Obstetrics

All prenatal outpatient visit evaluation and management (E&M) procedure codes must be modified with TH. The TH modifier is not required for observation or inpatient hospital physician services.

Initial Prenatal Visit(s)

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

Louisiana Medicaid considers the beneficiary a 'new patient' for each pregnancy whether or not the beneficiary is a new or established patient to the provider/practice. The appropriate level E&M *Current Procedural Terminology* (CPT) procedure code shall be billed for the initial prenatal visit with the TH modifier.

Reimbursement for the initial prenatal visit, which must be modified with TH, shall include, 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 may only be submitted with the appropriate level E&M 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 may be submitted for the subsequent prenatal visit(s). The E&M CPT code for each of these visits must be modified with the TH modifier**.**

The reimbursement for this service shall include, 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.

Delivery Codes

The most appropriate "delivery only" CPT code shall be submitted. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered except in cases related to third party liability.

In cases of multiple births (twins, triplets, etc.), providers must submit claims hardcopy. The diagnosis code must indicate a multiple birth and delivery records must be attached. A Modifier-22 for unusual circumstances is to 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 must use 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.

When a long-acting reversible contraceptive (LARC) is inserted immediately postpartum and prior to discharge, reimbursement shall be made separately for the insertion procedure and the LARC.

Postpartum Care Visit

The postpartum care CPT code (which is not modified with –TH) may 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, but is not limited to:

- 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.

Prenatal Laboratory and Ultrasound Services

Prenatal Lab Panels

The obstetric panel test as defined by CPT shall only be reimbursed once per pregnancy.

A complete urinalysis is reimbursable only once per pregnancy (270 days) per billing provider unless medically necessary, for example, to diagnose a disease or infection of the genitourinary tract.

Non-Invasive Prenatal Testing

Non-Invasive Prenatal Testing (NIPT) is a genetic test which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is completed during the prenatal period of pregnancy to screen for the presence of some common fetal chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

- Trisomy 21 (Down syndrome);
- Trisomy 18 (Edwards syndrome); and
- Trisomy 13 (Patau syndrome).

NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:

- Abnormal first trimester screen, quad screen or integrated screen;
- Abnormal fetal ultrasound scan indicating increased risk of aneuploidy;

- Prior family history of aneuploidy in first (1st) degree relative for either parent;
- Previous history of pregnancy with aneuploidy; and
- Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

NOTE: 1st degree relative is defined as a person's parent, children, or sibling.

NIPT is NOT covered for women with multiple gestations.

Ultrasounds

Three obstetric ultrasounds shall be reimbursed per pregnancy (270 days) when medically necessary and performed by providers other than maternal fetal medicine specialists:

- When an obstetric ultrasound is performed for an individual with multiple gestations, leading to more than one procedure code being submitted, this shall only be counted as one obstetric ultrasound; and
- Obstetric ultrasounds performed in inpatient hospital, emergency department, and labor and delivery triage settings are excluded from this count.

Payment for additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation. Documentation must include evidence of an existing condition or indicate that the ultrasound is necessary to rule out a suspected abnormality.

If more than three ultrasounds must be performed 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.

When a beneficiary is sent to an outpatient facility for the ultrasound, the obstetrical provider must forward the information supporting the medical need for additional ultrasounds to the radiologist.

For maternal fetal medicine specialists, there shall be no prior authorization or medical review required for reimbursement of obstetric ultrasounds. In addition, reimbursement for CPT codes 76811 and 76812 is restricted to maternal fetal medicine specialists. In all cases, obstetric ultrasounds must be medically necessary to be eligible for reimbursement.

17 Alpha Hydroxyprogesterone Caproate (17-P)

Medicaid covers 17-alpha hydroxyprogesterone caproate (17P) without the requirement of prior authorization when substantiated by an appropriate diagnosis and all of the following criteria are met:

- Pregnant woman with a history of pre-term delivery before 37 weeks gestation;
- No symptoms of pre-term in the current pregnancy;
- Current singleton pregnancy; and
- Treatment initiation between 16 weeks 0 days and 23 weeks 6 days gestation.

Fetal Testing

Fetal Non-Stress Test

Fetal non-stress tests are covered and considered medically necessary when one of the following is met:

- The pregnancy is post-date/post-maturity (after 41 weeks gestation);
- The treating provider suspects fetal problems in an otherwise normal pregnancy; or
- The pregnancy is high risk, including but not limited to diabetes mellitus, pre-eclampsia, eclampsia, multiple gestations, and previous intrauterine fetal death.

Fetal Biophysical Profile

Fetal biophysical profiles are covered and considered medically necessary when at least two of the following are met:

- Gestation period is at least 28 weeks;
- Pregnancy must be high risk, as determined by the provider; or
- Uteroplacental insufficiency is suspected in a normal pregnancy.

Tobacco Cessation Counseling During Pregnancy

Tobacco cessation counseling is covered for pregnant beneficiaries when provided by the beneficiary's primary care provider (PCP) or obstetrical (OB) provider. Tobacco cessation counseling may be provided by other appropriate healthcare professionals upon referral from the member's PCP or OB provider, but all care must be coordinated.

During the prenatal period through 60 days postpartum, beneficiaries may receive up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded if deemed medically necessary.

Reimbursement for tobacco cessation counseling shall be a flat fee based on the applicable current procedural terminology (CPT) code and must be supported by appropriate documentation. The -TH modifier is required when submitting claims for tobacco cessation counseling within the prenatal period, but is not to be used for services in the postpartum period.

If tobacco cessation counseling is provided as a significant and separately identifiable service on the same day as an E/M visit, and is supported by clinical documentation, a modifier to indicate a separate service may be used when applicable.