Obstetrics

All prenatal outpatient visit evaluation and management codes must be modified with -TH in order to process correctly. The modifier must be placed in the first position after the *Current Procedural Terminology* (CPT) code.

The -TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

Louisiana Medicaid allows two initial prenatal visits per pregnancy (270 days). These two visits cannot be performed by the same attending provider.

Louisiana Medicaid considers the recipient a 'new patient' for each pregnancy whether or not the recipient is a new patient to the provider and meets the standard CPT criteria for a new patient. The appropriate CPT procedure code from the range of codes for new patient "Office or Other Outpatient Services" shall be billed for the initial prenatal visit. A pregnancy-related diagnosis code must also be used on the claim form as either the primary or secondary diagnosis.

Reimbursement for the initial prenatal visit, **which must be modified with -TH**, includes the following:

- A routine dipstick urinalysis,
- The examination,
- Record preparation, and
- Health/dietetic counseling.

If the pregnancy is not verified, or if the pregnancy test is negative, the appropriate level evaluation and management service may be billed **WITHOUT** the -TH modifier.

Follow-Up Prenatal Visits

The appropriate evaluation and management CPT code from the range of procedure codes for an established patient in the "Office or Other Outpatient Services" may be billed for each follow-up prenatal office visit. The procedure code for each of these visits **must be modified with –TH.** The reimbursement for this service includes:

- Payment for routine dipstick urinalysis,

- The examination,
- Routine fetal monitoring (excluding fetal non-stress testing), and
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy.

Treatment for such conditions as minor vaginal problems, infections, sinusitis, etc. is considered an essential part of maternal care during pregnancy.

Delivery Codes

The most appropriate CPT code should be billed for deliveries.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth, and delivery records should be attached. A -22 modifier for unusual circumstances should be used with the most appropriate CPT code for a vaginal or Cesarean section (C-section) delivery when the method of delivery is the same for all births.

If the multiple gestation results in a C-section delivery and a vaginal delivery, the provider should bill the most appropriate CPT code for the C-section delivery without a modifier and should also bill the most appropriate CPT code for the vaginal delivery and append modifier -51.

Postpartum Care Visit

The appropriate specific postpartum care CPT code, which should NOT be modified with -TH, may be billed for the postpartum care visit IF the delivery code submitted does not include postpartum care in its description. The reimbursement for postpartum care includes:

- A routine dipstick urinalysis,
- The examination,
- Weight and blood pressure checks, and
- Routine services normally associated with releasing a patient from obstetrical care.

Reimbursement is allowed for one postpartum visit IF this service is not included in the description of the procedure code paid for with the delivery.

Laboratory Services

One laboratory obstetric panel is reimbursable per pregnancy.

A complete urinalysis is reimbursable only once per pregnancy per billing provider unless medically necessary and the primary diagnosis for the additional urinalysis is within the ICD-9 diagnosis code range under "Other Diseases of Urinary System" or "Infections of genitourinary tract in pregnancy".

Ultrasounds

Beginning October 15, 2011, two ultrasounds shall be allowed per pregnancy (270 days). This includes ultrasounds performed by all providers regardless of place of treatment. Obstetrical providers shall utilize the obstetrical ultrasound section of CPT.

Louisiana Medicaid anticipates one medically necessary ultrasound will have been performed by week 16-20 of the pregnancy. Providers are cautioned not to maximize reimbursement by performing more than the medically necessary number of ultrasounds per pregnancy. Abuse of the ultrasound limit to maximize reimbursement is subject to review and possible recoupment or sanctions.

Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. Documentation should include evidence of an existing condition or documentation to rule out an expected abnormality.

If the two ultrasound limit has been exceeded due to multiple pregnancies (failed or completed) within 270 days, providers must submit a hardcopy claim and attach documentation with each submission for these subsequent ultrasounds indicating a previous pregnancy within 270 days.

The recipient's obstetrical provider should forward the information supporting the additional ultrasounds to the radiologist when recipients are sent to an outpatient facility for the procedure. Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists.

Injections

Refer to the "Injectable Medications" section for information.

Fetal Testing

Fetal Oxytocin Stress Test

A fetal oxytocin stress test is payable in an office setting to those professionals who have provided written verification to the fiscal intermediary's Provider Enrollment Unit of their capacity to perform the procedure in their office.

- The full service is payable to physicians only when the service is performed in the office setting. The full service is not payable to physicians if the place of service is inpatient or outpatient hospital.

- The "professional component only" aspect of this code is payable to all physicians, regardless of the place of service.

Fetal Non-stress Test

Fetal non-stress test is payable only in the following instances:

- Post-date/post-maturity pregnancies (after 41 weeks gestation).

- The treating physician has reason to suspect potential fetal problems in a "normal" pregnancy. If so, the diagnosis should reflect this.

- High-risk pregnancies, including but not limited to diabetic patient, toxemia, pre-eclampsia, eclampsia, multiple gestation, and previous intrauterine fetal death.

In addition, if the place of service is either inpatient or outpatient hospital, or the billing physician is rendering the "interpretation" only in his/her office, only the professional component modifier should be used.

NOTE: See the Medical Review section for additional information.

Fetal Biophysical Profile

Fetal biophysical profiles are reimbursable, but claims must be substantiated by at least two of the three criteria listed below:

- Gestation period is at least 28 weeks

- Pregnancy must be high-risk

- Uteroplacental insufficiency must be suspected in a normal pregnancy

Hospital Observation Care

Louisiana Medicaid considers "Initial Observation Care" a part of the evaluation and management services provided to recipients designated as "observation status" in a hospital. The key components of the codes used to report physician encounter(s) are defined in CPT's "Evaluation and Management Services Guidelines". These guidelines indicate that professional services include those face-to-face and/or bedside services rendered by the physician and reported by the appropriate CPT code. In order to submit claims to the Louisiana Medicaid program for hospital observation care, the service provided by the physician must include face-to-face and/or bedside care.