North Carolina Medicaid Special Bulletin

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Pregnancy Medical Home

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The Division of Medical Assistance (DMA), in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including Medicaid providers, local health departments, and the Division of Public Health, has created a program that provides pregnant Medicaid recipients with a Pregnancy Medical Home (PMH). The goal is to improve birth outcomes in North Carolina by providing evidence-based, high-quality maternity care to Medicaid patients. This will be done by modeling the PMH after the enhanced primary care case management (PCCM) program developed by CCNC. PMH practices agree to work toward quality improvement goals. Patients at risk of poor birth outcome are identified through standardized risk screening and are referred for pregnancy care management to address those risk factors. Local health departments, working in partnership with CCNC networks, provide pregnancy care management services. The PMH program became effective on March 1, 2011.

Becoming a PMH Provider

Providers must be enrolled as a N.C. Medicaid provider. Any provider who bills the OB global fee, package codes or individual pregnancy procedures is eligible to participate in this program as long as he/she agrees to the program requirements. It is **not** just for obstetric providers.

To become a PMH provider, contact your local CCNC network to obtain a contract. Please visit http://www.ncdhhs.gov/dma/provider/ccncnetwork.htm for CCNC network contact information. Return the signed contract to your network and they will forward it to DMA for processing once it is signed by network leadership. The contract includes all providers in the practice. Please include the names of all practitioners in your office on your contract. When a change in staff occurs, contact your CCNC network so Medicaid can make the appropriate updates. The contract will remain active unless termination is requested. Contracts are effective the first day of the month following the month in which they are signed. If you turn in your contract after the 19th of the month, submit your claims after the 15th of the following month to allow time for your contract to process.

Once a practice signs a contract, all of the pregnant Medicaid patients in the practice are considered PMH patients. Patients are not assigned or linked to PMH practices as they are through Carolina ACCESS for primary care. Providers will not see PMH information on the recipients Medicaid card or when viewing online eligibility. Local DSS offices will share information about the PMH program and provide a list of local PMH practices when a patient applies for Medicaid for Pregnant Women or notifies the DSS worker that she is pregnant.

Carolina ACCESS and PMH

It is possible for a Medicaid recipient to have both a Carolina ACCESS Primary Care Provider (PCP) and a PMH. It is also possible for a provider to be both a primary care medical home and a PMH. Each program has its own performance measures and payment structure.
If the patient is linked to a PCP through Carolina ACCESS, and the PCP and PMH are different providers, the PMH will need a referral from the PCP to provide services. If the PCP and PMH is the same provider, no referral is necessary.

Provider Responsibilities

Providers interested in enrolling as a PMH must complete a CCNC/PMH contract and return it to their local CCNC network.

To qualify for participation as a PMH, the provider must agree to the following:

- Ensure that no elective deliveries (induction and cesarean section) are performed before 39 weeks of gestation
- Offer and provide 17p (17alpha hydroxyprogesterone) to eligible patients (more information below)
- Maintain a primary cesarean section rate at or below 20%
- Complete a standardized risk screening on each pregnant Medicaid recipient in your practice at the first prenatal appointment
- Integrate the plan of care with the local pregnancy care management program (more information below)

- Participate in chart reviews to evaluate progress on the PMH performance measures
- Agree to become an affiliate member of Community Care of North Carolina (CCNC)

Prenatal care providers who do not perform obstetric delivery are eligible to serve as a PMH. In order to ensure continuity of care and smooth transitions among care providers, these PMHs are expected to develop a Memorandum of Understanding (MOU) with the practice that delivers their patients. This should be completed within one year of becoming a PMH and should describe arrangements to coordinate patient care, such as availability of medical records at the time of delivery, coordination of transitions to and from intrapartum care, information for patients on how these transitions will take place, and description of how postpartum care will be managed. At the time a practice becomes a PMH, the expectation is that the practice will describe to the CCNC network what its current arrangements are for providing intrapartum care to its patients.

17p

Patients with a history of spontaneous preterm birth or preterm rupture of the membranes (prior to 37 weeks of gestation) who are currently pregnant with a singleton should be offered 17p to prevent recurrent preterm birth. PMH practices are expected to provide their eligible patients with weekly 17p injections. 17p is available through compounding pharmacies or as a commercially licensed product called Makena™. In order for the dose to be reimbursed by Medicaid, it must be administered by a clinician (nurse, mid-level practitioner or physician). Some local health departments offer in-home administration of 17p through a Maternal Health Skilled Nurse Home Visit. Contact your local health department for more information. Practices may bill an administration fee as long as a nurse visit is not billed on the same date of service.

Medicaid has covered ***compounded* 17P** in the Physician's Drug Program since date of service April 1, 2007 and in the Outpatient Pharmacy Program when a rebatable National Drug Code (NDC) is used. Refer to articles in the April 2007, February 2009 and June 2011 general Medicaid bulletins. In the Physician's Drug Program, the practice purchases the 17p and submits

a claim to Medicaid for each dose administered. A multi-dose vial acquired through the Physician Drug Program can be used for multiple patients. In the Outpatient Pharmacy Program, a prescription is written for a specific patient and the pharmacy bills Medicaid directly using that patient's Medicaid ID. Some compounding pharmacies do not offer this option.

Medicaid began coverage of **Makena**, the commercially licensed hydroxyprogesterone caproate, in the Physician's Drug Program on March 14, 2011. Makena is available in a 5-ml multi-dose vial containing 250 mg/ml (five doses). Refer to the article in the July 2011 general Medicaid bulletin for details about billing codes. This product is not billable under the Outpatient Pharmacy Program at this time due to the 5 ml (35-day) packaging size.

The ICD-9-CM **diagnosis code** required for billing both compounded 17P and Makena™ is **V23.41** (supervision of pregnancy with history of pre-term labor). Providers must verify that the recipient's history includes a singleton preterm birth or preterm rupture of the membranes (prior to 37 weeks of gestation). The recipient must currently be pregnant with a single fetus. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment must end before week 37 (through 36 weeks, 6 days). It may be appropriate to start a recipient at a later gestational age if she presents for prenatal care at that time.

Progesterone therapy as a technique to prevent preterm labor is considered investigational/not medically necessary for pregnant women who do **not** meet the above criteria or for those with other risk factors for preterm delivery including, but not limited to, multiple gestations, short cervical length or positive tests for cervicovaginal fetal fibronectin. N.C. Medicaid does not cover services that are considered investigational or not medically necessary.

Risk Screening

At the patient's initial OB visit, or upon confirmation of Medicaid eligibility, risk screening should be completed by a nurse, mid-level practitioner (nurse midwife, nurse practitioner or physician assistant) or physician. One side of the form has medical history for the physician, PA, nurse practitioner, nurse midwife, or nurse to complete. The other side has psychosocial

information for the patient to complete, if literacy allows, or to be completed through a patient interview. A version of the form with the patient questions in Spanish is also available. Any condition containing an asterisk (*) is considered a priority risk factor and will trigger an assessment from a pregnancy care manager. Risk screening forms must be provided to the pregnancy care manager within 7 days of completion. Patients should be re-screened at mid-pregnancy (by 28 weeks) to identify risk factors not present or not disclosed at the initial risk screening. See DMA Clinical Policy 1E-6 for copies of the form and additional information about risk screening. It can be found at http://www.ncdhhs.gov/dma/mp/1E6.pdf

Pregnancy Care Management

The Maternity Care Coordination (MCC) program has transitioned to the Pregnancy Care Management (PCM) program. The PCM program provides care management for the pregnant Medicaid population. In most cases, care management is provided by the Local Health Department, by contract with CCNC. Each PMH has a care manager assigned to the practice. Providers must submit all risk screenings to their care manager within seven business days. Care managers are expected to conduct a thorough assessment of all priority patients within 30 days. Non-PMH prenatal care providers and other community agencies may refer a patient for assessment with a pregnancy care manager, who evaluates the patient's level of need and develops a care plan accordingly.

Pregnant Medicaid patients identified as being at risk for poor birth outcome receive individualized case management services. The level of service provided is in proportion to the individual's identified needs. Care managers closely monitor the pregnancy through regular contact with the physician and patient to promote a healthy birth outcome. Care managers are an integral part of the patient's care team.

Provider Incentives

In exchange for meeting the program expectations described above, the PMH receives the following incentives:

- Exemption from medical necessity prior approval on ultrasounds
    - PMH providers still must register ultrasounds with MedSolutions
    - Other high tech imaging continues to require prior approval
- $50 incentive for completing the risk screening tool at initial OB visit
    - By billing for this incentive payment, providers establish themselves as the patient's PMH
- $150 incentive for the postpartum visit per Medicaid recipient
    - Visit must include, at a minimum, depression screen using a validated instrument, reproductive life planning, and a referral for ongoing care
- Increased rate for a vaginal delivery, antepartum, and postpartum care when billed using CPT codes reflecting obstetric care (59400, 59425, 59426, 59409, 59430 and 59410
    - E&M codes should only be billed if the patient has a high risk condition (see OB policy 1E-5 for high risk criteria and more information).

Bypass of Prior Approval for OB Ultrasound

Ultrasounds must be registered to MedSolutions within five business days of the date of service. Practices may register ultrasounds by phone, fax or internet; the registration process is the same as the process for reporting ultrasounds to MedSolutions prior to becoming a PMH. The differences are that PMH practices no longer have to wait for prior approval before performing the ultrasound, they may register procedures up to 5 business days after they were performed, and it is not required to submit supporting clinical documentation. The on-line registration process looks identical to the prior authorization process, but "the survey" does not pop up requesting the information regarding medical necessity. MedSolutions issues an authorization number when the procedure is registered. The following information is required for a PMH practice to register an OB ultrasound:

- Demographics – member name, date of birth, Medicaid ID number
- Ordering physician name, physical location, Medicaid provider number
- Performing provider (facility) name and physical location

- CPT code(s)
- ICD9 code(s)

The ultrasound CPT codes that bypass medical necessity PA are:

- 76801
- 76802
- 76805
- 76810-76821
- 76825-76828

All other imaging codes still require prior approval. If a test is performed in the PMH office, that office is the billing/rendering provider. The PMH individual provider is the ordering/attending provider. If a test is performed in an outpatient hospital, radiology office or any setting other than the PMH office, that setting is the billing/rendering provider. The rendering facility does not need to be a PMH to bypass prior authorization, as long as the **ordering** provider is a PMH provider. If the recipient has Carolina Access, the PCP is the referring provider.

New EOB Codes

There are four new EOB codes associated with the PMH program. They are:

- 3395: Code allowed once per gestational period
  - To ensure incentive codes are paid only once even if there are multiple births
- 3396: Payment of the appropriate postpartum service to this attending provider is required to meet Medicaid guidelines for reimbursement of this code
  - To ensure a postpartum code is paid in history before S0281 incentive is paid. The date of service for S0281 must be within 60 days of the delivery date.

- 3397: Service denied. The procedure billed is only payable to a Pregnancy Medical Home Provider
    - To ensure non PMH providers do not get paid for incentive codes
- 3398: PMH initial assessment and PMH post partum assessment, not allowed same day, same or different provider
    - To ensure initial assessment and post partum visit do not have the same date of service

Additional Billing Information for PMH Incentives

- Incentives are paid to the practice and not the individual physician unless he or she is a sole proprietor.
- The incentive payments are only paid one time per pregnancy, regardless of the number of PMH practices that provide care for the patient.
- The PMH practice receives only one incentive even if there are multiple births.
- The procedure code for the $50 initial risk screening is **S0280 (**medical home comprehensive care coordination and planning initial).
- If billing retroactively for care provided during a time that the patient was covered by Medicaid, the PMH practice can bill code S0280. The practice cannot bill Medicaid for risk screenings done before the effective date on the PMH contract.
- PMH practices can bill S0280 during the Presumptive Eligibility period.
- A CPT code reflecting postpartum care must be paid in history before the $150 incentive for the postpartum visit can be paid. One of the following procedure codes will qualify for the $150 incentive: 59400, 59410, 59510, 59515 and 59430. (FQHC/RHCs are excluded from this requirement).
- The date of service for the postpartum visit must be within 60 days of the delivery.
- Postpartum codes cover all routine care provided during the postpartum period; they cannot be divided among two different practices.
- Procedure code **S0281** (medical home comprehensive care coordination and planning maintenance of plan) is used to bill and pay the $150.

- The attending provider for the postpartum visit and the postpartum incentive (S0281) must be the same.
- The $150 incentive is not paid for miscarriages, spontaneous abortions or terminations.
- The $150 postpartum incentive is paid for vaginal or cesarean delivery.
- A practice can bill S0281 and a code reflecting postpartum care on the same claim. S0281 must be on the first detail and postpartum code on the second detail. It must be done this way because a claim reads from the bottom up and it must read the post partum visit before the S0281 visit.
- **If billed alone, the S0280 and S0281 will bypass Medicare and Third Party primary filing requirements. If billed with other details such as delivery, antepartum or postpartum care, the claim must be filed to the primary insurance first. Once the primary insurance adjudicates the claim, it can be filed to Medicaid as a secondary claim.**
- S0280 and S0281 are paid once per gestational period which is 270 days. If a patient has a second pregnancy within a shorter timeframe, submit the claim for the incentive payment and then request an adjustment when it is denied.
- Place of Service: place of service 11 (office) and place of service 22 (outpatient hospital) are acceptable places of service for the incentive codes.
- Diagnosis codes: there are no new diagnosis codes associated with the PMH program. Continue to use the same OB diagnosis codes you use today.
- FQHC and RHC's delivery and incentive codes pay as an ancillary service (c-suffix)
- RHCs are allowed to bill a multi line detail for RC510 on the UB, claim type M and list the incentive code on the first detail line, for example:

  For healthcare screening (risk screening tool)

  RC510 for regular services

  RC510 S0280 for $50 incentive

Increased Rate for Vaginal Deliveries

- The global, package and individual rates for vaginal delivery are increased; the cesarean delivery rates remain the same.

- This applies to facility and non facility rates. Facility refers to a hospital setting. Non facility refers to an office setting. Providers put a place of service code on their claims to identify whether service occurred in facility or non facility.
- Only the physician rates for ante partum, delivery and post partum are impacted by this program. There are no changes to the hospital rates or the pediatrician rates.
- There are no changes to the pricing for standby services.

Resources

For questions regarding PMH claims, contact HP Enterprise Services at 1-800-688-6696, option 3. For policy related PMH questions, contact DMA or your local CCNC network. Please visit http://www.ncdhhs.gov/dma/provider/ccncnetwork.htm for CCNC network contact information.

Also, visit the DMA PMH website at http://www.ncdhhs.gov/dma/services/pmh.htm for a list of frequently asked questions.