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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.

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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)* ~~*Medical Home (PMH)*~~
1E-4, *Fetal Surveillance*
1E-7, *Family Planning Services*
1H, *Telehealth, Virtual Patient Communications, and Remote Patient Monitoring*
~~*1K-7, Prior Approval for Imaging ServicesProcedures*~~
1L-1, *Anesthesia Services*
1M-2, *Childbirth Education*
1M-3, *Health and Behavioral Intervention*
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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 female beneficiary.~~mother.~~

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 female beneficiary or her 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 female 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 female's abdomen and uterus.

f. **Anesthesia Standby** – Anesthesia standby occurs when the anesthesiologists, or the 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.

~~None Apply.~~
~~Information on services provided in clinical coverage policy 1E-6, *Pregnancy Medical Home (PMH)* can be found on DMA's Website at http://www.ncdhhs.gov/dma/mp/~~

2.0 Eligibility Requirements ~~Eligible Beneficiaries~~

2.1 ~~General~~ Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*; or
b. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

a. Medicaid

~~Medicaid beneficiaries may have service restrictions due to their eligibility category that would make them ineligible for this service.~~

1. Regular Medicaid

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

2. Medicaid for Pregnant Women

   Female beneficiaries ~~of all ages~~ with Medicaid for Pregnant Women (MPW) coverage are eligible for antepartum, labor and delivery, and postpartum care in addition to full Medicaid coverage. ~~pregnancy-related antepartum, labor and delivery, and postpartum care as well as services other than pregnancy or postpartum for conditions that, in the judgment of their physician, may complicate pregnancy. Conditions that may complicate the pregnancy can be further defined as any condition that~~

may be problematic or detrimental to the well-being or health of the mother female beneficiary or the unborn fetus., such as undiagnosed syncope, excessive nausea and vomiting, anemia, and dental abscesses. (This list is not all-inclusive.). 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]. the 60th postpartum day occurs [42 CFR 447.53(b)(2)].
Refer to **Subsection 5.1** for information on referring prior approval (PA) requirements related to MPW eligible beneficiaries for non-obstetrical pregnancy-related treatment services.

3. Undocumented Aliens

   Undocumented aliens shall be ~~are~~ eligible for Medicaid for care and services necessary for the treatment of an emergency condition. ~~as found in 10A NCAC 23E.0102(c)(1)(2). only for emergency medical services [42 CFR 440.255(c)], which includes labor and vaginal or c-section (C-section) delivery as defined in 10A NCAC 21B .0302.~~ Services are authorized ~~only~~ for actual dates that the emergency services were provided up to a maximum of five (5) days. ~~Undocumented aliens may qualify for presumptive eligibility. Refer to section 2.1.2.4 Presumptive Eligibility.~~

   Note: The local department of social services in the county where the 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 woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care while her eligibility status is being determined. Presumptive eligibility is determined based on evidence of pregnancy and income only. ~~This includes physical examinations; routine laboratory assessments; appropriate screening tests including basic fetal ultrasound (s), AFP tests, glucola tests, and etc.; and prenatal information and education.~~

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

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

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

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5. Retroactive Eligibility

   Retroactive eligibility applies to this policy.

b. NCHC

NCHC beneficiaries are not eligible for Obstetrical services.. ~~Obstetrics.~~

Note: NCHC beneficiaries who become pregnant shall be transitioned to an appropriate Medicaid eligibility category, if applicable.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

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

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

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for 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 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, 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.

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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 Routine Antepartum Visits

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

Initial prenatal history and physical exam, subsequent prenatal history, and physical exams. Each antepartum visit routinely consists of the recording of weight, blood pressures 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:

a. ~~Every 4 weeks for the first 28 weeks of gestation~~Monthly visits up to 28 weeks;

b. ~~Every 2 to 3 weeks until the 36th week of gestation~~Biweekly visits from 28 to 36 weeks gestation; and

c. Weekly visits from 36 weeks until delivery.

Note: T~~t~~he female beneficiary may be seen more frequently if her 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.

3.2.2 Non-Routine Individual Antepartum Services

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

a. A pregnancy is high risk and requires more than the normal amount of services for a routine uncomplicated pregnancy; ~~or~~

b. Less than four (4) antepartum care visits are rendered ~~prior to~~ before delivery; ~~or~~
Note: Hospital-Based Entities as defined by 42 CFR 413.174~~65~~ must bill individual or package codes as specified in **Attachment A: Claims Related Information,** antepartum care services without the restrictions of this **Subsection**

c. T~~t~~he female beneficiary is seen by a provider between one and three office visits as specified in **Attachment B: Billing for Obstetrical Services**.

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

~~Clinical coverage policy 1E-6, *Pregnancy Medical Home,* on DMA's Website at http://www.ncdhhs.gov/dma/mp/, provides information on the definition of high-risk pregnancy and risk factors.~~

~~Note: Hospital-Based Entities as defined by 42 CFR 413.65 shall bill individual antepartum services without the restrictions of **Subsection 3.2.2**~~

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**.

3.2.3 Counseling

Refer to clinical coverage policy 1M-3, *Health and Behavioral Intervention* at https://medicaid.ncdhhs.gov/, for 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.

3.2.3.1 Tobacco Cessation Counseling

Tobacco use screening should be provided to all female pregnant beneficiaries and an appropriate referral made for those willing to quit and a brief motivational intervention for those not ready to quit.

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

3.2.4 Fetal Surveillance Testing

Medicaid shall cover~~s~~ medically necessary fetal surveillance testing. Refer to clinical coverage policies 1E-4*, Fetal Surveillance* ~~and 1K-7, *Prior Approval for Imaging Procedures*~~, at https://medicaid.ncdhhs.gov/ for additional information.

3.2.5 Case Management

Case management services for pregnant women are covered through NC Medicaid's clinical coverage policy 1E-6, *Pregnancy Management Program (PMP)* ~~*Medical Home*~~ for beneficiaries assessed as high-risk and clinical coverage policy 12B, *Human Immunodeficiency Virus (HIV) Case Management* policy~~. Refer to DMA's Website at http://www.ncdhhs.gov/dma/mp/ for~~

~~additional information on case management services for PMH and HIV case management services.~~

3.2.6 Vaccinations

Medicaid shall cover vaccinations for female 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 ~~that is~~ 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 ~~mother~~ female beneficiary and her Rh-positive fetus. Rh (D) blood typing and antibody testing is covered for all female beneficiaries during their first visit for pregnancy related care. Repeated Rh (D) antibody testing for all unsensitized Rh(D) negative female 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 beneficiaries with MPW eligibility and traditional Medicaid

3.3 Package Services

3.3.1 Antepartum Care Package Services

Medicaid shall cover antepartum package services ~~are covered~~ 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 female beneficiary 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 ~~(CPT codes 59400 or 59510)~~ when:

a. at least 4 antepartum care visits were rendered ~~prior to~~ before the delivery; and

b. the same provider who renders the antepartum care performs the delivery and postpartum care.

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3.3.3 Postpartum Care Package Services

~~Postpartum~~ The postpartum period normally lasts six (6) to eight (8) weeks following delivery. Postpartum package services are covered when the attending provider:

a. has not provided any antepartum care, but performs the delivery, and provides postpartum care ~~(CPT codes 59410 or 59515)~~; or
b. has not provided any antepartum care, and did not perform the delivery, but performs all postpartum care ~~(CPT code 59430)~~; or
c. bills individual visits for antepartum care due to a high-risk condition ~~(CPT codes 59410, 59430, or 59515)~~.

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.

3.4 Consultations

Medicaid shall cover inpatient and outpatient consultations ~~are covered~~ when ~~medical~~ health records substantiate that the services are medically necessary. This applies to a female 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/ 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 (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 and the placenta, membranes and umbilical cord from the uterus to the outside world. This includes vaginal delivery with or without episiotomy and Cesarean delivery. Assisted vaginal delivery includes help with the use of forceps or vacuum device when necessary. ~~consists of an episiotomy, the delivery of the placenta external cephalic version, and special services associated with delivery.~~

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

In the absence of maternal or fetal indications for cesarean delivery, a plan for vaginal delivery should be recommended. 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 female beneficiary should 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 covers complications related to delivery when the diagnosis substantiates medical necessity.

3.5.3 Multiple Gestation Deliveries

If the female beneficiary delivers multiple babies, vaginally or by C-section, the appropriate modifiers and diagnosis codes ~~shall~~ 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 ~~mother~~ female beneficiary can be billed. The service must be requested by a physician, and a diagnosis substantiating the high risk ~~shall~~ must be documented on the claim ~~(A list of these diagnosis codes can be found in **Attachment A,** letter B "Diagnosis Codes")~~. ~~Medical~~ Health records documenting the high-risk delivery and the need for stand-by services are not required with the claim submission, but ~~shall~~ must be available for NC Medicaid or ~~its agents~~ DHHS fiscal contractor upon request.

Medicaid shall cover stand-by services for:

a. Care provided to the ~~mother~~ female beneficiary during a high-risk delivery ~~[refer to **Attachment A,** letter B (Diagnosis Codes)]~~; and

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

3.6 Postpartum Care

Postpartum care services encompass management of the ~~mother~~ female beneficiary immediately after delivery and during the six to eight-week period following delivery. ~~postnatal period.~~ Components of this service may ~~must~~ consist of a postpartum examination and contraceptive counseling. Contraceptive counseling is a component of the postpartum visit and is not separately reimbursable.

Medicaid covers medically approved family planning methods to prevent conception for beneficiaries with traditional Medicaid or MPW coverage during their postpartum eligibility period. ~~such as Nuva Ring, Birth Control Pills, Depo-Provera, IUD's (Paraguard and Mirena), Ortho Evra, sterilizations, including the Essure procedure, Implanon, emergency contraceptive counseling, contraceptive management procedures, and pharmaceuticals to prevent conception. This includes services for beneficiaries with MPW coverage during their postpartum eligibility period.~~ **Refe**r to clinical coverage

policy 1E-7 *Family Planning Services* at https://medicaid.ncdhhs.gov/, for Medicaid covered contraceptive services.

For female beneficiaries 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. ~~after the 60th postpartum day occurs. Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs.~~

Note: For continued services after the 12-month postpartum period ends ~~60th day~~, refer MPW beneficiaries to the Department of Social Services for continuing eligibility determination.

~~**Vaccinations**~~

~~Medicaid shall cover vaccinations for female beneficiaries who do not have evidence of immunity, and other vaccinations during pregnancy and postpartum. 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. Medicaid covers vaccinations for measles, mumps, rubella (MMR)/rubella component for women who do not have evidence of immunity and other vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP) and the Center for Disease Control (CDC). The vaccine is provided upon completion or termination of pregnancy and before discharge from the health care facility.~~

~~The ACIP recommendations for varicella vaccination indicate that women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy, according to ACIP protocol, and before discharge from the health care facility. The second dose should be administered between 4 and 8 weeks after the first dose. Medicaid covers the varicella vaccine series when provided according to this schedule and if the beneficiary is eligible for Medicaid on the day the service is provided.~~

~~Rho D immune globulin (Rhogam) is a medication that is 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 mother female beneficiary and her Rh-positive fetus. Rh (D) blood typing and antibody testing is covered for all female beneficiaries during their first visit for pregnancy related care. Repeated Rh (D) antibody testing for all unsensitized Rh(D) negative female 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 beneficiaries with MPW eligibility and traditional Medicaid. Medicaid covers rebatable NDCs for Rho D immune globulin in the postpartum period. This includes beneficiaries with MPW coverage.~~

~~Medicaid covers inpatient and outpatient immunizations for Tetanus toxoid, Diptheria toxoid, and Acellular Pertussis (Tdap) for beneficiaries during the postpartum period. ACIP recommends that adults who have or who anticipate having close contact with an infant less than 12 months of age and who previously have not received Tdap should receive a single dose of Tdap to protect against pertussis and reduce the likelihood of~~

~~transmission. Tdap can be administered regardless of interval since the last tetanus- or diphtheria-toxoid-containing vaccine. After receipt of Tdap, persons should continue to receive Td for routine booster immunization against tetanus and diphtheria, according to immunization guidelines.~~

~~Refer to **Attachment A, Claims-Related Information,** for a list of covered procedures.~~

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 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 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.

~~Total reimbursable units for the first year after delivery or until the female beneficiary's eligibility ends is three units. 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. ~~the 60th post-delivery day occurs.~~

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 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 (e.g., 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.

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3.8 United States Preventive Services Task Force (USPSTF) Recommendations

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

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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; and
f. Home tocolytic infusion therapy.

4.2.2 Non- Emergency Services for Undocumented Aliens

a. Medicaid shall not cover specific antepartum and postpartum services for undocumented aliens 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.

~~The following antepartum and postpartum services are not covered for undocumented aliens for emergency services.~~

~~ICD-10-CM Code(s)~~		
~~0U570ZZ~~	~~0UL70DZ~~	~~0UL74DZ~~
~~0U573ZZ~~	~~0UL70ZZ~~	~~0UL74ZZ~~
~~0U574ZZ~~	~~0UL73CZ~~	~~0UL77DZ~~
~~0U577ZZ~~	~~0UL73DZ~~	~~0UL77ZZ~~
~~0U578ZZ~~	~~0UL73ZZ~~	~~0UL78DZ~~
~~0UL70CZ~~	~~0UL74CZ~~	~~0UL78ZZ~~

~~CPT Code~~	~~Description~~
~~58600~~	~~Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral~~
~~58605~~	~~Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)~~
~~58611~~	~~Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure)(List separately in addition to code for primary procedure)~~
~~58615~~	~~Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach~~
~~58670~~	~~Laparoscopy, surgical; with fulguration of oviducts (with or without transection)~~
~~58671~~	~~Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)~~

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

The following CPT procedure codes will be considered for coverage only in an emergency situation such as an ectopic pregnancy:

CPT Code	Description
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Sterilization procedures are not included in the definition of emergency services and therefore are not covered for undocumented aliens. Refer to **Subsection 2.1.3, Undocumented Aliens.**

4.3 Stand-by Services

a. Medicaid ~~does~~ shall not cover stand-by services for pre-anesthesia evaluations.
b. Medicaid ~~does~~ shall not cover stand-by services for the ~~mother~~ 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.

~~Medicaid shall require~~ Prior prior approval is required for an MPW beneficiary ~~following the same guidelines as those for a beneficiary with full Medicaid coverage. when the physician determines that any of the services listed below are needed for the treatment of a medical illness, injury, or trauma that may complicate the pregnancy.~~ Providers shall maintain, in the female beneficiary's health record, documentation of the referral from the obstetric provider documenting the medical necessity of these services during the pregnancy.

~~e. Podiatry;~~

~~f. Chiropractic;~~

~~g. Optometric and optical services;~~

~~h. Home health;~~

~~i. Personal care services;~~

~~j. Hospice;~~

~~k. Private duty nursing;~~

~~l. Home infusion therapy; or~~

~~m. Durable medical equipment;~~

~~n. Outpatient specialized therapies.~~

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

~~Clinical coverage policy 4A, *Dental Services*, at https://medicaid.ncdhhs.gov/ describes dental services available to beneficiaries with MPW eligibility. These services require the same prior approval as dental services to any other beneficiary with full Medicaid coverage and are covered through the day of delivery.~~

5.2 Limitations

a. The following limitations apply to obstetric care services.

b. 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.

c. Antepartum care package services are covered once during the beneficiary's pregnancy. In special circumstances (such as when the female beneficiary moves), up to three different providers can bill for ~~59425 (A~~ antepartum care; 4–6 visits~~)~~. This does not apply to different providers in the same group.

d. Postpartum care services are covered through the end of the month in which the 12-month postpartum period ends~~. 60th postpartum day occurs~~ after vaginal and cesarean delivery. Refer to **Subsection 3.6, Postpartum Care.**

e. Stand-by services related to ~~the mother~~ a female beneficiary for a high-risk delivery are limited to two hours per day.

f. 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.

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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).

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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.

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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.
	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)

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Date	Section Revised	Change
	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.
	~~Section 1.0~~	~~Removed repeat wording. Added clarifying language.~~
	Section 1.1	Added Definitions section to policy and added pertinent definitions.
	Section 2.0	Updated heading from "Eligible Beneficiaries" to "Eligibility Requirements"
	Section 2.1	Removed "General" from "General Provisions" in subheading.
	Section 2.1.1	Updated subheading from "Regular Medicaid" to "General" and added general criteria to this section.
	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.
	Section 2.1.2.1	Section 2.1.1 became Section 2.1.2.1 "Regular Medicaid"
	Section 2.1.2.2	Section 2.1.2. became Section 2.1.2.2 "Medicaid for Pregnant Women." ~~Removed unnecessary language; added clarifying language;~~ Removed 42 CFR 447.53(b)(2). ~~Removed examples of non-OB covered services and made reference to services "other than pregnancy and postpartum."~~ 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.
	Section 2.1.2.3	Section 2.1.3 became Section 2.1.2.3 "Undocumented Aliens." ~~Removed unnecessary language; added clarifying language;~~ Removed 10A NCAC 21B.0302; added 10 A NCAC 23E.0102(C)(1)(2).

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Date	Section Revised	Change
	Section 2.1.2.4	Section 2.1.4 became Section 2.1.2.4 Presumptive Eligibility. ~~Removed unnecessary language; added clarifying language.~~
	Section 2.1.2.5	Section 2.1.5 became Section 2.1.2.5 "Retroactive Eligibility." Included information related to NCHC eligible beneficiaries.
	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.
	~~Sections 3.2~~	~~Removed unnecessary language; added clarifying language.~~
	Section 3.2.1	Added "Routine" to subheading. Added clarifying language for uncomplicated pregnancy, removed unnecessary language.
1	Section 3.2.2	Added "Non-Routine" to subheading. ~~Added clarifying language. Removed unnecessary language.~~ 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.
	Section 3.2.3	~~Removed unnecessary language; added clarifying language;~~ 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*
	Section 3.2.3.1	Added coverage guidelines for Tobacco Cessation Counseling.
	Sections 3.2.4 ~~and 3.2.5~~	~~Removed unnecessary language; added clarifying language.~~ Removed reference to CCP 1K-7, Prior Approval for Imaging Procedures;
	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.

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Date	Section Revised	Change
	Sections 3.3.1, 3.3.2	Added "Care" to subheading of 3.3.1. Added "Package" to subheading of 3.3.2. ~~Removed unnecessary language; added clarifying language.~~ 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.
	Section 3.3	Note added to clarify that a telehealth visit will count as a visit in a global or package service.
	Section 3.3.3	Added "Care" to subheading. ~~Removed unnecessary language; added clarifying language;~~ Removed CPT codes found in these sections. Clarified length of postpartum period of 6 to 8 weeks following delivery.
	Sections 3.4, 3.5, 3.5.1, 3.5.2, 3.5.3 and 3.5.4	~~Removed unnecessary language; added clarifying language.~~ Added language to further define services covered in Labor and Delivery. Added Maternal Skilled Nurse home visit policy reference for consultations.
	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.
	Section 3.5 Note	Changed "attending physician" to "delivery provider" to include certified nurse midwives.
	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.
	Section 3.6	~~Removed unnecessary language; added clarifying language;~~ 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.
	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.

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Date	Section Revised	Change
	Section 3.7	Added Section "Hybrid Telehealth Visit with Supporting Home Visit" for coverage and corresponding guidelines.
	Section 3.8	Added United States Preventive Services Task Force (USPSTF) Recommendations
	Section 4.0	Moved information related to non-emergency services for undocumented aliens to this section.
	Section 4.2	Modified subheading from "Emergency Services for Undocumented Aliens" to "Specific Non-Covered Criteria."
	Section 4.2.1	Added Section 4.2.1 Added subsection "Non-Emergency Criteria" and added non-covered criteria.
	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.
	~~Section 4.3~~	~~Removed unnecessary language; added clarifying language.~~
	Section 5.1	~~Removed unnecessary language; added clarifying language. Added Outpatient Specialized Therapies as services of medical necessity.~~ Due to 12 month postpartum expansion and increased MPW benefit coverage, removed PA requirements for Non-Obstetrical services.
	Section 5.2	Removed ~~unnecessary language and~~ CPT codes from this section~~.; added clarifying language~~.
	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.
	~~Section 7.1~~	~~Removed unnecessary language; added clarifying language.~~
	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.
	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.

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Date	Section Revised	Change
	Attachment A, Letter C	~~Removed unnecessary language.~~ Added section (c.) for billing guidance within table that follows; added NPP/LHD, as needed to table headings. ~~removed unnecessary language and~~ 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.
	Attachment A, Letter D	Added Modifier GT criteria for Telehealth Claims for Global/Package Billing and Individual Visit Billing.
	~~Attachment A, Letter D~~	~~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).~~
	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).
	Attachment B	~~Added clarifying language.~~ Removed description for CPT codes and removed CPT codes for services that are not considered part of global package and can be billed separately. Rearranged format for ease of readability.
	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 ~~some~~ billing scenarios and instructions for billing individual perinatal visits. Changed CPT code 99201 to 99202 as 99201 is an end dated code.
	Attachment B, Letter B	Added Section "Billing for Observation and Inpatient Services" and corresponding billing guidance.
	Attachment B, Letter C	Added Section "Postpartum Services" and corresponding billing guidance.
	Attachment B, Letter D	Added Section "Billing Prenatal and Postpartum Services Via Telehealth" and corresponding billing guidance.
	Attachment B, Letter E	Added Section "Billing for Hybrid Telehealth Visit with a Supporting Home Visit" and corresponding billing guidance.
	Attachment B, Letter F	Added Section "Billing for Tobacco Cessation Counseling" and corresponding billing guidance.

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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 and NCHC:

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.

~~**Diagnosis Codes that Substantiate High-Risk Deliveries for Maternal Stand-by Service**~~

~~**ICD-10-CM Code(s)**~~			
~~0U570ZZ~~	~~O14.03~~	~~O41.1032~~	~~O47.03~~
~~0U573ZZ~~	~~O14.12~~	~~O41.1033~~	~~O71.02~~
~~0U574ZZ~~	~~O14.13~~	~~O41.1034~~	~~O71.03~~
~~0U577ZZ~~	~~O14.22~~	~~O41.1035~~	~~O71.1~~
~~0U578ZZ~~	~~O14.23~~	~~O41.1039~~	~~O74.1~~
~~0UL70CZ~~	~~O14.92~~	~~O41.1211~~	~~O74.2~~
~~0UL70DZ~~	~~O14.93~~	~~O41.1212~~	~~O74.3~~
~~0UL70ZZ~~	~~O15.02~~	~~O41.1213~~	~~O74.8~~
~~0UL73CZ~~	~~O15.03~~	~~O41.1214~~	~~O75.0~~
~~0UL73DZ~~	~~O15.9~~	~~O41.1215~~	~~O75.1~~
~~0UL73ZZ~~	~~O16.1~~	~~O41.1219~~	~~O75.2~~
~~0UL74CZ~~	~~O16.2~~	~~O41.1221~~	~~O75.3~~
~~0UL74DZ~~	~~O16.3~~	~~O41.1222~~	~~O87.1~~
~~0UL74ZZ~~	~~O22.31~~	~~O41.1223~~	~~O88.011~~
~~0UL77DZ~~	~~O22.32~~	~~O41.1224~~	~~O88.012~~
~~0UL77ZZ~~	~~O22.33~~	~~O41.1225~~	~~O88.013~~
~~0UL78DZ~~	~~O24.011~~	~~O41.1229~~	~~O88.02~~
~~0UL78ZZ~~	~~O24.012~~	~~O41.1231~~	~~O88.03~~
~~D65~~	~~O24.013~~	~~O41.1232~~	~~O88.111~~
~~D66~~	~~O24.111~~	~~O41.1233~~	~~O88.112~~
~~D67~~	~~O24.112~~	~~O41.1234~~	~~O88.113~~
~~D68.0~~	~~O24.113~~	~~O41.1235~~	~~O88.211~~
~~D68.1~~	~~O24.311~~	~~O41.1239~~	~~O88.212~~

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~~D68.2~~	~~O26.611~~	~~O41.1411~~	~~O88.213~~
~~D68.311~~	~~O26.612~~	~~O41.1412~~	~~O88.22~~
~~D68.312~~	~~O26.613~~	~~O41.1413~~	~~O88.23~~
~~D68.318~~	~~O26.831~~	~~O41.1414~~	~~O88.311~~
~~D68.4~~	~~O26.832~~	~~O41.1415~~	~~O88.312~~
~~D68.8~~	~~O26.833~~	~~O41.1419~~	~~O88.313~~
~~I09.9~~	~~O30.001~~	~~O41.1421~~	~~O88.32~~
~~I50.1~~	~~O30.002~~	~~O41.1422~~	~~O88.33~~
~~I50.20~~	~~O30.003~~	~~O41.1423~~	~~O88.811~~
~~I50.22~~	~~O30.011~~	~~O41.1424~~	~~O88.812~~
~~I50.23~~	~~O30.012~~	~~O41.1425~~	~~O88.813~~
~~I50.30~~	~~O30.013~~	~~O41.1429~~	~~O88.82~~
~~I50.31~~	~~O30.031~~	~~O41.1431~~	~~O88.83~~
~~I50.32~~	~~O30.032~~	~~O41.1432~~	~~O99.111~~
~~I50.33~~	~~O30.033~~	~~O41.1433~~	~~O99.112~~
~~I50.40~~	~~O30.041~~	~~O41.1434~~	~~O99.113~~
~~I50.41~~	~~O30.042~~	~~O41.1435~~	~~O99.281~~
~~I50.42~~	~~O30.043~~	~~O41.1439~~	~~O99.282~~
~~I50.43~~	~~O30.091~~	~~O44.11~~	~~O99.283~~
~~I50.9~~	~~O30.092~~	~~O44.12~~	~~O99.311~~
~~I51.9~~	~~O30.093~~	~~O44.13~~	~~O99.312~~
~~I97.130~~	~~O30.101~~	~~O45.001~~	~~O99.313~~
~~I97.131~~	~~O30.102~~	~~O45.002~~	~~O99.321~~
~~O10.011~~	~~O30.103~~	~~O45.003~~	~~O99.322~~
~~O10.012~~	~~O30.111~~	~~O45.011~~	~~O99.323~~
~~O10.013~~	~~O30.112~~	~~O45.012~~	~~O99.341~~
~~O10.02~~	~~O30.113~~	~~O45.013~~	~~O99.342~~
~~O10.03~~	~~O30.121~~	~~O45.021~~	~~O99.343~~
~~O10.111~~	~~O30.122~~	~~O45.022~~	~~O99.351~~
~~O10.112~~	~~O30.123~~	~~O45.023~~	~~O99.352~~
~~O10.113~~	~~O30.191~~	~~O45.091~~	~~O99.353~~
~~O10.211~~	~~O30.192~~	~~O45.092~~	~~O99.411~~
~~O10.212~~	~~O30.193~~	~~O45.093~~	~~O99.412~~
~~O10.213~~	~~O30.201~~	~~O45.8X1~~	~~O99.413~~
~~O10.22~~	~~O30.202~~	~~O45.8X2~~	~~O99.42~~
~~O10.23~~	~~O30.203~~	~~O45.8X3~~	~~O99.43~~
~~O10.311~~	~~O30.211~~	~~O45.91~~	~~O99.841~~
~~O10.312~~	~~O30.212~~	~~O45.92~~	~~O99.842~~
~~O10.313~~	~~O30.213~~	~~O45.93~~	~~O99.843~~
~~O10.32~~	~~O30.221~~	~~O46.001~~	~~Q24.8~~
~~O10.33~~	~~O30.222~~	~~O46.002~~	~~Q25.9~~
~~O10.411~~	~~O30.223~~	~~O46.003~~	~~Q26.9~~
~~O10.412~~	~~O30.291~~	~~O46.011~~	~~Q27.9~~
~~O10.413~~	~~O30.292~~	~~O46.012~~	~~Q28.9~~
~~O10.42~~	~~O30.293~~	~~O46.013~~	~~Z20.4~~
~~O10.43~~	~~O41.1011~~	~~O46.021~~	~~Z20.820~~
~~O10.911~~	~~O41.1012~~	~~O46.022~~	~~Z20.828~~
~~O10.912~~	~~O41.1013~~	~~O46.023~~	
~~O10.913~~	~~O41.1014~~	~~O46.091~~	

~~O10.92~~ ~~O10.93~~ ~~O11.1~~ ~~O11.2~~ ~~O11.3~~ ~~O13.1~~ ~~O13.2~~ ~~O13.3~~ ~~O14.02~~	~~O41.1015~~ ~~O41.1019~~ ~~O41.1021~~ ~~O41.1022~~ ~~O41.1023~~ ~~O41.1024~~ ~~O41.1025~~ ~~O41.1029~~ ~~O41.1031~~	~~O46.092~~ ~~O46.093~~ ~~O46.8X1~~ ~~O46.8X2~~ ~~O46.8X3~~ ~~O46.91~~ ~~O46.92~~ ~~O46.93~~ ~~O47.02~~	

C. Code(s)

a. Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

~~The following table combines obstetrical codes and instructions for **physicians** and **FQHC/RHC providers.** Information for **anesthesia providers** follows in a separate table.~~

b. Information for reimbursement of PMP~~H~~ procedure codes (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 ~~will~~ be found in clinical coverage policy 1E-6, *Pregnancy Management Program* ~~*Medical Home*~~ at https://medicaid.ncdhhs.gov/. PMP~~H~~ providers shall bill according to the specifications in the table below. Indian Health Service PMP~~H~~ providers bill RC 510, S0280, and S0281 for reimbursement for PMP~~H~~ services.

1. 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.
2. 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**.
3. 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.

c. 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.

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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.

Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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.<br~~The provider billing for OB care shall have rendered at least 3 months of consecutive antepartum care to the beneficiary.~~ ✦ The date the provider first saw the beneficiary for antepartum care ~~shall~~ must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim for the OB care ~~shall~~ must be the date of delivery. ✦ This code cannot be billed in addition to other OB global codes, package, or individual codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Letter C** of this Attachment for a list of these codes. ✦ This code cannot be billed by hospital-based entities.	N/A

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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. ~~below.~~ ✦ 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, package, or individual OB codes by the same provider except as outlined in **Section E** of this Attachment. Refer to **Letter C** of this Attachment for a list of CPT codes. ~~OB 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.

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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 **Letter C** of this Attachment for a list of CPT 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.

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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 ~~shall~~ must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim ~~shall~~ 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 ~~global~~ 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

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
59426	Package	Antepartum care only; 7 or more visits	The date the provider first saw the beneficiary for antepartum care ~~shall~~ must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim ~~shall~~ must be the date of delivery. ✦ This code cannot be billed in addition to other OB ~~global~~ 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

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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 provider billing for OB care shall have rendered at least 3 consecutive months of antepartum care to the beneficiary.~~ ✦ The date the provider first saw the beneficiary for antepartum care ~~shall~~ must be entered in block 15 of the CMS-1500 form. ✦ The date of service on the claim for the OB care must ~~shall~~ be the date of delivery. ✦ This code cannot be billed in addition to other OB global codes, package, or individual codes by the same provider, except as outlined in **Section E** of this Attachment. Refer to **Letter C** of this Attachment for a list of these codes. ✦ This code cannot be billed by hospital-based entities.	N/A

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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 package, or individual OB codes by the same provider except as outlined in **Section E** of this Attachment. Refer to **Letter C** of this Attachment for a list of these codes. ~~OB codes~~. ✦ If antepartum care ~~and~~/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.

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Routine Obstetrical Procedure Codes				
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**	**FQHC/RHC Guidelines**
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 **Letter C** of this Attachment for a list of these codes.	N/A

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Additional Obstetrical Services Procedure Codes				
CPT Code	**Type**	**Description**	**Physician Services Guidelines**	**FQHC/RHC Guidelines**
99360	Individual	~~Physician~~ ~~s~~ Standby service, requiring prolonged ~~physician~~ attendance, each 30 minutes (eg, 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 female beneficiary.~~mother.~~ ✦ Services ~~shall~~ must be requested by a physician, and this request ~~shall~~ must be documented in the health ~~medical~~ record. ✦ Diagnosis substantiating the high risk ~~shall~~ 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 female beneficiary.~~mother.~~ ✦ Services ~~shall~~ must be requested by a physician, and this request ~~shall~~ must be documented in the health ~~medical~~ record. ✦ Diagnosis substantiating the high risk ~~shall~~ 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.

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Stand-by Services for Anesthesia Providers			
HCPCS Code	**Type**	**Description**	**Anesthesia Guidelines**
99360	Individual	~~Physicians~~ Standby service, requiring prolonged ~~physician~~ attendance, each 30 minutes (eg, 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 ~~mother~~female beneficiary. ✦ Services ~~shall~~ must be requested by a physician, and this request ~~shall~~ must be documented in the ~~medical~~ health record. ✦ Diagnosis substantiating the high risk ~~shall~~ 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.

~~Postpartum Vaccinations~~	
~~CPT Code~~	~~Description~~
~~90396~~	~~Varicella-zoster immune globulin, human, for intramuscular use~~
~~90706~~	~~Rubella virus vaccine, live, for subcutaneous use~~
~~90707~~	~~Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use~~
~~90716~~	~~Varicella virus vaccine, live, for subcutaneous use~~

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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**

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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 or 59410	59409-51 (one line for each vaginal additional birth) or 59514-51,59 (one line for each additional cesarean birth)	59409-51,59 (one line with one unit for each 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.

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F. Place of Service

Inpatient hospital, Outpatient hospital, Office, Birthing Center

Telehealth claims should 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

For NCHC refer to NCHC 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/

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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.

CPT Code	Description
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel (Calcium, total)
80050	General health panel
80051	Electrolyte panel
80055	Obstetric panel
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constitutents; automated, without microscopy
82731	Fetal fibronectin, cervicovaginal secretions, semiquantitative
83020	Hemoglobin fractionation and quantitation; electrophoresis (e.g., A2, S, C, and/or F)
83021	Hemoglobin fractionation and quantitation; chromatography (e.g., A2, S, C, and/or F)
83026	Hemoglobin; by copper sulfate method, non-automated
83030	Hemoglobin; F (fetal), chemical
83036	Hemoglobin; glycosylated (A1C)
83045	Hemoglobin; methemoglobin, qualitative
83050	Hemoglobin; methemoglobin, quantitative
83051	Hemoglobin; plasma
83055	Hemoglobin; sulfhemoglobin, qualitative
83060	Hemoglobin; sulfhemoglobin, quantitative
83065	Hemoglobin; thermolabile
83068	Hemoglobin; unstable, screen
83069	Hemoglobin; urine
85046	Blood count; automated differential WBC count; reticulocytes, automated, including one or more cellular parameters (e.g., reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [MRV], RNA content), direct measurement

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~~CPT Code~~	~~Description (Evaluation and Management)~~
~~99201 through 99215~~	~~Office or other outpatient services~~
~~99217~~	~~Observation care discharge day management~~
~~99218 through 99220~~	~~Initial observation care~~
~~99221 through 99239~~	~~Hospital inpatient services~~
~~99241 through 99245~~	~~Office or other outpatient consultations~~
~~99251 through 99255~~	~~Inpatient consultation~~

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:

1. ~~When~~ An obstetrical patient 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 patient is new to the provider ~~physician~~, codes 99202-99205 ~~shall~~ must be reported for the new patient initial visit. E/M codes 99211-99215 for an established patient ~~shall~~ must be reported for the next two (2) visits.
2. Services provided to a pregnant female beneficiary with an acute medical condition unrelated to the pregnancy ~~(excludes MPW beneficiaries)~~ 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;
3. When services are provided to a pregnant female 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;
4. A pregnancy becomes high-risk after the female 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;
5. A pregnancy is high risk and requires more than the normal amount 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 female 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

6. Additional high-risk visits for complications must be linked to an appropriate diagnosis code. If a high-risk female 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.
7. The pregnancy results in a spontaneous pregnancy loss (miscarriage), intrauterine fetal demise or ectopic pregnancy.

Note: E/M services provided to a pregnant female beneficiary in addition to global or package obstetric codes in excess of three (3) 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 ~~or Other Outpatient~~ Services	~~No~~Yes
99211 through 99215	Established Patient Office ~~or Other Outpatient~~ 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
99347 through 99350	Home Services- Established Patient	Yes

B. Billing Observation and Inpatient Services

1. There are services provided to a pregnant female beneficiary with an acute medical condition related or unrelated to the pregnancy under observation status. If the female 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; or
2. There are services provided to a pregnant female beneficiary with an acute medical condition related or unrelated to the pregnancy who is admitted to the hospital as an inpatient. If the female 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.
3. There are services provided to a pregnant female 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.

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~~**Note: Services provided to MPW beneficiaries must be related to the pregnancy or a condition that, in the judgment of the provider, may complicate pregnancy.**~~

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) ~~Z13.89 (encounter for screening for other disorder)~~ 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

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

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

D. 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., 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 be conducted in person within the first trimester of pregnancy.

1. **Providers Billing Global OB or Package Codes**:

   a. 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.
   b. 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.

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

2. Providers Billing Individual Prenatal Visits and Postpartum Care:

a. 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.

b. 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.

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

1. Providers Billing Global OB or Package Codes:

a. 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.

b. 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:

1. The assistance delivered in the home must be given by an appropriately trained delegated staff person.

2. The fee must be billed with the date of service for which the home visit is conducted.
3. HCPCS code Q3014 must be appended with the GT modifier and billed with a place of service "12" to designate that the originating site was the home.
4. 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.

2. Providers Billing Individual Prenatal Visits:

a. Providers should 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.

b. Providers should not bill an originating site facility fee.

F. 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.

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) visit but the service should be offered and the female 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.