Obstetrics

All prenatal outpatient visit evaluation and management (E&M) 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 or established patient to the provider/practice. The appropriate level E&M CPT procedure code from the range of codes for new patient "Office or Other Outpatient Services" shall be billed for the initial prenatal visit with the TH modifier. 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, but is not limited to the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.);
- Identification of patient at risk for complications including those with prior preterm birth;
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

If the pregnancy is not verified, or if the pregnancy test is negative, the service can only be billed at the appropriate level E&M service without the TH modifier.

Follow-Up Prenatal Visits

The appropriate level E&M CPT code from the range of procedure codes used for an established patient in the "Office or Other Outpatient Services" may be billed for the subsequent prenatal visit(s). The E&M CPT code for each of these visits **must be modified with –TH.**

The reimbursement for this service includes, but is not limited to:

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

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

Delivery Codes

The most appropriate "delivery only" CPT code should be billed. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered.

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 "delivery only" CPT code for the C-section delivery and also bill the most appropriate vaginal "delivery only" procedure code with modifier -51 appended.

Postpartum Care Visit

The postpartum care CPT code (which should NOT be modified with –TH) should be billed for the postpartum care visit when performed. Reimbursement is allowed for one postpartum visit per 270 days.

The reimbursement for the postpartum care visit includes:

- Physical examination,
- Body mass index (BMI) assessment and blood pressure check,

- Routine dipstick urinalysis,
- Follow up plan for women with gestational diabetes,
- Family planning counseling,
- Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed,
- Screening for postpartum depression and intimate partner violence, and
- Other counseling and or services associated with releasing a patient from obstetrical care.

Laboratory Services

One laboratory "Obstetric Panel" is reimbursable per pregnancy. See current CPT manual for the appropriate procedure code for the "Obstetric Panel".

A complete urinalysis is reimbursable only once per pregnancy (270 days) per billing provider unless medically necessary and the primary diagnosis for the additional urinalysis supports a disease or infection of the genitourinary (GU) tract.

Ultrasounds

Two medically necessary ultrasounds shall be allowed per pregnancy (270 days). This includes OB ultrasounds performed by all providers regardless of place of treatment. Obstetrical providers shall utilize the obstetrical ultrasound section of CPT.

Louisiana Medicaid anticipates that two medically necessary ultrasounds will have been performed by the end of the second trimester of the pregnancy, one for determination of gestational age and one for survey of fetal anatomy. 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 and/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 medical need for additional ultrasounds to the radiologist when recipients are sent to an outpatient facility for the ultrasound.

Reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. (These are not included in the two per pregnancy limit described previously for the attending OB provider.)

Injections

Refer to the "Injectable Medications" section for more information on 17 Alpha Hydroxyprogesterone Caproate (17-P) and the billing of other injectable medications.

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 in an 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. The diagnosis should reflect high risk.

In addition, if the place of service is either in an inpatient or outpatient hospital, or the billing physician is rendering the "interpretation only" in his/her office, only the professional component (modifier-26) 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, if so, the diagnosis should reflect high risk, or
- Uteroplacental insufficiency must be suspected in a normal pregnancy.

Hospital Observation Care

Louisiana Medicaid considers "Initial Observation Care" a part of the E&M 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.