NC Medicaid

Prenatal and Postpartum Care F Code Requirement:
Frequently Asked Questions

BACKGROUND

NC Medicaid's Obstetrical Services Clinical Coverage Policy No: 1E-5, updated June 15, 2024, requires the use of two new CPT billing codes for prenatal and postpartum care. These codes will assist in capturing information about the timeliness of prenatal and postpartum care provided to NC Medicaid members (see Table 1).

Table 1: F Codes for Capturing Prenatal and Postpartum Care Added to NC Medicaid's Clinical Policy

CPT Code	Type	Description	Physician/Non-Physician Provider/LHD Services Guidelines
0500F	Individual	Initial Prenatal Care Visit*	Code reported to identify initiation of prenatal care. Report at first prenatal encounter with an obstetrical provider or other prenatal care practitioner. Report date of visit and in a separate field the date of the last menstrual period (LMP).
0503F	Individual	Postpartum Care Visit	Code reported to identify the comprehensive postpartum care visit. Postpartum visit can be to an obstetrical provider or other postpartum care practitioner, or primary care provider (PCP). Do not include postpartum care provided in an acute inpatient setting or other urgent/emergency room setting.

*NOTE: Primary care providers who do not perform prenatal care should not submit claims for 0500F.

After July 1, 2025, delivery claims (including global or package billing codes) submitted to NC Medicaid Direct and Managed Care Plans will be denied without a code for 0500F (Initial Prenatal Care Visit). NC Medicaid is revising billing guidelines and communicating directly with billing and claims professionals at the Managed Care Plans ahead of the July 1, 2025 implementation of this change.

ADDITIONAL RESOURCES

This FAQ document serves as a supplement to a fact sheet disseminated to the Managed Care Plans and providers. The fact sheet details the current changes, the rationale behind them, and the subsequent actions related to the new CPT billing codes for prenatal and postpartum care. Additionally, a webinar for providers in collaboration with the North Carolina Area Health Education

Center (NC AHEC) will be held in early August of 2024 to provide context around implementation and provider specific details.

FREQUENTLY ASKED QUESTIONS

Global Billing and the New F Codes

1. Why require these additional billing codes when comprehensive global billing packages already exist?
    a. Current global billing processes fail to capture when initial prenatal or postpartum care began. Implementing these codes will enable NC Medicaid and Managed Care Plans to gather essential data aligning with North Carolina and National Committee for Quality Assurance (NCQA) standards concerning prenatal and postpartum care.

2. According to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications, there are multiple ways to adequately document prenatal and postpartum care without the use of CPT-II Codes. Why is NC Medicaid requiring the use of these new F codes if there are other acceptable ways to fulfill the prenatal and postpartum care (PPC) quality measure requirements?
    a. Even with multiple methods of recording prenatal and postpartum care delivery, this care has been inconsistently and improperly documented, contributing to NC Medicaid's low performance on the PPC quality measure. Additionally, commercial payors are using these F codes. By adopting these codes, NC Medicaid hopes to improve data collection and workflow, reduce administrative burden, and collect more consistent and accurate data.

3. Will all delivery claims be denied in the absence of these codes or only those that are globally billed?
    a. The updated billing guidelines will deny all delivery billing claims that do not include 0500F, not just those that are globally billed. Claims will not be denied due to the absence of 0503F (postpartum care). However, the State may issue additional guidance or billing requirements if utilization does not mirror that of 0500F. As a reminder, global obstetric service claims are not to be submitted until postpartum care has been rendered.

4. Will these new codes negatively impact the PPC quality measure rate?
    a. This reporting will more accurately depict the course of care that a beneficiary receives. By reporting only a global delivery code, or individual package codes, NC Medicaid cannot determine when prenatal and postpartum care was received. With these new codes, NC Medicaid will be able to filter claims across providers and plans to identify when services actually began and concluded.

Preparing for the Use of these New Codes

5. Is this policy specific to NC Medicaid Direct or are Managed Care Plans expected to follow this as well?

   a. This requirement will apply to claims billed to NC Medicaid Direct and Managed Care Plans. NC Medicaid is implementing this requirement for Managed Care Plans through a forthcoming update to the Health Plan Billing Guide.

6. The revised policy was posted June 15, 2024, but claim denials will not begin until July 1, 2025. Will I be required to submit corrected claims to include 0500F for deliveries prior to July 1, 2025?
   a. The State is in the process of updating NCTracks to mirror the language outlined in the updated policy and is also allowing time for providers to update their systems and become familiar with the new billing requirements. Providers will not be required to submit corrected claims for dates of service prior to July 1, 2025.

7. Do the F codes need to be billed with a charge? Historically, some quality codes needed a charge of $0.01.
   a. They do not need to be billed with a charge since they are not reimbursable codes. However, depending on a provider's electronic health record (EHR), they may have to enter a "penny charge" in order for the code to process appropriately.

8. I need to make system upgrades to my electronic health record to comply – how long do I have?
   a. Practices have until July 1, 2025, to comply with the updated policy. After this time, delivery claims submitted to NC Medicaid Direct or Managed Care Plans will be denied without 0500F. Some private and commercial insurers already require the use of the 0500F and 0503F codes to document prenatal and postpartum visits, so these codes may already be a part of your current processes.

Prenatal Care (0500F)

9. My practice bills individual evaluation and management (E/M) visits for our high-risk patients. Do I still need to use 0500F for the initial visit with the obstetric provider?
   a. The initial visit with an obstetrician/gynecologist or certified nurse midwife should be captured using 0500F, regardless of how the practice submits their claims (E/M, antepartum package, or globally).

10. Our practice confirms pregnancies and refers patients to an obstetric practice after the 1st trimester. Should we be documenting 0500F?
   a. If the practice does not provide antepartum services, 0500F should not be appended to the provider's claims.

11. Our practice received a patient from another provider after the 1st trimester. Should we report 0500F on our claim, or submit our obstetric service claim with the date 0500F was filed from the previous provider?
   a. NCTracks will not allow a claim line for 0500F to process if the line is submitted using a provider not affiliated with your office. To receive reimbursement for the delivery, the current provider should submit their first obstetric claim (antepartum, antepartum with

delivery, delivery only, or global obstetric code) with 0500F on claim line 1. Providers should reach out to the beneficiary's health plan for direction if enrolled in a managed care plan.

12. Is the expectation that the 0500F code will align with the quality measure technical specifications: *The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization* – What if the prenatal visit occurs prior to the member enrolling in the Plan?
    a. 0500F should always be submitted with the date of service (DOS) that the beneficiary first sees an obstetrician/gynecologist or certified nurse midwife. If a beneficiary transfers into a practice after prenatal care has been established and records are not readily available, the current practice should submit a claim for 0500F, regardless of trimester. Medicaid will filter claims to identify the first date 0500F was reported.

13. What if a beneficiary arrives in labor without having received prenatal care, or it's uncertain if they have? Will my delivery charge be denied?
    a. The policy states, "to comply with the requirement, 0500F can be billed on line 1, and the delivery on line 2 of a professional (CMS-1500) claim for the same date of service." In other words, prenatal care would have the same DOS as the delivery and listing 0500F on line 1 and delivery on line 2 will satisfy the requirement and the delivery claim will continue to process.

14. Is there a way to indicate a DOS for the prenatal visit that is earlier than the delivery date if both are on the same claim?
    a. 0500F would be reported on line 1 with the DOS the beneficiary was initially seen. All other services would be reported on subsequent lines with the DOS that they were provided. Providers should reach out to the beneficiary's health plan for direction if enrolled in a managed care plan.

15. What if the prenatal visit was with a PCP who may or may not have billed using 0500F, and postpartum care was provided by an OB practice?
    a. If the delivering provider/practice does not know the date of the first prenatal visit with a PCP, or if 0500F was not submitted, the delivery claim should be appended with 0500F on the same DOS as the delivery. If a practice provides the delivery and postpartum care, they should bill 0500F on line 1 (date of delivery if the date of prenatal care delivery is unknown), 0503F on line 2 (date of postpartum exam), and the delivery/postpartum package on line 3. These should be submitted after the postpartum service is rendered.

Postpartum Care (0503F)

16. What constitutes the postpartum period? There seems to be inconsistencies between the postpartum period as defined by NC Medicaid and the technical specifications for NCQA's HEDIS *PPC* quality measure.

a. NCQA's HEDIS notes that a postpartum visit should occur sometime between seven and 84 days postpartum. The timeframe identified by NC Medicaid is very similar, defined as the period between delivery and the end of the month in which the 60th postpartum day falls. To prevent possible claim denials and to comply with clinical coverage policies 1E-5 Obstetrical Services, and 1E-6 Pregnancy Management Program, providers should continue to follow Medicaid's defined postpartum period.
b. It is important to note that the American College of Obstetricians and Gynecologists (ACOG) recommends an interaction within the first three weeks of delivery with the obstetrical/gynecological provider concluding with a comprehensive postpartum examination and contraceptive counseling.

17. Is there a limit on the number of times/dates of service the 0503F code can be submitted?
    a. While there are no limitations in NCTracks on the number of times that 0500F and 0503F may be submitted, 0503F should ONLY be reported once by the provider who performed the postpartum exam (see question #9). Providers should contact the Health Plans for guidance on claims for 0500F and 0503F.

18. Are there any requirements for the addition of secondary indicators to capture the 0503F CPT-II Code for postpartum care?
    a. No additional modifiers or secondary indicators (such as Z codes) are required.

19. A global billing delivery claim is typically submitted post-birth, not after the postpartum check-up. Is it appropriate for 0503F to be submitted before the visit actually occurs?
    a. Claims cannot be submitted until care is rendered. If a beneficiary moves, becomes eligible for commercial coverage, or otherwise does not seek postpartum care from the delivering practice, a claim for services including postpartum care could be audited and viewed as fraudulent billing.

Use of Additional Codes

20. Should providers still use S codes in addition to these new F codes?
    a. Yes. These codes should be billed in addition to the 0500F and 0503F, respectively. The first visit should be billed with both codes (0500F and S0280) if the patient completes the Pregnancy Risk Screening Form. Providers should use the 0503F and S0281 codes after completing the comprehensive postpartum visit.
    b. Per Clinical Coverage Policy 1E-6 Pregnancy Management Program, S0281 must be billed within 60 days of delivery and only after the postpartum visit has been completed. This code is to be billed once, even if there are multiple births. After this time, services for care management will end and those beneficiaries still requiring services should be referred to an appropriate provider.

CODING/BILLING EXAMPLES

1. First Obstetric Visit Billing
    a. LMP: 1/1/23

b. First Visit with Obstetric Provider (0500F): 2/14/23
c. First of three prenatal risk screening assessments (S0280): Completed on 2/14/23

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 01 23 QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN John Smith, MD
17a.
17b. NPI 1897657328
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. Z34.01 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	14	23	02	14	23	11		0500F		A	0 00	1		NPI	1982476891
02	14	23	02	14	23	11		S0280		A	50 00	1		NPI	1982476891
														NPI	
														NPI	
														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

2. First Obstetric Visit with Prenatal Risk Screenings and Antepartum Package (Billed as a Single Claim)
   a. LMP: 1/1/23
   b. First Visit with Obstetric Provider (0500F): 2/14/23
   c. Prenatal Risk Screenings at First Visit, 28 Weeks, and 36 Weeks
   d. Antepartum Services (59426): Provided 2/14/23 - 10/7/23

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 01 23 QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN John Smith, MD
17a.
17b. NPI 1897657328
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. Z34.01 B. Z34.03 C. Z34.0 D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	14	23	02	14	23	11		0500F		A	0 00	1		NPI	1982476891
02	14	23	02	14	23	11		S0280		A	50 00	1		NPI	1982476891
07	16	23	07	16	23	11		S0280		B	50 00	1		NPI	1982476891
09	10	23	09	10	23	11		S0280		B	50 00	1		NPI	1982476891
02	14	23	10	07	23	11		59426		C	696 18	1		NPI	1982476891
														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

3. Global Obstetric Billing on a Single (Multi-Page) Claim
   a. LMP: 1/1/23
   b. First Visit with an Obstetric Provider (0500F): 2/14/23
   c. Prenatal Risk Screenings at First Visit, 28 Weeks, and 36 Weeks
   d. Postpartum Visit (0503F and S0280): Completed 10/31/23
   e. Global Code for Antepartum, Vaginal Delivery, and Postpartum Care (59400)

* NOTE: To comply with signed Medicaid provider agreements, global and packaged service claims should only be submitted after **all** services included in the description of the service have been rendered.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 01 DD 01 YY 23 QUAL.
15. OTHER DATE: QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN John Smith, MD
17a.
17b. NPI 1897657328
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. Z34.01 B. Z34.03 C. Z34.0 D. O80
E. Z39.2 F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	14	23	02	14	23	11		0500F		A	0	00	1		NPI	1982476891
02	14	23	02	14	23	11		S0280		A	50	00	1		NPI	1982476891
07	16	23	07	16	23	11		S0280		B	50	00	1		NPI	1982476891
09	10	23	09	10	23	11		S0280		B	50	00	1		NPI	1982476891
10	31	23	10	31	23	11		0503F		E	0	00	1		NPI	1982476891
10	31	23	10	31	23	11		S0281		E	150	00	1		NPI	1982476891

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM 01 DD 01 YY 23 QUAL.
15. OTHER DATE: QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN John Smith, MD
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18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. Z34.01 B. Z34.03 C. Z34.0 D. O80
E. Z39.2 F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	14	23	10	31	23	22		59400		D	1747	98	1		NPI	1982476891
															NPI	
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															NPI	
															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

4. Delivery Only

a. LMP: 1/1/23
b. First Encounter with Obstetric Provider/Practice on 10/8/23 when Beneficiary Presents to Emergency Department in Labor
c. Include 0500F on Claim Line 1: Establishes Care with Obstetric Provider, with Diagnosis O09.30 (Supervision of Pregnancy with Insufficient Antenatal Care), If Applicable
d. Include Delivery on Claim Line 2

*NOTE: 0500F may be reported on the same date of service as delivery if:

- History of antepartum care is unknown at time of billing,
- Outside records are not available, and
- The beneficiary did not seek antepartum care with the delivering provider/practice.

If records are available, and a prior claim with 0500F had been submitted to NC Medicaid Direct, reporting of 0500F may be omitted from the delivery claim.

*NOTE: Additional guidance will be provided at a later date for documenting 0500F on NC Medicaid Direct claims when beneficiaries have transferred from a standard plan or commercial coverage during the course of their pregnancy. For beneficiaries enrolled in a standard plan at time of delivery, providers must contact the plan for billing requirements.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 01 01 23 QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN John Smith, MD
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17b. NPI 1897657328
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. O09.30 B. O80 C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10	08	23	10	08	23	22		0500F		A	0 00	1		NPI	1982476891
10	08	23	10	08	23	22		59409		B	697 93	1		NPI	1982476891
														NPI	
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														NPI	
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PHYSICIAN OR SUPPLIER INFORMATION