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Related Clinical Coverage Policies

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:

1E-5 *Obstetrics*

1K-7, *Prior Approval for Imaging Procedures*

1.0 Description of the Procedure, Product, or Service

Pregnancy Medical Home (PMH) services are defined as managed care services to provide obstetric care to pregnant Medicaid beneficiaries with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care. The PMH seeks to engage the participation of any provider that is eligible to bill NC Medicaid (Medicaid) for obstetric services. Case Management services are provided for all pregnant Medicaid beneficiaries who are determined to be high-risk and qualify for services. To allow the PMH to stay abreast of PMH beneficiary medical needs, DMA's designated vendor shall provide the PMH alerts, including: emergency department (ED) visits, visits to a specialist, missed appointments, and etc.

1.1 High-Risk Pregnancy Definition

A high-risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth.

Note: Refer to **Subsection 3.2.5** Risk Factors Related to High-Risk Pregnancy

Note: The qualified PMH provider shall adhere to documented guidelines in DMA clinical coverage policy 1E-5 *Obstetrics*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>.

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 Apply.

b. **NCHC**

NC Health Choice (NCHC) shall not cover PMH. NCHC beneficiaries, ages 6 through 18 years of age, who become pregnant shall be transitioned to another appropriate Medicaid eligibility category that includes pregnancy coverage, if eligible.

2.1.3 Regular Medicaid

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA’s Web site at <http://www.ncdhhs.gov/dma/mp/>.

2.1.4 Medicaid for Pregnant Women

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA’s Web site at <http://www.ncdhhs.gov/dma/mp/>. Prior approval for MPW beneficiaries as documented in **Subsection 5.1** in clinical coverage policy 1E-5, *Obstetrics* on DMA’s Web site at <http://www.ncdhhs.gov/dma/mp/> is effective for the PMH.

2.1.5 Undocumented Aliens

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA’s Website at <http://www.ncdhhs.gov/dma/mp/>.

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

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

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

2.1.7 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: <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

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 provider.

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

a. Antepartum Care

Antepartum care shall be covered in accordance with clinical coverage policy #1E-5, *Obstetrics* on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>.

b. Individual Antepartum Services

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for additional information on coverage of Evaluation and Management (E/M) services and individual antepartum care.

c. Counseling

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on counseling services.

d. **Fetal Surveillance Testing**

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>, for information on fetal surveillance services.

Refer to clinical coverage policy 1K-7, *Prior Approval for Imaging Procedures* on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on prior approval for obstetric ultrasounds and other imaging services.

e. **Risk Factors Related to High-Risk Pregnancy**

The PMH model designates certain pregnancy risk factors as "priority" risk factors for the purposes of ensuring the beneficiaries with these risk factors are 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 PMH's are responsible.

f. **Care Management**

The Pregnancy Medical Home provider shall complete risk screening on all pregnant Medicaid beneficiaries participating in a PMH. The screening must be completed by a physician, nurse practitioner, certified nurse midwife 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.

1. **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.
- 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 PMH providers to ensure proper care of the beneficiary during the pregnancy.
- E. The pregnancy care manager shall refer MPW beneficiaries at the end of their postpartum Medicaid eligibility period to the Family Planning Waiver (FPW) program.
- F. For beneficiaries with full Medicaid, the pregnancy care manager shall ensure that the beneficiary is referred back to her original provider of care prior to the pregnancy. If she 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.

Note: Refer to DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on other Medicaid services.

3.3 Package Services

Refer to clinical coverage policy 1E-5, *Obstetrics* on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on antepartum package, global obstetrics, and postpartum package services.

3.4 Referrals

Current Primary Care Provider (PCP) guidelines require Carolina Access (CA) beneficiaries to receive a referral before seeing a specialist. Guidelines for PMH providers are as follows:

- a. Referrals to PMH providers to initiate obstetric care shall only be necessary if the beneficiary is enrolled in CA.
- b. Prior approval requirements for MPW beneficiaries still apply.
- c. If a PCP and the PMH is the same provider and the beneficiary becomes pregnant, no referral is necessary.
- d. If the PMH and the PCP are different providers and the beneficiary is enrolled in CA, the beneficiary needs a referral from the PCP to be seen by the PMH.
- e. If the beneficiary is not enrolled in CA, no referral is needed to initiate obstetric care at a PMH.
- f. If the beneficiary is enrolled with a CA PCP, a referral is required from the PCP to see a specialist.
- g. If the beneficiary is not enrolled in CA, the beneficiary does not need a referral to see a specialist.

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

None Apply.

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

Prior approval is not required.

5.2 Ultrasounds

- a. PMH providers are not required to obtain prior approval for any obstetrical ultrasound. Refer to **Attachment D** for a list of exempt ultrasound procedure codes.
- b. The PMH provider shall register all ultrasounds with DMA's designated vendor in order to receive reimbursement.
- c. 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, H “Reimbursement.”**
- d. For all other high tech imaging procedures, the PMH provider shall obtain prior approval before rendering the imaging procedure. Refer to clinical coverage policy 1K-7, *Prior Approval for Imaging Procedures* on DMA’s Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on prior approval for obstetric ultrasounds and other imaging services.

5.3 Program Requirements

5.3.1 Pregnancy Risk Screening

- a. The pregnancy risk screening tool must be used to identify pregnant women in need of pregnancy care management services.
- b. Providers shall complete the pregnancy risk screening tool at the beneficiary’s initial visit, and follow-up screening by the end of the 28th week of pregnancy. Providers may rescreen the beneficiary at any time during the pregnancy if high-risk conditions are suspected.
- c. Medicaid beneficiaries with a priority risk factor present on the pregnancy risk screening tool shall be referred for pregnancy care management

assessment. A copy of the pregnancy risk screening tool must be provided to the high-risk case management agency.

- d. Beneficiaries shall be eligible to receive pregnancy care management services at any time during pregnancy or the postpartum period.

Note: The Pregnancy Risk Screening Tool can be found on the following web sites:

<http://www.ncdhhs.gov/dma/services/pmh.htm>

<https://www.communitycarenc.org/emerging-initiatives/pregnancy-home/>

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

Individual physicians or physician groups enrolled with Medicaid as one of the following:

- a. General/family practice;
- b. Obstetrics/Gynecology; or
- c. Multi-specialty.
 1. Federally Qualified Health Clinics (FQHC);
 2. Rural Health Clinics (RHC);
 3. Nurse Practitioners;
 4. Nurse Midwives;
 5. Physician Assistants

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: March 1, 2011

Revision Information:

Date	Section Revised	Change
3/1/11	Throughout	Initial promulgation of new policy for Pregnancy Medical Home
3/9/11	Subsection 6.0.b.4	Removed reference to local health departments
3/9/11	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.

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)

B. International Classification of Diseases, 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, *Obstetrics*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, 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 PMH Pregnancy Risk Screening Tool and the PMH Postpartum plan maintenance:

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

Refer to **Section C** of **Attachment A: Claims-Related Information**, of clinical coverage policy 1E-5, *Obstetrics*, on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>, for additional information on covered CPT codes.

Refer to **Attachment B: Billing for Obstetrical Services**, of clinical coverage policy 1E-5, *Obstetrics*, on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>, for additional information on covered Evaluation and Management Services codes.

D. Modifiers

Providers shall follow applicable modifier guidelines.

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: Claims-Related Information**, of clinical coverage policy 1E-5, *Obstetrics*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for additional information on billing for multiple births.

F. Place of Service

Inpatient hospital, Outpatient hospital, 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.

H. Reimbursement

Providers shall bill their usual and customary charges.

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

Any provider who bills global, package or individual pregnancy procedures within their scope of practice is eligible to participate in this program, as long as the provider agrees to the program requirements.

The PMH provider can only bill HCPCS codes S0280 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 PMH practice will be 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.

HCPCS code S0281 will not be reimbursed for miscarriage, spontaneous abortion, and terminations.

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 PMH may refer a beneficiary to another provider or may perform these codes in office only if they meet the following:

1. OB ultrasound providers certified with the American Institute of Ultrasound in Medicine (AIUM) or an American College of Radiology (ACR) accredited practice; or

2. 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 will be reimbursed: 59400, 59410, 59430, 59510, or 59515.

Refer to **Section C** of **Attachment A: Claims-Related Information**, of clinical coverage policy 1E-5, *Obstetrics*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>, for information on obstetrical codes and instructions for **physicians** and **FQHC/RHC** provider billing for PMH.

Attachment B: Risk Factors Related to High-Risk Pregnancy

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

- a. History of preterm birth (less than 37 weeks);
- a. History of low birth weight (less than 2500g);
- b. Multiple gestation;
- c. Fetal complications;
- d. Chronic condition which may complicate pregnancy (e.g., diabetes, hypertension, Human Immunodeficiency Virus (HIV), Systemic Lupus Erythematosus (SLE), sickle cell, asthma, seizure disorder, renal disease, substance abuse diagnosis, mental illness);
- e. Unsafe living environment (e.g., homelessness, inadequate housing, family violence, sexual abuse/coercion, community violence);
- f. Substance use;
- g. Tobacco use;
- h. Missing two or more prenatal appointments without rescheduling; or
- i. Inappropriate hospital utilization (Emergency Department/Labor & Delivery triage visit by pregnant patient with no prenatal care provider, antepartum hospitalization, two or more Emergency Department/Labor and Delivery triage visits by a patient 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 PMHs are responsible.

Attachment C: Requirements for Pregnancy Medical Home Providers

The Pregnancy Medical Home provider shall agree to all of the following:

- a. Allow DMA or DMA's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
- b. Eliminate elective deliveries prior to 39 weeks gestation if not medically necessary;
- c. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation. 17p will be prescribed when the beneficiary is deemed an appropriate candidate at the physician's discretion for 17p intramuscular injection and consents to participate after being informed by the provider of the benefits and risks.
- d. Complete a risk screening on each pregnant Medicaid beneficiary and integrate the plan of care with local pregnancy care management; and
- e. Decrease the primary cesarean delivery rate if the rate is over DMA's designated cesarean rate.

Attachment D: OB Ultrasound Codes Exempt from Prior Approval (PA) for Pregnancy Medical Home 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 (eg, fetal heart beat, 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