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 2
2.1 Provisions 2
2.1.1 General 2
2.1.2 Specific 2
2.2 Special Provisions 4
2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 4

3.0 When the Procedure, Product, or Service Is Covered 5
3.1 General Criteria Covered 5
3.1.1 Telehealth Services 5
3.2 Antepartum Care 5
3.2.1 Initial Prenatal Care Visit 5
3.2.2 Routine Antepartum Visits 6
3.2.3 Group Prenatal Care 6
3.2.4 Non-Routine Individual Antepartum Services 6
3.2.5 Pregnancy Risk Screening 7
3.2.6 Counseling 7
3.2.7 Fetal Surveillance Testing 8
3.2.8 Case Management 8
3.2.9 Vaccinations 8
3.3 Package Services 9
3.3.1 Antepartum Care Package Services 9
3.3.2 Global Obstetrics Package Services 9
3.3.3 Postpartum Care Package Services 9
3.4 Consultations 10
3.5 Labor and Delivery Services 10
3.5.1 Anesthesia 10
3.5.2 Complications Related to Delivery 10
3.5.3 Multiple Gestation Deliveries 11
3.5.4 Stand-by Services 11
3.6 Postpartum Care 11
3.6.1 Postpartum Depression Screening 11
3.7 Hybrid Telehealth Visit with Supporting Home Visit 12
3.8 United States Preventive Services Task Force (USPSTF) Recommendations 12

4.0 When the Procedure, Product, or Service Is Not Covered 13
4.1 General Criteria Not Covered 13
4.2 Specific Non-Covered Criteria 13
4.2.1 Non-Covered Services 13

4.2.2 Non- Emergency Services for ~~Undocumented Aliens~~ Population Groups Without State Coverage 13
4.3 Stand-by Services 14

5.0 Requirements for and Limitations on Coverage 14
5.1 Prior Approval for MPW Beneficiaries 14
5.2 Limitations 14

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service 14
6.1 Provider Qualifications and Occupational Licensing Entity Regulations 15
6.2 Provider Certifications 15

7.0 Additional Requirements 15
7.1 Compliance 15

8.0 Policy Implementation/Update Information 16

Attachment A: Claims-Related Information 24
A. Claim Type 24
B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) 24
C. Code(s) 24
D. Modifiers 36
E. Billing for Multiple Births 37
F. Place of Service 38
G. Co-payments 38
H. Reimbursement 38

Attachment B: Billing for Obstetrical Services 39
~~A. Billing Individual Evaluation and Management Antepartum Services~~ 39
B. ~~Billing Observation and Inpatient Services~~ 40
~~C. Billing Postpartum Services~~ 40
B. Billing Prenatal and Postpartum Services Via Telehealth 41
C. Billing for Hybrid Telehealth Visit with a Supporting Home Visit 41
~~Billing for Hybrid Telehealth Visit with a Supporting Home Visit~~ 42
E. Billing for Tobacco Cessation Counseling 43

~~This clinical coverage policy has an effective date of April 1, 2023 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.~~

Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*
1E-6, *Pregnancy Management Program (PMP)*
1E-4, *Fetal Surveillance*
1E-7, *Family Planning Service*s
1H, *Telehealth, Virtual Patient Communications, and Remote Patient Monitoring*
1L-1, *Anesthesia Services*
1M-2, *Childbirth Education*
1M-3, *Health and Behavioral Intervention*
1M-5, *Home Visit for Postnatal Assessment and Follow-up Care*
1M-6, *Maternal Care Skilled Nurse Home Visit*
4A, *Dental Services*
8A, *Enhanced Mental Health and Substance Abuse Services*
1-I, *Dietary Evaluation and Counseling and Medical Lactation Services*
8B, *Inpatient Behavioral Health Services*
8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*
8L, *Mental Health/Substance Abuse Targeted Case Management*
12B, *Human Immunodeficiency Virus (HIV) Case Management*

1.0 Description of the Procedure, Product, or Service

Obstetrical Services are antepartum care, labor and delivery, and postpartum care. Standards of care are published by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and the American College of Nurse Midwifery (ACNM) for the perinatal care of the pregnant beneficiary.

1.1 Definitions

a. Obstetrics- A branch of medical science that deals with pregnancy, childbirth, and the postpartum period.

b. High risk pregnancy- A pregnancy that threatens the health or life of the pregnant beneficiary or the fetus, often requiring specialized care. Risk factors for high-risk pregnancy can include existing health conditions, overweight and obesity, multiple births and young or old maternal age.

c. Pregnancy complication- Any condition that may be problematic or detrimental to the well-being or health of the pregnant beneficiary or the unborn fetus.,

d. Ambulatory Antepartum Care- Medically necessary pregnancy related health care services that are provided on an outpatient basis.

e. Cesarean Delivery (C-Section) - The surgical delivery of a baby by an incision through the pregnant beneficiary's abdomen and uterus.

f. Certified Registered Nurse Anesthetist (CRNA) ~~when the anesthesiologists, or the Certified Registered Nurse Anesthetist (CRNA), is available in the facility in the event they are needed for a procedure requiring anesthesia but is not physically present or providing services. The anesthesia provider may not provide care or services to other patients during this time. Anesthesia standby may be necessary in obstetric emergencies, such as with breech presentation or twin delivery.~~

An advanced practice RN specializing in the administration and monitoring of anesthesia for medical and surgical procedures.

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

1. Regular Medicaid
In addition to antepartum, labor and delivery, and postpartum care, ~~female~~ ~~beneficiaries~~ a beneficiary in this eligibility category are eligible for full Medicaid coverage. This coverage shall extend through at least the last day of the month in which the 12-month postpartum period ends.

2. Medicaid for Pregnant Women
~~Female~~ A beneficiary ~~Beneficiaries~~ with Medicaid for Pregnant Women (MPW) coverage are eligible for antepartum, labor and delivery, and postpartum care in addition to full Medicaid coverage. The eligibility period for MPW coverage ends on the last day of the month in which the 12-month postpartum period ends [NCGA SL 2021-180].

~~**3. Undocumented Aliens**~~
~~Undocumented aliens shall be eligible for Medicaid for care and services necessary for the treatment of an emergency condition. Services are authorized for actual dates that the emergency services were provided up to a maximum of five calendar days.~~

Population Groups Without State Coverage

For a population group for whom the state cannot provide coverage, Medicaid for care and services shall be provided for the treatment of an emergency condition. Services are authorized for actual dates that the emergency services are provided up to a maximum of five calendar days.

Note: The local department of social services in the county where the individual ~~alien~~ resides determines labor and delivery emergency service coverage dates. NC Medicaid determines coverage eligibility for all other pregnancy related emergencies.

4. Presumptive Eligibility

Section 1920(b) of the Social Security Act allows for a pregnant beneficiary who is determined by a qualified provider to be presumptively eligible for Medicaid, to receive ambulatory antepartum care while the beneficiary's eligibility status is being determined. Presumptive eligibility is determined based on evidence of pregnancy and income only.

The pregnant beneficiary must apply for Medicaid no later than the last day of the month following the month the beneficiary is determined presumptively eligible. If the pregnant beneficiary applies for Medicaid within this time frame, they remain presumptively eligible for Medicaid until the local department of social services makes a determination on the beneficiary's application.

If a pregnant beneficiary fails to apply for Medicaid within this time period, the beneficiary is eligible only through the last calendar day of the month following the month the beneficiary 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 the beneficiary's 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.

5. Retroactive Eligibility

Retroactive eligibility applies to this policy.

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; so 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 a Medicaid Beneficiary 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 there is 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 B**~~, ~~s~~ 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 Refer to https://medicaid.ncdhhs.gov/

3.2 Antepartum Care

Medicaid shall cover services provided in maternity cases to include antepartum care, delivery, and postpartum care. Confirmation of pregnancy during a problem oriented or preventative care visit is not considered part of antepartum care and the visit must be reported using an appropriate Evaluation and Management code.

3.2.1 Initial Prenatal Care Visit

To capture the initial prenatal care visit, providers must use HCPCS code 0500F. (Initial prenatal care visit)

Note: Report at first prenatal encounter with health care professional providing obstetrical care). This would be the first visit with the obstetrical provider. Report date of visit and in a separate field, the date of the last menstrual period (LMP)) in addition to the customary services billed for this initial visit.

3.2.2 Routine Antepartum Visits

Medicaid shall cover the following antepartum care services in an uncomplicated routine obstetrical case:

a. Initial prenatal history and physical exam, subsequent prenatal history, and physical exams. Each antepartum visit routinely consists of the recording of weight, blood pressure and fetal heart tones. Chemical urinalysis, when indicated, is also included in the routine antepartum visit. These services must be covered for an uncomplicated pregnancy in the following frequency:
   1. Monthly visits up to 28 weeks
   2. Biweekly visits from 28 to 36 weeks gestation; and
   3. Weekly visits from 36 weeks until delivery.

Note: The pregnant beneficiary may be seen more frequently if the beneficiary's condition warrants.

Routine antepartum care is normally billed using a package procedure code in which all antepartum services are combined into one billing code. ~~Refer to **Attachment B:** Billing for Obstetrical Services.~~

3.2.3 Group Prenatal Care

Group Prenatal Care is an optional service that may be provided to pregnant beneficiaries. Medicaid shall pay an incentive for Group Prenatal Care when **five** or more visits are attended and documented in the health record.

3.2.4 Non-Routine Individual Antepartum Services

Medicaid shall cover individual ~~itemized antepartum services (use of Evaluation and Management codes). Refer to **Attachment B:** Billing for Obstetrical Services. These services are covered~~ evaluation and management codes for antepartum services when one of the following criteria is met:

a. A routine, uncomplicated pregnancy ~~is high risk and~~ that requires more than the current ACOG recommended ~~normal~~ number of antepartum visits ~~services for a routine uncomplicated pregnancy~~.

b. All prenatal visits after a high-risk diagnosis (at the initial visit or during the pregnancy) or;

c. Less than four antepartum care visits are rendered before delivery or termination of provider-patient relationship.

~~**Note**: Hospital-Based Entities as defined by 42 CFR 413.174 must bill individual or package codes as specified in **Attachment A: Claims Related Information,** antepartum care services without the restrictions of **this Subsection**.~~

~~d. The pregnant beneficiary is seen by a provider between one and three office visits as specified in **Attachment B: Billing for Obstetrical Services.**~~

~~e. A pregnancy is terminated such as with miscarriage, intrauterine fetal demise, or ectopic pregnancy.~~

Note: Local Health Departments (LHDs) who provide high-risk antepartum care shall bill the appropriate Evaluation and Management (E/M) codes for individual antepartum services~~. as specified in **Subsection 3.2.2.**~~

3.2.5 Pregnancy Risk Screening

a. The pregnancy risk screening form must be used to identify a pregnant beneficiary in need of pregnancy care management services at the initial prenatal encounter.

~~b.~~ Providers shall complete the pregnancy risk screening form as current indications dictate. ~~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 also be completed at the visits closest to 28 weeks gestation and 36 weeks gestation.~~

c. A Medicaid beneficiary shall be referred for pregnancy care management assessment if a risk factor is identified. ~~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 post delivery period which ends on the last day of the month during which the 60th day post-delivery occurs.

Note: The Care Management Pregnancy Risk Screening Form can be found on the following web site: https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp

~~https://medicaid.ncdhhs.gov/providers/forms/care-management-forms~~

3.2.6 Counseling

Refer to clinical coverage policy 1M-3, *Health and Behavioral Intervention* at https://medicaid.ncdhhs.gov/, or information on counseling services for behavioral intervention including substance use.

Refer to clinical coverage Policy, IE-7*, Family Planning* at

https://medicaid.ncdhhs.gov/,-for information related to family planning counseling services.

Refer to clinical coverage policies *8A, Enhanced Mental Health and Substance Abuse Services, 8B, Inpatient Behavioral Health Services, 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, and 8L, Mental Health/Substance Abuse Targeted Case Management, at*

https://medicaid.ncdhhs.gov/ for information on behavioral health treatment.

Refer to clinical coverage policy 1-I, *Dietary Evaluation and Counseling and Medical Lactation Services* at https://medicaid.ncdhhs.gov/, for information on dietary counseling and medical lactation services.

3.2.6.1 Tobacco Cessation Counseling

Tobacco use screening ~~should~~ shall be provided to all pregnant beneficiaries and an appropriate referral made for those willing to quit and a brief motivational intervention for those not ready to quit. The pregnant beneficiary who uses tobacco should be referred to Quitline NC for assistance.

Tobacco Cessation Counseling services may be billed by Physicians, Nurse Practitioners (NP), Physician Assistants (PA) and Certified Nurse Midwives enrolled under their own NPI (National Provider Identifier) number. LHDs may also provide screening and counseling by a qualified Registered Nurse (RN) who has demonstrated all competency and certification in the tobacco cessation program in use in their agency and billed under their supervising Physician, NP, or CNM, PA NPI.

3.2.7 Fetal Surveillance Testing

Medicaid shall cover medically necessary fetal surveillance testing. Refer to clinical coverage policies 1E-4*, Fetal Surveillance,* at https://medicaid.ncdhhs.gov/ for additional information.

3.2.8 Case Management

Case management services for pregnant beneficiaries are covered through NC Medicaid's clinical coverage policy 1E-6, *Pregnancy Management Program (PMP)* for beneficiaries assessed as high-risk and clinical coverage policy 12B, *Human Immunodeficiency Virus (HIV) Case Management* policy.

3.2.9 Vaccinations

Medicaid shall cover vaccinations for pregnant beneficiaries who do not have evidence of immunity, and other vaccinations during pregnancy and the postpartum period. Providers shall follow guidance related to maternal vaccines, found on the Center for Disease (CDC) website at https://www.cdc.gov/vaccines/pregnancy/hcp-toolkit/guidelines.html. Vaccinations are covered for beneficiaries with MPW eligibility and traditional Medicaid. Rho D immune globulin (RhoGAM) is a medication given to prevent Rhesus (Rh) hemolytic disease of the newborn (HDN). HDN is a serious, often fatal disease caused by incompatibility between a Rh-negative ~~female~~ pregnant beneficiary and the beneficiary's Rh-positive fetus. Rh (D) blood typing and antibody testing is covered for all ~~female~~ pregnant beneficiaries during their first visit for pregnancy related care. Repeated Rh (D) antibody testing for all unsensitized Rh(D) negative ~~female~~ pregnant beneficiaries is also covered at 24 to 28 weeks gestation (unless the biological father is known to be Rh (D) negative) and then covered again in the postpartum period. Coverage for RhoGAM is also available for any antepartum fetal-maternal bleeding, actual or threatened pregnancy loss at any stage of gestation, and with an ectopic

pregnancy. RhoGAM is covered for ~~female~~ pregnant beneficiaries with MPW eligibility and traditional Medicaid.

3.3 Package Services

3.3.1 Antepartum Care Package Services

Medicaid shall cover antepartum package services when the attending provider rendering the antepartum care does not perform the delivery. The attending provider or group provider shall have rendered at least four antepartum care visits to the pregnant beneficiary before ~~prior to~~ delivery.

~~**Note:** Individual antepartum visits are not covered in conjunction with antepartum package services. Refer to **Attachment A, Claims-Related Information,** for billing instructions.~~

3.3.2 Global Obstetrics Package Services

Antepartum care, labor and delivery, and postpartum care are covered as an all-inclusive service when:

a. at least 4 antepartum care visits were rendered before the delivery and
b. the same provider who renders the antepartum care performs the delivery and postpartum care.

*The date the provider first saw the beneficiary for antepartum care must be entered in block 15 of the CMS-1500 form. The date of service on the claim for the OB care must be the date of delivery.

Note: E/M services provided to a pregnant beneficiary in addition to global or package obstetric codes, in excess of three visits must require submission of health record documentation to support medical necessity.

3.3.3 Postpartum Care Package Services

The postpartum period ~~normally lasts six to eight weeks~~ is defined by Medicaid as the period between delivery and the end of the month in which the 60th post partum day falls ~~following delivery~~. Postpartum package services are covered when the attending provider:

a. has not provided any antepartum care, but performed the delivery, and provided the postpartum care; or
b. has not provided any antepartum care, and did not perform the delivery, but performs all postpartum care~~; or~~
c. ~~bills individual visits for antepartum care due to a high-risk condition.~~

Note: Prenatal and postpartum visits conducted via telehealth (interactive audio and video) shall count as a visit within a global or package service. Telephone calls or online communications do not replace a telehealth or in person visit for prenatal care and do not count towards global or package services. The postpartum delivery period should not be confused with the twelve month postpartum MPW coverage.

3.4 Consultations

Medicaid shall cover inpatient and outpatient consultations when health records supports ~~substantiate~~ that the services are medically necessary. This applies to a pregnant beneficiary with traditional Medicaid and MPW eligibility.

Refer to clinical coverage policies 1M-6, *Maternal Care Skilled Nurse Home Visit* and 1M-5, *Home Visit for Postnatal Assessment and Follow-up Care*, at ~~https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies~~ https://medicaid.ncdhhs.gov/ for additional information on these services. ~~These services require a physician's referral~~. The *Maternal Care Skilled Nurse Home Visit* policy requires that the client be referred by their prenatal care physician or ~~physician extender~~ advanced practice provider (certified nurse midwife, nurse practitioner, physician assistant).

3.5 Labor and Delivery Services

Medicaid shall cover the labor and delivery process of delivering a baby, the placenta, membranes, and umbilical cord from the uterus to the outside world. This includes vaginal delivery with or without episiotomy, ~~and~~ or Cesarean delivery. Assisted vaginal delivery includes help with the use of forceps or vacuum device when necessary.

Cesarean Delivery (C-Section) is performed when it is determined to be a safer method than a vaginal delivery for the pregnant beneficiary and the baby.

~~In the absence of maternal or fetal indications for cesarean delivery, a plan for vaginal delivery should be recommended; even if a cesarean was performed during a primary delivery.~~ Elective cesarean delivery by maternal request in the absence of indications for early delivery, should not be performed before 39 weeks gestational age, and the pregnant beneficiary ~~should~~ shall be counseled regarding the risks of placenta previa, placenta accreta spectrum, and gravid hysterectomy with each subsequent cesarean delivery.

Note: When there are extenuating circumstances and a certified or licensed provider other than the attending provider or provider group performs the episiotomy, it may be covered as a separate procedure. When a provider other than the delivering provider or provider group performs the delivery of the placenta, it may be covered as a separate procedure. Refer to **Section 5.0, Requirements for and Limitations on Coverage,** for additional information.

3.5.1 Anesthesia

Anesthesia services are covered separately. Refer to clinical coverage policy 1L-1, *Anesthesia Services*, at https://medicaid.ncdhhs.gov/ for information on anesthesia and obstetrics.

3.5.2 Complications Related to Delivery

Medicaid shall cover complications related to delivery when the diagnosis substantiates medical necessity.

3.5.3 Multiple Gestation Deliveries

If the pregnant beneficiary delivers multiple babies, vaginally or by C-section, the appropriate modifiers and diagnosis codes must be used for reimbursement. Refer to **Attachment A, Claims-Related Information.**

3.5.4 Stand-by Services

Anesthesia physician's or certified registered nurse anesthetist's (CRNA's) stand-by service is covered for anesthesia services. This service is available only for physician stand-by services at high-risk deliveries. Only stand-by services related to the pregnant beneficiary can be billed. The service must be requested by a physician, and a diagnosis substantiating the high risk must be documented on the claim Health records documenting the high-risk delivery and the need for stand-by services are not required with the claim submission but must be available for NC Medicaid or DHHS fiscal contractor upon request.

Medicaid shall cover stand-by services for:

a. Care provided to the pregnant beneficiary during a high-risk delivery; and

b. Attendance at delivery and initial stabilization of the newborn during a high-risk delivery ~~(refer to **Attachment A, letter C (Codes), c (tables).**~~

3.6 Postpartum Care

To capture the postpartum visit, providers must use HCPCS code 0503F Postpartum care. **Report this code at the postpartum visit.** Postpartum care services encompass management of the beneficiary immediately after delivery and during the ~~six to eight~~ four to twelve-week period following delivery. ~~ACOG recommends that~~ From the latest ACOG publication, components of this service ~~may~~ must consist of an interaction within the first 3 weeks of delivery with the obstetrical/gynecological provider concluding with a comprehensive postpartum examination and contraceptive counseling no later than 12 weeks post delivery. (Contraceptive counseling is a component of the postpartum visit and is not separately reimbursable). For a beneficiary with chronic medical condition or pregnancy-related complication, transition and coordination of medically necessary primary or specialty care shall be implemented as soon as possible.

Medicaid covers medically approved family planning methods to prevent conception for beneficiaries with traditional Medicaid or MPW coverage during their postpartum eligibility period. **Refe**r to clinical coverage policy 1E-7 *Family Planning Services* at ~~https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies~~ https://medicaid.ncdhhs.gov/, for Medicaid covered contraceptive services.

For ~~female~~ a pregnant ~~beneficiaries~~ beneficiary with MPW Medicaid, postpartum care services are covered during their eligibility period which ends on the last day of the month in which the 12-month postpartum period ends.

Note: For continued services after the 12-month postpartum period ends, refer MPW beneficiaries to the Department of Social Services for continuing eligibility determination.

3.6.1 Postpartum Depression Screening

Appropriate maternal depression screening with scientifically validated screening tools is necessary to ensure that postpartum depression is addressed, and care is

administered in a timely manner to improve quality of care and long-term outcomes for both ~~female~~ beneficiary and child. Maternal depression screening identifies ~~female~~ a beneficiary ~~beneficiaries~~ with depression and may lead to initiation of treatment or discussion of referral strategies to mental health providers for appropriate treatment.

Obstetric, family practice, and pediatric providers may be reimbursed for ~~three~~ four brief emotional behavioral assessments, with scoring and documentation, per standardized instrument – during the first year after the delivery date or until the beneficiary eligibility ends, in addition to global obstetrics and postpartum package services. If a problem is identified, the ~~female~~ beneficiary shall be referred to their primary care provider or other appropriate providers.

Note: Medicaid for Pregnant Women (MPW) eligibility ends the last date of the month in which the 12-month postpartum period ends.

~~**Note:** Refer to **Attachment B (C) Postpartum Services** for guidance related to postpartum depression screening~~.

3.7 Hybrid Telehealth Visit with Supporting Home Visit

Physicians, nurse practitioners, physician assistants and certified nurse midwives shall conduct antepartum or postpartum care via a telehealth visit with a supporting ~~home~~ visit to the beneficiary's private residence made by an appropriately trained, delegated staff person when medically necessary.

Reimbursement for this care model is open to both new and established patients. The supporting delegated staff person may perform vaccinations in the home, subject to compliance with all applicable requirements for vaccinations (it is within delegated staff person's scope of practice to administer vaccinations) and may conduct other tests or screenings, as appropriate. ~~Refer to **Attachment B, Letter E** for billing guidance~~.

3.8 United States Preventive Services Task Force (USPSTF) Recommendations

NC Medicaid encourages screening for all ~~the following~~ current United States Preventative Services Task Force (USPSTF) recommendations in all pregnant beneficiaries.

~~a. Asymptomatic bacteriuria using urine culture.~~

~~b. Hepatitis B virus (HBV) and Hepatitis C virus (HCV) infection at the first prenatal visit.~~

~~c. HIV infection, including those presenting in labor or at delivery whose HIV status is unknown.~~

~~d. Preeclampsia with blood pressure measurements throughout pregnancy.~~

~~e. Appropriate use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks gestation in women who are at high risk for preeclampsia.~~

~~f. Gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks gestation.~~

~~g. Syphilis infection.~~

~~h. Rh (D) blood typing and antibody testing during the first visit for pregnancy related care. (Refer to **section 3.6.1** Vaccinations for specific details).~~

~~i. Repeated Rh (D) antibody testing for all unsensitized Rh (D) negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D) negative. (Refer to **section 3.6.1** Vaccinations for specific details).~~

~~j. Tobacco use, advising pregnant beneficiaries to stop using tobacco, and providing behavioral interventions for cessation to those beneficiaries who use tobacco. (Refer to Attachment B (F) Tobacco Cessation Counseling) for guidance related to billing.~~

~~k. Intention to breastfeed, providing breastfeeding interventions and support during pregnancy and after birth.~~

l. ~~Perinatal depression, providing or referring pregnant and postpartum beneficiaries who are at increased risk of perinatal depression for counseling interventions~~.

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 a Medicaid Beneficiary 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 Non-Covered Criteria

4.2.1 Non-Covered Services

a. Duplications of OB services;
b. Home pregnancy tests;
c. Ultrasounds performed only for determination of gender of fetus or to provide a keepsake picture;
d. Paternity testing;
e. Parenting classes;
f. Home tocolytic infusion therapy; and
g. More than 3 pregnancy risk screenings per pregnancy.

4.2.2 Non- Emergency Services for ~~Undocumented Aliens~~ Population Groups Without State Coverage

a. Medicaid shall not cover specific antepartum and postpartum services for ~~undocumented aliens~~ any individual without state coverage who are **only** eligible for emergency services.
b. Sterilization procedures are not defined as emergency services and therefore shall not be covered for undocumented aliens.
c. Specific procedures are covered only in an emergency, such as an ectopic pregnancy.

4.3 Stand-by Services

a. Medicaid shall not cover stand-by services for pre-anesthesia evaluations.
b. Medicaid shall not cover stand-by services for the ~~female~~ beneficiary and for the newborn when provided by the same provider.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval for MPW Beneficiaries

Medicaid shall not require prior approval for Obstetric Services.

Refer to clinical coverage policies at ~~-~~https://medicaid.ncdhhs.gov/ for specific requirements for prior approval for non-Obstetric services.

5.2 Limitations

The following limitations apply to obstetric care services:

~~a. Individual delivery procedures (vaginal delivery and delivery of placenta) are not covered more than once in a 225 consecutive calendar day period.~~

~~**Note:** When there is more than one pregnancy within 225 consecutive calendar days and both pregnancies result in separate deliveries on different dates of service within 225 consecutive calendar days, the service is covered.~~

a. Labor Antepartum care package services are covered once during the beneficiary's pregnancy. In special circumstances (such as when the pregnant beneficiary moves), up to three different providers may bill for antepartum care 4–6 visits. This does not apply to different providers in the same group.
b. Postpartum ~~care services are covered~~ coverage will extend through the end of the month in which the 12-month postpartum period ends after ~~vaginal and cesarean delivery. Refer to **Subsection 3.6, Postpartum Care.**~~ the end of the birth event.
c. Stand-by services related to a pregnant beneficiary for a high-risk delivery are limited to two hours per day.
d. Performance of an episiotomy or delivery of a placenta by a provider other than the attending provider is covered only through the paper adjustment process.

6.0 Provider(s) 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

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 a Medicaid Beneficiary 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 DHHS fiscal contractor(s).

8.0 Policy Implementation/Update Information

Original Effective Date: October 1, 1985

Revision Information:

Date	Section Revised	Change
8/1/09	Throughout	Updated language to DMA's current standard.
8/1/09	Section 7.0	Deleted previous paragraphs on Federal & State Requirements and Records Retention and substituted Compliance.
8/1/09	Subsection 3.5.4, Att. A	Added diagnosis codes allowable for billing anesthesia stand-by for high-risk deliveries related to the mother.
8/1/09	Attachment A	Clarified billing practices for multiple births.
8/1/09	Attachment B	Added E/M codes 99217 through 99239 to the "Evaluation and Management Services" section; they cannot be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430, 59510, or 59515.
9/1/11	1.0, added 2.1.5, 3.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, 3.3.3, 3.4, 3.6, 3.6.1, Attachment A-Sections C and E.	Added PMH reference in Section 1.0. Added Subsection 2.1.5. Revised wording in Subsections 3.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, and 3.3.3. Added information about policy 1M-6. Added family planning information in Subsection 3.6 and added RhoGAM and Tdap information in Subsection 3.6.1. Revised the information for FQHC and RHC billing for codes T1015, 59409, 59410, 59430, 59514, and 59515 in Attachment A, Section C. Clarified billing for multiple births in Attachment A, Section E.
9/1/11	Section 1.0	Added reference to PMH.
9/1/11	Subsection 2.1.2 and 2.1.4	Clarified conditions that complicate the pregnancy. Added definition of Ambulatory Antepartum Care and clarified Presumptive Eligibility coverage.
9/1/11	Subsection 2.1.5	Added this section to the policy.

Date	Section Revised	Change
9/1/11	Subsections 3.2, 3.2.2, 3.2.3, 3.2.4, 3.2.5, 3.3.1, 3.3.2, and 3.3.3	Referenced PMH and added information about Hospital-Based Entities in Subsection 3.2.2. Referenced LHDs in Subsection 3.2.2. and added letter "c". Revised wording to remove Maternity Care Coordination section and to add information about Health and Behavioral Intervention, Enhanced Mental Health and Substance Abuse, Inpatient Behavioral Health Services, and Mental Health/Substance Abuse Targeted Case Management to Subsection 3.2.3. Added reference to the Prior Approval for Imaging Procedures policy to Subsection 3.2.4. Revised information for case management and removed information about the Baby Love Program. Removed statement " …with the intention of performing the delivery." from Subsection 3.3.1. Added CPT codes to match the service in Subsections 3.3.2 and 3.3.3. Added letter "c" in 3.3.3.
9/1/11	Subsection 3.4	Added reference to the Maternal Care Skilled Nurse Home Visit and Postnatal Assessment and Follow-up Care policies. Deleted Prior Approval note.
9/1/11	Subsection 3.5.4	Removed statement regarding anesthesia stand-by services related to the mother.
9/1/11	Subsection 3.6	Added family planning information.
9/1/11	Subsection 3.6.1	Added RhoGAM information and Tdap information.
9/1/11	Attachment A-Section B	Added numbers and changed title of the table.
9/1/11	Attachment A-Section C	Added information about PMH, Indian Health Services and PMH procedure codes. Added information regarding LHD billing. Moved information regarding Birthing Center billing from CPT code 59410 to CPT code 59409.
9/1/11	Attachment A-Section E	Added new table to depict billing for multiple gestations.
9/1/11	Attachment A-Section E	Clarified billing for multiple births. Removed the word "Consecutive" and added the word "Additional" in the table title.
9/1/11	Attachment B	Added Billing information for 1-3 visits using E/M codes.
9/1/11	Throughout	Updated language to DMA's current standard
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.
04/01/2022	All Sections and Attachments	Updated template language to include clarifying language and removed unnecessary language. Changed references to 1E-6, Pregnancy Medical Home (PMH) to 1E-6, Pregnancy Management Program (PMP)

Date	Section Revised	Change
04/01/2022	Related Clinical Coverage Policy Section	Added clinical coverage policies 1E-7 Family Planning Services and 1M-2 Childbirth Education. Changed 1E-6, Pregnancy Medical Home to 1E-6, Pregnancy Management Program (PMP). Removed 1K-7 Prior Approval for Imaging Procedures; Updated 1L-1 Anesthesia to 1L-1 Anesthesia Services; Updated 1-I Dietary Evaluation and Counseling to 1-I Dietary Evaluation. and Counseling and Medical Lactation Services, added 1D-4 Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics and 1-H Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.
04/01/2022	Section 1.1	Added Definitions section to policy and added pertinent definitions.
04/01/2022	Section 2.0	Updated heading from “Eligible Beneficiaries” to “Eligibility Requirements”
04/01/2022	Section 2.1	Removed “General” from “General Provisions” in subheading.
04/01/2022	Section 2.1.1	Updated subheading from “Regular Medicaid” to “General” and added general criteria to this section.
04/01/2022	Section 2.1.2	Updated subheading from “Medicaid for Pregnant Women” to “Specific.” Clarified language. Note section- clarified that NC Medicaid determines emergency eligibility for pregnancy related emergencies other than labor and delivery. Removed examples of emergency services.
04/01/2022	Section 2.1.2.1	Section 2.1.1 became Section 2.1.2.1 “Regular Medicaid”
04/01/2022	Section 2.1.2.2	Section 2.1.2. became Section 2.1.2.2 “Medicaid for Pregnant Women.” Removed 42 CFR 447.53(b)(2). Moved definition of pregnancy complication to Section 1.1. Change “Mother” to “female beneficiary and all throughout policy.” For 12-month postpartum extension, clarified that MPW Medicaid includes full coverage in addition to pregnancy services and removed reference to Prior Authorization Subsection 5.1.
04/01/2022	Section 2.1.2.3	Section 2.1.3 became Section 2.1.2.3 “Undocumented Aliens.” Removed 10A NCAC 21B.0302; added 10 A NCAC 23E.0102(C)(1)(2).
04/01/2022	Section 2.1.2.4	Section 2.1.4 became Section 2.1.2.4 Presumptive Eligibility.
04/01/2022	Section 2.1.2.5	Section 2.1.5 became Section 2.1.2.5 “Retroactive Eligibility.” Included information related to NCHC eligible beneficiaries.

Date	Section Revised	Change
04/01/2022	Section 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: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.
04/01/2022	Section 3.2.1	Added "Routine" to subheading. Added clarifying language for uncomplicated pregnancy, removed unnecessary language.
04/01/2022	Section 3.2.2	Added "Non-Routine" to subheading. Added reference to Attachment A for billing antepartum services. Changed guidelines for individual antepartum care billing from "less than three months before delivery" to "less than four antepartum visits" before delivery. Removed reference to the 1E-6 Pregnancy Medical Home policy for definition of high-risk pregnancy and defined in Section 1.1.
04/01/2022	Section 3.2.3	Included information related to clinical coverage policy 1E-7 Family Planning Services. Corrected the title of policy 1-I, *Dietary Evaluation and Counseling and Medical Lactation Services*
04/01/2022	Section 3.2.3.1	Added coverage guidelines for Tobacco Cessation Counseling.
04/01/2022	Sections 3.2.4	Removed reference to CCP 1K-7, Prior Approval for Imaging Procedures;
04/01/2022	Section 3.2.6	Added Subsection with heading "Vaccinations" and provided reference to CDC guidelines for pregnancy and postpartum periods. Removed specific coverage indications and added link for reference to CDC vaccination guidelines for coverage. Included guidelines for RhoGAM.
04/01/2022	Sections 3.3.1, 3.3.2	Added "Care" to subheading of 3.3.1. Added "Package" to subheading of 3.3.2. Changed guidelines for global package billing from "at least three months prior to delivery" to "at least four antepartum visits" before delivery. Removed CPT codes as covered in billing guidance.
04/01/2022	Section 3.3	Note added to clarify that a telehealth visit will count as a visit in a global or package service.
04/01/2022	Section 3.3.3	Added "Care" to subheading. Removed CPT codes found in these sections. Clarified length of postpartum period of 6 to 8 weeks following delivery.
04/01/2022	Sections 3.4, 3.5, 3.5.1, 3.5.2, 3.5.3 and 3.5.4	Added language to further define services covered in Labor and Delivery. Added Maternal Skilled Nurse home visit policy reference for consultations.

Date	Section Revised	Change
04/01/2022	Section 3.5	Added "Services" to the heading Labor and Delivery. Added Cesarean delivery to labor and delivery Services coverage criteria. Added limitations of coverage for elective c-sections. Clarified assisted vaginal delivery to include use of forceps or vacuum device.
04/01/2022	Section 3.5 Note	Changed "attending physician" to "delivery provider" to include certified nurse midwives.
04/01/2022	Section 3.5.4	Removed definition of Anesthesia standby and added it to Section 1.1 Definitions. Clarified language of service description for stand-by services.
04/01/2022	Section 3.6	Included reference to clinical coverage policy 1E-7 Family Planning Services and removed specific covered services. Added "traditional Medicaid" as a covered program for postpartum services. Due to legislated postpartum extension, changed MPW coverage end from the last day of the month in with the 60th postpartum day occurs to the last day of the month in which the 12-month postpartum period ends.
04/01/2022	Section 3.6.1	Moved Vaccinations policy to appropriate section 3.2.6. Subsection 3.6.1 became new section "Postpartum Depression Screening" with related coverage criteria. Added family practice and pediatric providers coverage to render postpartum depression screening.
04/01/2022	Section 3.7	Added Section "Hybrid Telehealth Visit with Supporting Home Visit" for coverage and corresponding guidelines.
04/01/2022	Section 3.8	Added United States Preventive Services Task Force (USPSTF) Recommendations
04/01/2022	Section 4.0	Moved information related to non-emergency services for undocumented aliens to this section.
04/01/2022	Section 4.2	Modified subheading from "Emergency Services for Undocumented Aliens" to "Specific Non-Covered Criteria."
04/01/2022	Section 4.2.1	Added Section 4.2.1 Added subsection "Non-Emergency Criteria" and added non-covered criteria.
04/01/2022	Section 4.2.2	Added Subsection "Non-Emergency Services for Undocumented Aliens" with list of non-covered services. Removed ICD-10 CM codes, CPT codes and unnecessary language.
04/01/2022	Section 5.1	Due to 12-month postpartum expansion and increased MPW benefit coverage, removed PA requirements for non-obstetrical services.
04/01/2022	Section 5.2	Removed CPT codes from this section

Date	Section Revised	Change
04/01/2022	Section 5.2 (d)	Due to legislated postpartum extension, changed MPW postpartum coverage end from the last day of the month in with the 60th postpartum day occurs to the last day of the month in which the 12-month postpartum period ends.
04/01/2022	Attachment A, Letter B	Removed ICD-10 CM list, related to high-risk deliveries for maternal stand by services. Referenced section E. of Attachment A for ICD-10-CM requirements for the billing of multiple births.
04/01/2022	Attachment A, Letter C	Corrected requirement for package service billing of CPT codes 59400 and 59510 for at least four antepartum care visits rendered before the delivery.
04/01/2022	Attachment A, Letter C	Added section (c.) for billing guidance within table that follows; added NPP/LHD, as needed to table headings. Added clarifying language to billable CPT codes with table throughout. Removed postpartum vaccinations CPT codes from section as list is not all inclusive and reference had been made to follow CDC guidelines.
04/01/2022	Attachment A, Letter D	Added Modifier GT criteria for Telehealth Claims for Global/Package Billing and Individual Visit Billing.
04/01/2022	Attachment A, Letter F	Added place of service, birthing centers. Added the following for Place of Service: Telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).
04/01/2022	Attachment B	Removed description for CPT codes and removed CPT codes for services that are not considered part of global package and cannot be billed separately. Rearranged format for ease of readability.
04/01/2022	Attachment B, Letter A	Added section entitled "Billing Individual Evaluation and Management Codes for 1-3 Visits and moved CPT codes related to billing for individual E/M codes from Attachment B under heading) to this section. Added billing scenarios and instructions for billing individual perinatal visits. Changed CPT code 99201 to 99202 as 99201 is an end dated code.
04/01/2022	Attachment B, Letter B	Added Section "Billing for Observation and Inpatient Services" and corresponding billing guidance.
04/01/2022	Attachment B, Letter C	Added Section "Postpartum Services" and corresponding billing guidance.
04/01/2022	Attachment B, Letter D	Added Section "Billing Prenatal and Postpartum Services Via Telehealth" and corresponding billing guidance.
04/01/2022	Attachment B, Letter E	Added Section "Billing for Hybrid Telehealth Visit with a Supporting Home Visit" and corresponding billing guidance.

Date	Section Revised	Change
04/01/2022	Attachment B, Letter F	Added Section "Billing for Tobacco Cessation Counseling" and corresponding billing guidance.
02/01/2023	Throughout the policy	Changed text to a neutral gender text.
02/01/2023	Subsection 3.2.3	Added text regarding Pregnancy Risk Screening.
02/01/2023	Subsection 4.2.1. g.	Added the text: No more than 3 pregnancy risk screenings per pregnancy.
02/20/2023	Attachment A; Section C	Corrected wording from Letter C to Section C. Amended date not changed.
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.
	Page 1 Header	Removed Health Choice language and Temporary Coverage due to Covid 19 Public Health Emergency
	Index pg ii	Removed B of Attachment B Billing for Obstetrical Services A.-F.
	Throughout policy	Removed "female" and changed to "beneficiary" or "individual"
	Throughout policy	Updated all weblinks and all references to Attachment B
	Section 1.1	Added a more detailed definition of Certified Registered Nurse Anesthetist (CRNA
	Section 2.1.2	Replaced definition of **Undocumented Aliens** to **Population Group Without State Coverage** and defined. Used this new title throughout policy to replace Undocumented Aliens.
	Section 2.1.2. 4.	Added that presumptive eligibility beneficiaries have emergency coverage until their status is determined
	Section 3.2.1	Added Initial Prenatal Care Visit **and the addition** of F codes for capturing maternal data.
	Section 3.2.3	Added the coverage of Group Prenatal Care and defined.
	Section 3.2.4	Added criteria for Evaluation and Management codes for antepartum services.
	Section 3.2.5	Added that a beneficiary shall be referred for Pregnancy Care Management if a risk factor is found through the Pregnancy Risk Form
	Section 3.3.1	Removed Note

Date	Section Revised	Change
	Section 3.3.2	Added billing guidance for Global Obstetrics Package Services
	Section 3.3.3	Added and defined the postpartum period post-delivery and clarified it is separate from the 12 month postpartum extension
	Section 3.4	Removed physician extender and added new reference advanced practice provider
	Section 3.5	Added "even if a cesarean was performed during a primary" for defining vaginal plan
	Section 3.5.4	Removed reference to Attachment A
	Section 3.6	Added" To capture the post partum visit, providers must use HCPCS code 0503F"Postpartum care. **Report this code at this the postpartum visit** and ACOG's guidelines for postpartum care post delivery
	Section 3.6.1	Changed postpartum depression screenings from three to four
	Section 3.8	Removed specific criteria for United States Preventive Services Task Force (USPSTF) Recommendations and changed to "current"
	Section 5.2	Removed the Note under **Limitations** and added language for clarification of when the coverage will occur during the post partum period.
	Attachment A Section C	Added codes 59610, 59612, 59614, 59618, 59620 and 59622. Removed codes S0280 and S0281 and referenced that they are covered in policy 1E-6 . Removed specific billing guidance for Local Health Departments pertaining to those that only deliver antepartum services, postpartum care or high risk antepartum care. Removed all Routine Obstetrical Procedure Codes
	Attachment B	Removed Sections A . B. C.; Added under A. "with EP modifier"; Added under E. " Append modifier GT if performed via telehealth". Removed CPT description code chart Removed and added guidance for conducting and billing telehealth services. Changed CC4C to CMARC

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)

Institutional (UB-04/837I 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 **"Billing for Multiple Births" in Attachment A (E)** for ICD-10-CM requirements for billing Multiple Births.

C. Code(s)

1. 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.

2. Information for PMP reimbursement of care coordination can ~~(S0280 Medical home program, comprehensive care coordination and planning, initial plan and S0281 Medical home program, comprehensive care coordination and planning, maintenance of plan)~~ ~~shall~~ be found in clinical coverage policy 1E-6, *Pregnancy Management Program* at https://medicaid.ncdhhs.gov/. ~~PMP providers shall bill according to the specifications in the table below~~.

3 Indian Health Service PMP-providers bill RC 510, S0280, and S0281 for reimbursement for PMP services~~.~~

~~Local Health Departments (LHDs) who provide only antepartum and postpartum care for pregnancy services shall bill CPT codes 59425, 59426, and 59430 for antepartum and postpartum care.~~

~~LHDs who provide high-risk antepartum care shall bill appropriate Evaluation and Management (E/M) codes for individual antepartum services as specified in **Subsection 3.2.2**.~~

4. LHDs who provide complete antepartum, labor and delivery, and postpartum care by employing or contracting with obstetric providers shall bill 59400, 59409, 59410, 59425, 59426, 59430, 59510, 59514, or 59515, 59610, 59612, 59614, 59618, 59620, and ~~59622. The following table combines obstetrical codes and instructions for physicians, non-physician practitioners (NPP), Local Health Departments (LHD's), and FQHC/RHC providers. Information for anesthesia providers follows in a separate table~~.
   Please note that Postpartum visits are billed with global codes or postpartum package codes.

5. External cephalic version with or without tocolysis, may be billed in addition to delivery codes. FHQC and RHC 's will use the "C" suffix provider number.

6. Attendance at delivery may not be billed with newborn resuscitation.

~~Routine Obstetrical Procedure Codes~~				
~~HCPCS Code~~	~~Type~~	~~Description~~	~~Physician/NPP/LHD Services Guidelines~~	~~FQHC/RHC Guidelines~~
~~T1015~~	~~Individual~~	~~Clinic visit/ encounter, all-inclusive~~	~~N/A~~	~~Rendering antepartum and postpartum care is a core service.~~ ✦ ~~Use the "A" suffix provider number.~~

59400	Global	Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	This code is covered as all-inclusive service when antepartum care was initiated, and at least four (4) antepartum care visits rendered before the delivery. The same provider who rendered antepartum care performs the vaginal delivery and postpartum care. ✦ The date the provider first saw the beneficiary for antepartum care must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim for the OB care must be the date of delivery. ✦ This code cannot be billed in addition to global, individual or package OB codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Section C** of this Attachment for a list of these codes. ✦ This code cannot be billed by hospital-based entities.	N/A

59409	Individual	Vaginal delivery only (with or without episiotomy and/or forceps)	This code is limited to one unit within 225 consecutive calendar days when billed by the same or different provider except as described in **Section E** of this Attachment. ✦ If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code. ✦ This code cannot be billed in addition to global, individual or package OB codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Section C** of this Attachment for a list of these codes. ✦ Birthing Centers use this code for reimbursement. ✦ This code is not part of the inpatient postpartum care provided in a hospital facility. ✦ This code is used when E/M codes are exclusively used for high-risk antepartum care and when the provider does not perform postpartum care.	This code is limited to one unit within 225 consecutive calendar days when billed by the same or different provider. ✦ Postpartum care services are not included in this code. ✦ Use the "C" suffix provider number.

59410	Package	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	This code is limited to one unit within 225 consecutive calendar days when billed by the same or different provider. ✦ If antepartum care and/or postpartum care are performed by the same provider, bill the appropriate global code. ✦ This code cannot be billed in addition to global, individual or package OB codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Section C** of this Attachment for a list of these codes. ✦ This code cannot be billed by hospital-based entities. ✦ Postpartum package services are covered when the attending provider has not provided any antepartum care but performs the delivery and provides postpartum care. ✦ Postpartum package services are covered when the attending provider bills individual visits for antepartum care due to a high-risk condition. ✦ This code is part of both inpatient and outpatient postpartum care.	N/A
59412	Individual	External cephalic version, with or without tocolysis	Use 59412 in addition to code(s) for delivery (59400, 59409, 59410, 59510, 59514, and 59515).	Use 59412 in addition to code(s) for delivery. ✦ Use the "C" suffix provider number.

59414	Individual	Delivery of placenta (separate procedure)	This code cannot be billed in conjunction with another delivery code (59400, 59409, 59410, 59510, 59514, and 59515). . ✦ This code is limited to one unit within 225 consecutive calendar days when billed by the same or different provider.	This code cannot be billed in conjunction with another delivery code. ✦ This code is limited to one unit within 225 calendar days when billed by the same or different provider. ✦ Use the "C" suffix provider number.
59425	Package	Antepartum care only; 4–6 visits	The date the provider first saw the beneficiary for antepartum care must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim must be the date of the last visit if the date of delivery is not known. ✦ This code cannot be billed in addition to other OB codes that are antepartum care codes (59400, 59426, and 59510) if billed by the same provider. ✦ This code can be billed only once during the pregnancy with one unit by the same provider. (Refer to **Subsection 5.2, letter b.**) ✦ If delivery and postpartum care are also performed by the same provider, do not bill this code. Select a global code that has all services provided.	N/A

59426	Package	Antepartum care only; 7 or more visits	The date the provider first saw the beneficiary for antepartum care must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim must be the date of delivery. ✦ This code cannot be billed in addition to other OB codes that are antepartum care codes (59400, 59425, and 59510) if billed by the same provider. ✦ This code can be billed only once during the pregnancy with one unit. ✦ If delivery and postpartum care are also performed by the same provider, do not bill this code. Select a global code that has all services provided.	N/A

59430	Individual	Postpartum care only (separate procedure)	This code cannot be billed in addition to other OB global codes that are postpartum care codes (59400, 59410, 59510, and 59515). ✦ This code entails 60 days postpartum. After the initial 60-day postpartum period, care should be billed using the appropriate Evaluation and Management or procedure codes. ✦ Do not use this code if delivery and antepartum care were performed by the same provider. Select a global code that includes all services provided. ✦ Postpartum package services are covered when the provider has provided antepartum care but did not perform the delivery. ✦ Postpartum package services are covered when the beneficiary was not under the care of the provider for antepartum care or the delivery.	N/A

59510	Global	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	This code is covered as all-inclusive service when antepartum care was initiated, and at least four (4) antepartum care visits rendered before the delivery. The same provider who rendered antepartum care performs the cesarean delivery and postpartum care. ✦ The date the provider first saw the beneficiary for antepartum care must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim for the OB care must be the date of delivery. ✦ This code cannot be billed in addition to global, individual or package OB codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Section C** of this Attachment for a list of these codes. ✦ This code cannot be billed by hospital-based entities.	N/A

59514	Individual	Cesarean delivery only	This code is limited to one unit within 225 consecutive calendar days when billed by the same or different provider except as described in **Section E** below. ✦ This code cannot be billed in addition to global, individual or package OB codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Section C** of this Attachment for a list of these codes. ✦ If antepartum care or antepartum and postpartum care are performed by the same provider, bill the appropriate global code. ✦ This code is not part of the inpatient postpartum care provided in a hospital facility. ✦ This code is used when E/M codes are exclusively used for high-risk antepartum care and when the provider does not perform postpartum care.	This code is limited to one unit within 225 calendar days when billed by the same or different provider. ✦ Use the "C" suffix provider number.

59515	Package	Cesarean delivery only; including postpartum care	This code is limited to one unit within 225 consecutive calendar days when billed by the same or different provider. ✦ If antepartum care is performed by the same provider, bill the appropriate global code. ✦ This code cannot be billed by hospital-based entities. ✦ Postpartum package services are covered when the attending provider has not provided any antepartum care but performs the delivery and provides postpartum care. ✦ Postpartum package services are covered when the attending provider bills individual visits for antepartum care due to a high-risk condition. ✦ This code is part of both inpatient and outpatient postpartum care. ✦ This code cannot be billed in addition to global, individual or package OB codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Section C** of this Attachment for a list of these codes.	N/A

99360	Individual	Standby service, requiring prolonged attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Use this code with high-risk deliveries. ✦ Use this code when services are related only to the pregnant beneficiary. ✦ Services must be requested by a physician, and this request must be documented in the health record. ✦ Diagnosis substantiating the high risk must be listed on the claim form. ✦ This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦ This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦ Refer to the CPT book for the descriptions and indications for physician standby services. ✦ This code is limited to two (2) hours per day.	Use this code with high-risk deliveries. ✦ Use this code when services are related only to the pregnant beneficiary. ✦ Services must be requested by a physician, and this request must be documented in the health record. ✦ Diagnosis substantiating the high risk must be listed on the claim form. ✦ This code cannot be billed on the same date of service as, or in conjunction with, code 99464. ✦ This code cannot be billed on the same date of service as CPT codes 99354 through 99357. ✦ Refer to the CPT book for the descriptions and indications for physician standby services. ✦ This code is limited to two (2) hours per day. ✦ Use the "C" suffix provider number.
99464	Individual	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	This code cannot be billed in conjunction with newborn resuscitation (99465). ✦ This code cannot be billed on the same date of service as code 99360 by the same provider.	This code cannot be billed in conjunction with newborn resuscitation (99465). ✦ This code cannot be billed on the same date of service as code 99360 by the same provider. ✦ Use the "C" suffix provider number.

Stand-by Services for Anesthesia Providers			
HCPCS Code	**Type**	**Description**	**Anesthesia Guidelines**
~~99360~~	~~Individual~~	~~Standby service, requiring prolonged attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)~~	~~Use this code with high-risk deliveries.~~ ✦ ~~Use this code when services are related only to the pregnant beneficiary.~~ ✦ ~~Services must be requested by a physician, and this request must be documented in the health record.~~ ✦ ~~Diagnosis substantiating the high-risk must be listed on the claim form.~~ ✦ ~~This code cannot be billed on the same date of service as, or in conjunction with, code 99464.~~ ✦ ~~This code cannot be billed on the same date of service as CPT codes 99354 through 99357.~~ ✦ ~~This code cannot be billed on the same date of service as any other anesthesia codes.~~ ✦ ~~Refer to the CPT book for the descriptions and indications for physician standby services.~~ ✦ ~~This code is limited to one (1) hour (2 units) per day.~~

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

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.
Telehealth Claims:
Global/Package Billing- Append the GT modifier to the global or package code to indicate that one or more of the visits were conducted via telehealth under that package. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

Individual Visit Billing- When OB services are provided and billed per visit (refer to **Section 3.2.2** for billing individual prenatal visits) append GT modifier to each visit conducted via telehealth. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

E. Billing for Multiple Births

The appropriate multiple gestation diagnosis code must be reported on the claim for reimbursement.

Gestation	ICD-10-CM Code(s)		Additional Units to Be Billed
Twin	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	**1**
Triplet	O30.101 O30.102 O30.103 O30.111 O30.112 O30.113	O30.121 O30.122 O30.123 O30.191 O30.192 O30.193	**2**
Quadruplet	O30.201 O30.202 O30.203 O30.211 O30.212 O30.213	O30.221 O30.222 O30.223 O30.291 O30.292 O30.293	**3**

In addition to the multiple gestation diagnosis code, the correct delivery codes are also required.

Type of delivery	CPT Code for First Birth No Modifier	Effective with DOS on and after 8/01/2009 CPT code and modifier for Consecutive Births	Effective with DOS 3/31/11 CPT code and modifier for Consecutive Births
All vaginal	59400 or 59409 or 59410	59409-**51** (one line for each additional birth)	59409-51,**59** (one line with one unit for each additional birth)
All cesarean	59510 or 59514 or 59515	59514-**51** (one line for each additional birth)	59514-51,**59** (one line with one unit for each additional birth)
Mixed—vaginal first	59400 or	59409-51 (one line for each	59409-51,59 (one line with one unit for each

Type of delivery	CPT Code for First Birth No Modifier	Effective with DOS on and after 8/01/2009 CPT code and modifier for Consecutive Births	Effective with DOS 3/31/11 CPT code and modifier for Consecutive Births
	59409 or 59410	vaginal additional birth) or 59514-51,59 (one line for each additional cesarean birth)	additional birth) or 59514-51,59 (one line with one unit for each additional birth)

Note: For multiple births of more than four infants, submit the first claim electronically. It denies with a request for operative notes. Submit the second claim as an adjustment with operative notes attached.

F. Place of Service

Inpatient hospital, Outpatient hospital, Office, Birthing Center

Telehealth claims ~~should~~ shall be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

Attachment B: Billing for Obstetrical Services

CPT procedure codes 81000 and 81002 for chemical urinalysis may not be reimbursed separately if billed with CPT codes 59400, 59410, 59425, 59426, 59430, 59510, or 59515 by the same billing provider.

A. Billing Individual Evaluation and Management Antepartum Services

Billing of individual antepartum services using Evaluation and Management (E/M) codes in the table below are covered in the following circumstances:

a. An obstetrical beneficiary is seen by the obstetric provider between one (1) and three (3) visits. The visits shall be billed using E/M CPT codes, according to the services that were provided. These visits must be billed after it is apparent the beneficiary is no longer a patient of the specific provider or if the pregnancy becomes high-risk before the fourth (4th) obstetric visit. If the beneficiary is new to the provider, codes 99202-99205 must be reported for the new patient initial visit. E/M codes 99211-99215 for an established patient must be reported for the next two visits.

b. Services provided to a pregnant beneficiary with an acute medical condition unrelated to the pregnancy in the provider's office or in an outpatient or other ambulatory facility. Services to treat unrelated conditions are billed with E/M service codes at the time they are rendered. The appropriate E/M code from the table in **Attachment B (A)** below must be linked with a diagnosis that identifies the unrelated condition. A global or package obstetric code is billed at the end of the pregnancy.

c. When services are provided to a pregnant beneficiary with an acute medical condition related to the pregnancy in the provider's office or in an outpatient or other ambulatory facility. Services to treat related conditions are billed with E/M service codes at the time they are rendered. The appropriate E/M code from the table in **Attachment B (A)** below must be linked with a diagnosis that identifies the related condition. A global or package obstetric code is billed at the end of the pregnancy.

d. A pregnancy becomes high-risk after the pregnant beneficiary has been seen for normal obstetric visits, CPT code 59425 must be billed according to the appropriate number of visits. Appropriate E/M codes from the table in **Attachment B (A)** below may also be billed in conjunction with code 59425 according to the additional number of high-risk obstetric visits.

e. A pregnancy is high risk and requires more than the normal amounts of services for a routine pregnancy. Additional high-risk visits (over the usual 13) to treat complications of the pregnancy must be billed after the pregnant beneficiary delivers with a delivery date on the claim. For Professional (CMS-1500/837P transaction) claims, the delivery date must be placed in box #18 "Hospitalization dates related to current services." For Institutional (UB-04/837I transaction) claims, the delivery date must be placed in box #31 "Occurrence Date."; or

f. Additional high-risk visits for complications must be linked to an appropriate diagnosis code. If a high-risk pregnant beneficiary is seen more often than usual, but no complications develop, individual E/M codes must not be billed separately. A global or package obstetric code must be used.

g. Pregnancy results in a spontaneous pregnancy loss (miscarriage), intrauterine fetal demise or ectopic pregnancy.

Note: E/M services provided to a pregnant beneficiary in addition to global or package obstetric codes, in excess of three visits must require submission of health record documentation to support medical necessity.

CPT Code(s)	Code Range Description	Telehealth Eligible Services
99202 through 99205	New Patient Office Visit Services	Yes
99211 through 99215	Established Patient Office Services	Yes
99217 through 99220	Hospital Observation Services	No
99221 through 99223	Initial Hospital Care	No
99224 through 99226	Subsequent Observation Care	No
99231 through 99233	Subsequent Hospital Care	No
99234 through 99236	Observation or Inpatient Care Services	No
99238 through 99239	Hospital Discharge Services	No
99241 through 99245	Office or Other Outpatient Consultations	No
99251 through 99255	Inpatient Consultations	No
99341 through 99345	Home Services- New Patient	Yes No
99347 through 99350	Home Services- Established Patient	Yes

B. Billing Observation and Inpatient Services

a. There are services provided to a pregnant beneficiary with an acute medical condition related or unrelated to the pregnancy under observation status. If the pregnant beneficiary is admitted to observation care, and then delivers within 24 hours of admission, the services must not be billed using individual E/M codes. Global Package, or Individual Obstetrical codes as specified in **Attachment A: Claims- Related Information** must be used.

b. There are services provided to a pregnant beneficiary with an acute medical condition related or unrelated to the pregnancy who is admitted to the hospital as an inpatient. If the pregnant beneficiary is admitted to inpatient care and subsequently delivers within 24 hours of admission, the services must not be billed using individual E/M codes. Global Package, or Individual Obstetrical codes as specified **in Attachment A: Claims- Related Information** must be used.

c. There are services provided to a pregnant beneficiary with an acute medical condition related or unrelated to the pregnancy which complicates the pregnancy and results in observation or inpatient care during pregnancy and greater than 24 hours prior to delivery. These services shall be billed using the appropriate E/M code as specified in the table in Attachment B (A) above. These services shall be billed in addition to the Global package.

C. Billing Postpartum Services

Postpartum visits are billed with global codes or postpartum package codes. Postpartum services are **not** billed with E/M office visit codes.

Providers performing postpartum depression screening are required to bill diagnosis Z13.32 (Encounter for screening for maternal depression) in combination with one of the CPT codes below:

CPT Code	Code Description	Telehealth Eligible Service
96127 *For Mother's Provider*	Brief emotional/behavioral assessment [e.g., depression inventory, attention deficit hyperactivity disorder (ADHD) scale], with scoring and documentation, per standardized instrument	Yes
96161 *For Child's Provider*	Administration of caregiver-focused health risk assessment instrument (e.g., 'health hazard appraisal'), for benefit of the patient, with scoring and documentation per standardized instrument.	Yes

A. Additional Billing Guidance for FQHCs, FQHC-Lookalikes and RHC's

a. Postpartum screenings delivered as part of an obstetrics care visit are covered under core obstetrics billing (T1015) and not billed separately.
b. Postpartum depression screening delivered as part of Well Child visits are reimbursed on a fee-for-service basis and should must be billed using CPT 96161 with EP modifier.

B. Billing Prenatal and Postpartum Services Via Telehealth

Eligible providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives may conduct antepartum and postpartum care visits via telehealth. These visits may not be conducted via virtual patient communication (e.g., for example, telephone conversations). In order to promote early initiation of prenatal care, providers shall conduct the initial antepartum visit and pregnancy risk screen via telehealth or in-person in the office or clinic setting. When the initial visit is conducted via telehealth, a follow-up visit should must be conducted in person within the first trimester of pregnancy.

C. Billing for Hybrid Telehealth Visit with a Supporting Home Visit

a. Providers Billing Global OB or Package Codes:

1. The following table of Global and Package CPT codes contains services that may be rendered via telehealth. A limited number of services may be offered via telehealth and billed for new and established patients.
2. The code billed must be appended with the GT modifier to indicate that at least one visit was conducted via telehealth. This modifier is not appropriate for services performed telephonically or through patient portal. In addition, telephone calls or online communications do not replace a telehealth or in person visit for prenatal care and do not count towards global or package services.

Note: FQHCs, FQHC Look-Alikes and RHCs that bill T1015 for perinatal services may render some of these services via telehealth.

1. To reflect the additional cost of the delegated staff person attending the beneficiary's home, eligible providers may bill a telehealth originating site facility fee for each telehealth visit conducted with a supporting visit. The originating site fee shall be billed in addition to the pregnancy global package codes.
2. To be reimbursed for the originating site facility fee for this care model, all of the following requirements must be met for each home visit:

i. The assistance delivered in the home must be given by an appropriately trained delegated staff person.
ii. The fee must be billed with the date of service for which the home visit is conducted.
iii. The telehealth originating site facility fee must be appended with the GT modifier and billed with a place of service "12" to designate that the originating site was the home.
iv. The antepartum or postpartum hybrid telehealth visit is included in the global or package code for the pregnancy. There is no separate evaluation and management code billing outside of the package or global code for the providers portion of the home visit.

Note: **Refer** to Clinical Coverage Policy *1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring* for more information about originating site facility fees.

Codes	Description (See 2020 CPT Code Book for Complete Details)
~~59400~~	~~Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care~~
~~59510~~	~~Routine obstetric care including antepartum care, cesarean delivery, and postpartum care~~
~~59410~~	~~Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care~~
~~59515~~	~~Cesarean delivery only; including postpartum care~~
~~59425~~	~~Antepartum care only; 4-6 visits~~
~~59426~~	~~Antepartum care only; 7 or more visits~~
~~59430~~	~~Postpartum care only; separate procedure~~

~~**b. Providers Billing Individual Prenatal Visits and Postpartum Care:**~~

~~1. An appropriate Office evaluation and management code from the table in **Attachment B, Letter A** shall be billed for each prenatal visit. This code must be appended with the GT modifier to indicate that the visit was performed via telehealth.~~

~~The appropriate postpartum care package code from the table above shall be billed and must be appended with the GT modifier when a postpartum visit was performed via telehealth.~~

~~**Billing for Hybrid Telehealth Visit with a Supporting Home Visit**~~

~~**a. Providers Billing Global OB or Package Codes:**~~

3. To reflect the additional cost of the delegated staff person attending the patient's home, eligible providers may bill a telehealth originating site facility fee (HCPCS code Q3014) for each telehealth visit conducted with a supporting visit. The originating site fee shall be billed in addition to the pregnancy global package codes.
4. To be reimbursed for the originating site facility fee for this care model, all of the following requirements must be met for each home visit:
   v. The assistance delivered in the home must be given by an appropriately trained delegated staff person.
   vi. The fee must be billed with the date of service for which the home visit is conducted.
   vii. HCPCS code Q3014 The telehealth originating site facility fee must be appended with the GT modifier and billed with a place of service "12" to designate that the originating site was the home.
   viii. The antepartum or postpartum hybrid telehealth visit is included in the global or package code for the pregnancy. There is no separate evaluation and management code billing outside of the package or global code for the providers portion of the home visit.

Note: **Refer** to Clinical Coverage Policy *1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring* for more information about originating site facility fees.

b. Providers Billing Individual Prenatal Visits:

1. Providers should shall bill the appropriate level Home Service evaluation and management code from the table in **Attachment B, Letter A** for each telehealth visit with a supporting home visit made by an appropriately trained delegated staff person.
2. Providers should not bill the originating site facility fee.

E. Billing for Tobacco Cessation Counseling

Providers performing tobacco cessation counseling are required to bill with CPT codes 99406 or 99407 with an appropriate tobacco use disorder diagnosis code. Append modifier GT if performed via telehealth.

CPT Code	Code Description	Telehealth Eligible Service
99406	Preventive medicine, smoking/tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Yes
99407	Preventive medicine, smoking/tobacco use cessation counseling visit; intensive, greater than 10 minutes.	Yes

The Local Health Department (LHD) may bill for a prenatal clinic visit and for tobacco cessation counseling (when provided by qualified staff) on the same day.

Smoking and tobacco cessation counseling is a component of a Core Visit provided by Core Service providers (FQHCs, FQHC Look-Alikes and RHCs) and not separately billable as a core service. Refer to NC Medicaid Clinical Coverage Policy 1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics* for additional information on Core Service billing.

Tobacco cessation counseling cannot be billed in addition to a postnatal home assessment, skilled nurse visit, newborn home visit, OB Care Manager visit (OBCM), or ~~Care Coordination for Children (CC4C)~~ Care Management for At-Risk children (CMARC) visit but the service ~~should~~ must be offered and the pregnant beneficiary who uses tobacco should be referred to Quitline NC for assistance.

Coverage is not reimbursed for counseling for tobacco cessation in the home setting by any type of provider.