia)
- d. Cyanotic heart disease
- e. Pregestational diabetes
- f. Hypertensive disorders
- g. Pregnancy-induced hypertension
- h. Decreased fetal movement
- i. Oligohydramnios
- j. Polyhydramnios
- k. Intrauterine growth restriction
- l. Post-term pregnancy(greater than 41 weeks' gestation)
- m. Isoimmunization (moderate to severe)
- n. Previous fetal demise (unexplained or recurrent risk)
- o. Multiple gestation (with significant growth discrepancy)

### **Fetal Non-Stress Testing**

Medicaid covers fetal non-stress testing for a high-risk pregnancy when:

- a. Pregnancy is at least at a gestation of 26 weeks, **and**
- b. There is a high risk that the fetus' health could be compromised because of one of the following conditions, including but not limited to:
  - 1. Maternal conditions associated with uteroplacental compromise:
    - A. Diabetes mellitus (pre-existing or pregnancy related)
    - B. Underlying maternal hypertension
    - C. Pregnancy-induced hypertension
    - D. Anti-phospholipid syndrome
    - E. Hyperthyroidism (poorly controlled)
    - F. Hemoglobinopathies (hemoglobin SS, SC, or S-thalasemia)
    - G. Cyanotic heart disease
    - H. Isoimmunization (moderate to severe)
    - I. Previous fetal demise (unexplained or recurrent risk)
  - 2. Fetal conditions associated with uteroplacental compromise:
    - A. Fetal distress, identified by clinical history or examination
    - B. Poor fetal growth
    - C. Decreased fetal movement
    - D. Oligohydramnios



- E. Polyhydramnios
  - F. Preterm premature rupture of membranes
  - G. Intrauterine growth restriction
  - H. Post-term pregnancy(greater than 41 weeks' gestation)
  - I. Multifetal gestation (with significant growth discrepancy).
  - J. Known fetal anomaly
3. Other suspected causes of fetal distress

### **Fetal Biophysical Profiles (BPP)**

Medicaid covers fetal biophysical profiles during pregnancy when:

- a. Pregnancy is at least at a gestation of 26 weeks, **and**
- b. There is a high risk that the fetus' health could be compromised because of one of the following conditions, including but not limited to:
  - 1. Inconclusive Non-Stress testing (Non-Reactive) or
  - 2. Indications listed for Non-Stress Test above

### **Fetal Echocardiography**

Medicaid covers fetal echocardiography as a diagnostic tool for a fetus at high risk for congenital heart disease.

Medicaid covers fetal echocardiography for:

- a. Suspected congenital heart disease based on Obstetrical screening
- b. Elevated risk for congenital heart disease based on fetal risk factors (e.g. abnormal nuchal thickness, chromosomal abnormality, other fetal structural abnormalities)
- c. Elevated risk for congenital heart disease based on maternal risk factors (e.g. pre-gestational diabetes, fetal teratogen exposure)
- d. Elevated risk for congenital heart disease based on family risk factors (e.g. previous child with congenital heart disease, first degree relative with congenital heart disease)
- e. Elevated risk for acquired fetal heart disease (e.g. maternal autoimmune disease, maternal infectious exposure, maternal non-infectious illness)

For further information on fetal echocardiography, refer to DMA's Clinical Coverage Policy 1R-4 *Electrocardiography, Echocardiography, and Intravascular Ultrasound* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).

### **Amniocentesis**

Medicaid covers amniocentesis for the following clinical indications:

- a. to diagnose or determine the severity of neural tube defect
- b. in pregnancy where the mother will be 35 years of age or older at the expected time of delivery
- c. when a previous pregnancy resulted in the birth of a child with chromosomal or genetic abnormality or major malformations
- d. when a chromosomal or genetic abnormality is known to exist in either parent
- e. when a history of chromosomal or genetic abnormality is present in a blood relative
- f. abnormal maternal serum screening
- g. where there is history of three or more spontaneous abortions in this relationship or in a previous mating of either partner
- h. other conditions associated with increased risk for fetal aneuploidy such as first trimester thickened nuchal translucency.
- i. when the fetus is at increased risk for a detectable metabolism error
- j. for fetal sex determination in pregnancies at risk for an X-linked hereditary disorder such as, but not limited to the following:
  1. hemophilia
  2. mental retardation
  3. hydrocephalus
  4. Duchenne's muscular dystrophy
- k. to diagnose and monitor Rh incompatibility
- l. to gauge fetal lung maturity when early delivery is anticipated
- m. to control polyhydramnios (reduction amniocentesis)

### **Chorionic Villus Sampling**

Medicaid covers chorionic villus sampling for the following clinical indications:

- a. in pregnancy where the mother will be 35 years of age or older at the expected time of delivery.
- b. when a previous pregnancy resulted in the birth of a child with chromosomal or genetic abnormality or major malformations.
- c. when a chromosomal or genetic abnormality is known to exist in either parent.
- d. when a history of chromosomal or genetic abnormality is present in a blood relative.
- e. when there is history of three or more spontaneous abortions in this relationship or in a previous mating of either partner.
- f. other conditions associated with increased risk for fetal aneuploidy such as first trimester thickened nuchal translucency.
- g. when the fetus is at increased risk for metabolism error, detectable in vitro.

- h. for fetal sex determination in pregnancies at risk for an X-linked hereditary disorder such as, but not limited to the following:
  - 1. hemophilia.
  - 2. mental retardation.
  - 3. hydrocephalus.
  - 4. Duchenne's muscular dystrophy.

### **Cordocentesis**

Medicaid covers cordocentesis for the following indications:

- a. suspected chromosome abnormality when rapid diagnosis will influence management.
- b. suspected fetal hematologic abnormality when confirmation will influence management.

### **Fetal Fibronectin Testing**

Medicaid covers fetal fibronectin testing when all of the following criteria are met:

- a. amniotic membranes are intact; and
- b. cervical dilation is minimal (less than 3 cm); and
- c. sampling is performed between 24 weeks, 0 days and 34 weeks, 6 days of gestation.

### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

## **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 and NCHC 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 both Medicaid and NCHC**

None Apply.

#### 4.2.2 Medicaid Additional Criteria Not Covered

##### Ultrasound

Ultrasound is not covered when:

- a. it is a screening test used in the absence of medical indications or predisposing factors; or
- b. it is used solely to determine the sex of the fetus.

##### Fetal Echocardiography

Fetal echocardiography is not covered when:

- a. it is used for routine screening for congenital heart disease in the absence of risk factors listed in **Subsection 3.6**; or
- b. the pregnancy is low risk and there are normal anatomic findings on ultrasound examination; or
- c. premature contractions are occasional and without sustained tachycardia or signs of dysfunction or distress; or
- d. a non-cardiovascular system abnormality is present, but evaluation of the cardiovascular system will not alter either obstetrical decision making or fetal outcome.

##### Amniocentesis

Amniocentesis is not covered when it is performed for the following reasons:

- a. sex determination, in the absence of a documented risk of an X-linked disorder, or
- b. routine screening, in the absence of risk factors noted in **Subsection 3.7**.

#### 4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

## 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

Effective with date of service October 1, 2010, the non-PMH provider shall obtain prior approval for obstetrical ultrasounds, biophysical profiles, and fetal echocardiograms.

Refer to DMA's Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information.

Pregnancy Medical Home (PMH) providers are not required to obtain prior approval or register the procedure for obstetrical ultrasounds, biophysical profiles, and fetal echocardiograms.

Refer to DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information as related to PMH provider guidelines.

Refer to **Attachment A** for additional information regarding specific codes.

## **5.2 Prior Approval Requirements**

### **5.2.1 General**

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.
- c. If the Medicaid recipient is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

### **5.2.2 Specific**

None Apply.

## **5.3 Limitations**

### **5.3.1 Ultrasound**

Refer to **Subsection 5.1** Prior Approval regarding obstetric ultrasound limitations.

### **5.3.2 Fetal Non Stress Testing**

Up to three fetal non-stress tests are covered in a 280-day period or 40 weeks before a high-risk diagnosis must be on the claim. All non-stress tests must be medically necessary. Claim diagnoses will be reviewed for high-risk pregnancy.

### **5.3.3 Fetal Biophysical Profiles**

Fetal BPPs are allowed to be performed on each fetus. The diagnosis must support the number of units billed. Example: Two units can be billed when a BPP is performed on twins. Refer to **Subsection 5.1 Prior Approval** regarding fetal biophysical profiles.

### **5.3.4 Fetal Echocardiography**

Fetal echocardiography is allowed twice in a 280-day period. Claims submitted for testing that exceeds this limit will be reviewed for medical necessity. Refer to **Subsection 5.1** Prior Approval regarding fetal echocardiography.

**Note:** The intent of the above limitations is not to prevent or interfere with medically necessary repetition but to prevent medically unnecessary duplication. All fetal surveillance procedures must be medically necessary.

## **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 or NCHC 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**

None Apply.

### **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 DMA'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:** December 1, 1982

### Revision Information:

Date	Section Revised	Change
4/1/07	Sections 1.1 and 3.2, Attachment A	Coverage expanded to include chorionic villus sampling (59015)
4/1/07	Sections 1.7 and 3.8, Attachment A	Coverage expanded to include doppler velocimetry (76820, 76821)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
3/12/12	Section 1.5	Revised description of fetal echocardiography
3/12/12	Section 3.6	Revised Medicaid coverage of fetal echocardiography
3/12/12	Section 5.1	Revised prior approval requirements section
3/12/12	Attachment A	Added CPT codes 76813 and 76814, Moved Reimbursement guidelines for fetal surveillance and billing guidelines for multiple fetuses to Attachment B & C respectively.
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 5.1	Policy amended to correlate with changes to the 1K-7, <i>Prior Approval for Imaging Services</i> policy. Wording concerning clinical coverage policy 1K-7 revised to reflect those amendments.

## Attachment A: Claims-Related Information

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

### A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

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

Providers 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.

### C. Code(s)

Providers 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.

Code(s)	
Ultrasound in Maternity Care	
76801	76814
76802	76815
76805	76816
76810	76817
76811	76820
76812	76821
76813	
<b>Note:</b> CPT codes 76801 through 76817, 76820, and 76821 require prior approval for non-PMH providers.	

Refer to DMA's Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on obstetrical ultrasounds.



<b>Fetal Oxytocin Stress Testing</b>
59020
<b>Fetal Non-Stress Testing</b>
59025
<b>Biophysical Profile</b>
76818
76819
<b>Note:</b> 76818 and 76819 require prior approval for non-PMH providers.

Refer to DMA's Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>), for additional information on biophysical profiles.

<b>Fetal Echocardiography</b>
76825
76826
76827
76828
93325
<b>Note:</b> CPT codes 76825 through 76828 require approval for non-PMH providers.

For further information on fetal echocardiography, refer to DMA's Clinical Coverage Policy 1R-4 *Electrocardiography, Echocardiography, and Intravascular Ultrasound* and DMA's Clinical Coverage Policy 1K-7, *Prior Approval for Imaging Procedures* (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).

<b>Amniocentesis</b>
59000
59001
76946
82143
82963
83661
83662
83663
83664
84081
88235
88267
88269

<b>Chorionic Villus Sampling</b>
59015
76945
88235
88267

<b>Cordocentesis</b>
59012

<b>Fetal Fibronectin Testing</b>
82731

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Providers shall follow applicable modifier guidelines.

**E. Billing Units**

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

**F. Place of Service**

Inpatient, Outpatient, Physician's Office.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at

<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

[http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

Refer to **Attachment B** for specific billing guidelines for fetal surveillance.

Refer to **Attachment C** for specific billing guidelines for ultrasounds for multiple fetuses.

## **Attachment B: Billing Guidelines for Fetal Surveillance**

1. Medicaid does not allow separate reimbursement for components included in more comprehensive procedures. For example:
  - a. Fetal heart monitoring is included with non-stress testing and is not separately reimbursable.
  - b. Medicaid does not allow separate reimbursement for fetal monitoring performed during labor.
2. A medically necessary repeat or follow-up fetal ultrasound on the same date of service must be filed as an adjustment with medical records.
3. A fetal non-stress test (CPT code 59025) cannot be billed with fetal biophysical profile (CPT code 76818).
4. Neither fetal oxytocin stress testing (CPT code 59020) nor non-stress testing (CPT code 59025) can be billed on the same date of service as labor room delivery (RC720).
5. The number of fetal biophysical profiles billed must match the diagnosis billed. Example: if the diagnosis is either of the following O30.001, O30.002, O30.003, O30.011, O30.012, O30.013, O30.031, O30.032, O30.033, O30.041, O30.042, O30.043, O30.091, O30.092, O30.093 (twin pregnancy), the number of fetal biophysical profiles billed cannot exceed two.
6. Medicaid covers other procedures performed on the same date of service as amniocentesis if performed by the same provider and billed according to modifier rules.
7. Medicaid covers other related procedures performed during the amniocentesis follow-up period and unrelated procedures performed during the follow-up period if performed by the provider who performed the amniocentesis.

## Attachment C: Billing Guidelines for Ultrasounds for Multiple Fetuses

When billing for the ultrasound of multiple fetuses, the following guidelines should be observed.

1. The primary transabdominal code must be billed as one detail with one unit of service. (These codes are 76801, 76805, and 76811.)
2. The add-on code must be billed on one detail line with the units of service equaling the number of additional fetuses (76802, 76810, and 76812).
3. Each add-on code must be billed with the correct primary code.
4. The add-on codes for “each additional fetus” must be billed with the appropriate multiple gestation ICD-10-CM codes from the table below. (Do not use the fifth-digit sub-classification digit 0.) The units billed for the add-on ultrasound procedure code is based on the number of “each additional” living fetus(es).

ICD-10-CM Code(s)			
O30.001	O30.123	O31.21x1	O31.13x5
O30.002	O30.191	O31.21x2	O31.13x9
O30.003	O30.192	O31.22x1	O31.21x1
O30.011	O30.193	O31.22x2	O31.21x2
O30.012	O30.201	O31.23x1	O31.21x3
O30.013	O30.202	O31.23x2	O31.21x4
O30.031	O30.203	O31.11x1	O31.21x5
O30.032	O30.211	O31.11x2	O31.21x9
O30.033	O30.212	O31.11x3	O31.22x1
O30.041	O30.213	O31.11x4	O31.22x2
O30.042	O30.221	O31.11x5	O31.22x3
O30.043	O30.222	O31.11x9	O31.22x4
O30.091	O30.223	O31.12x1	O31.22x5
O30.092	O30.291	O31.12x2	O31.22x9
O30.093	O30.292	O31.12x3	O31.23x1
O30.101	O30.293	O31.12x4	O31.23x2
O30.102	O31.11x1	O31.12x5	O31.23x3
O30.103	O31.11x2	O31.12x9	O31.23x4
O30.111	O31.12x1	O31.13x1	O31.23x5
O30.112	O31.12x2	O31.13x2	O31.23x9
O30.113	O31.13x1	O31.13x3	
O30.121	O31.13x2	O31.13x4	
O30.122			

5. One combination of primary and add-on ultrasound codes is allowed per day. Claims denied for additional ultrasounds may be resubmitted as an adjustment with documentation to support the medical necessity of a repeat ultrasound on the same date of service.
6. 76815 is defined to include “one or more fetuses” and can only be reimbursed for one unit of service.
7. When billing 76816 for multiple fetuses, bill 76816 on one detail without a modifier and with one unit for the first fetus. Additional fetuses must be billed on the next detail line using

- 76816 with modifier 59; the units should equal the number of additional fetuses. This code must also be billed with the appropriate diagnosis code from ICD-10-CM series of diagnosis codes outlined above.
8. In addition to the transabdominal ultrasounds, one unit of 76817 is covered on the same date of service if medically necessary. No modifier is needed. Medical necessity must be documented in the beneficiary's medical record.
  9. Fetal biophysical profiles (76818 and 76819) are covered for additional fetuses. The profile for the first fetus must be billed on one detail, no modifier, and one unit of service. Profiles for additional fetuses must be billed on the next detail, using modifier 59, with the number of units equaling the number of additional fetuses. The appropriate diagnosis code from the ICD-10-CM series of diagnosis as outlined above must be billed.
  10. Claims for fetal biophysical profiles submitted with more than one unit and without the appropriate diagnosis code will be denied. Providers should correct the claim and resubmit as a new claim.
  11. Claims for multi-gestational transabdominal ultrasounds submitted without the appropriate diagnosis will be denied. Providers should correct the claim and resubmit as a new claim.
  12. Medical records are required for multiple gestation diagnosis codes from the ICD-10-CM series outlined above that note "fetal loss" or "other" and/or "unspecified multiple gestation."
  13. In cases of fetal demise, the ultrasound procedure that confirms the loss of one, or more, fetuses may be billed with units to include the total number of additional fetuses, deceased and living. Subsequent billings should be billed with the units based on the number of "each additional" living fetus.
  14. A fetal biophysical profile must not be billed for a fetus that is deceased.
  15. CPT code 76830 must not be billed for a transvaginal ultrasound performed for any pregnancy related condition.
  16. Because pregnancies with multiple fetuses are high-risk pregnancies, there is no limit to the number of ultrasounds performed during the pregnancy when billed according to these instructions. However, excessive billing of ultrasounds during a pregnancy is subject to post-payment review for medical necessity, which must be documented in the medical record.

See **Attachment B** for specific billing guidelines for fetal surveillance. See **Attachment C** for specific billing guidelines for ultrasounds for multiple fetuses.