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24 Maternity Care Program

The Alabama Medicaid Maternity Care Program allows Medicaid to establish locally coordinated systems of care, in which targeted populations receive maternity care in environments that emphasize quality, access, and cost-effective care.

The purpose of this managed care effort is to ensure that every Medicaid eligible pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health.

In most cases the Primary Contractor develops subcontracts with other providers capable of providing the requisite services. The responsibility remains with the Primary Contractor to assure qualitative and quantitative adequacy of the service.

Policy provisions for Maternity Care are found in the *Alabama Medicaid Agency Administrative Code,* Chapter 45, available on the Medicaid web page.

24.1 Enrollment

HP enrolls providers who contract with Alabama Medicaid as a Maternity Care Provider. A copy of this contract will be required with the request to enroll as a Maternity Care Provider.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Providers who contracts with Alabama Medicaid as a Maternity Care Provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Maternity Care related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Maternity care providers are assigned a provider type of Maternity Care (61). The valid specialty for maternity care providers is Maternity Care Program (920).

Districts

Medicaid has established fourteen maternity care districts. Potential Primary Contractors must show that a care system operates in the entire district. Contractors are required to provide maternity care services to most women eligible for maternity care in the specified district.

Providers should advise recipients that if they intentionally go outside of the provider network for non-emergency care, the recipient must pay the bill if they do not get approval from the Primary Contractor.

District	***Counties***
District 1	Colbert, Franklin, Lauderdale, Marion
District 2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
District 3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
District 4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
District 5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
District 6	Clay, Coosa, Randolph, Talladega, Tallapoosa
District 7	Greene, Hale
District 8	Choctaw, Marengo, Sumter
District 9	Dallas, Wilcox, Perry
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
District 11	Barbour, Chambers, Lee, Macon, Russell
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
District 13	Coffee, Dale, Geneva, Henry, Houston
District 14	Mobile

District	***Primary Contractor***	***Phone Number For Recipients***	***Phone Number For Providers***	***1-800 Phone Number***	***Start Date***
District 1	HealthGroup of Alabama	(256) 532-2744	(256) 532-2748 Laura Thompson	1 (888) 500-7343	01/01/10
District 2	HealthGroup of Alabama	(256) 532-2744	(256) 532-2748 Laura Thompson	1 (888) 500-7343	01/01/10
District 3	Quality of Life	(256) 492-0131	(256) 492-0131 Amelia Wofford	1 (888) 490-0131	01/01/10
District 4	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	01/01/10
District 5	Alabama Maternity, Inc. (VIVA Health)	(205) 558-7405	(205) 558-7587 Kim Reach	1 (877) 997-8377	01/01/10
District 6	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1 (877) 826-2229	01/01/10
District 7	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	01/01/10
District 8	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	11/16/13
District 9	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	01/01/10
District 10	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1 (877) 826-2229	01/01/10
District 11	Maternity Services of District 11	(334) 528-6830	(334) 528-6833 Donna Guinn-Taylor	1 (877) 503-2259	01/01/10
District 12	Southwest Alabama Maternity Care Program	(334) 272-1820	(334) 272-1820 Jeanette Gibson	1 (877) 826-2229	11/01/13
District 13	Southeast Alabama Maternity Care Program	(334) 699-8111	(334) 699-8111 Gary Bennett	1 (800) 735-4998	01/01/10
District 14	USA Medical Center	(251) 415-8585	(251) 415-8585 Susan Eschete	n/a	08/01/05

24.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 2, Verifying Recipient Eligibility, for general benefit information and limitations.

24.2.1 Eligibility

The following Medicaid recipients who are pregnant are required to participate in the Maternity Care Program:

- Those certified under the Affordable Care Act using the Modified Adjusted Gross Income (MAGI) rules for pregnant women
- Those certified through the Parent Other Caretaker Relative (POCR)
- Refugees
- Supplemental Security Income (SSI) eligible women

The following recipients are not required to participate and should not be enrolled:

- Dual eligibles (Medicare/Medicaid)
- Individuals granted emergency Medicaid due to their non-citizen status
- DYS women with a county code of 69

Recipients are notified at the time of Medicaid application of the requirement to participate in the program.

If a dual eligible recipient receives retroactive Medicare and has previously had a Medicaid paid maternity claim, you must reverse claim payment and inform all sub-contractors to bill Medicare. The Primary Contractor is to send a hard copy claim to the Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624, for procedure code 99199 and bill $365. $100 is the administration fee and the care coordination is $265. This claim will appear as an adjustment on your Remittance Advice (RA).

Hospital Presumptive Eligibility (HPE)

Effective January 1, 2014, Medicaid implemented HPE. HPE is temporary Medicaid coverage for up to 60 days. Coverage begins the first day of the month that the Hospital PE application is approved and ends the last day of the following month. If a recipient is approved as pregnancy only, services are limited to ambulatory prenatal and pregnancy-related care only (birthing expenses are not covered). For additional information refer to the Alabama Medicaid website at:
http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.6.7_Hospital_Presumptive_Eligibility.aspx

24.2.2 Covered Services

The Primary Contractor is responsible for all pregnancy-related care with the following exceptions: inpatient and outpatient hospital care related to the pregnancy diagnosis, and services provided by a teaching facility as described in the State Plan. The Primary Contractor is responsible from the 1st of the month in which the woman is certified until the end of the month in which the 60th postpartum day falls.

- Antepartum care
- Outpatient care

Effective 01/01/10 all outpatient hospital services associated with the pregnancy diagnosis are to be billed fee for service by the performing provider utilizing the most appropriate CPT codes with the exception of the professional component for ultrasounds and anesthesia. The professional components of ultrasounds and anesthesia remain the responsibility of the Primary Contractor and are a component of the global negotiated rate. Refer to section 24.6 for information regarding care provided by a teaching facility as described in the State plan.

- Delivery
- Hospitalization

Effective 01/01/10 all inpatient hospital services associated with the pregnancy diagnosis are to be billed fee for service by the performing provider utilizing the most appropriate CPT codes with the exception of the professional component for ultrasounds and anesthesia. The professional components of ultrasounds and anesthesia remain the responsibility of the Primary Contractor and are a component of the global negotiated rate. The 16 day benefit limit is applicable. If the recipient has exceeded the inpatient benefit limit additional days may be covered for the delivery only through the prior authorization process. Refer to section 24.6 for information regarding care provided by a teaching facility as described in the State plan.

- Postpartum care
- Care coordination services
- Assistant Surgeon Fees
- Associated services
- Anesthesia services
- Home visits
- Ultrasounds

Antepartum Care

Antepartum care includes the following usual prenatal services:

- Initial visit at the time pregnancy is diagnosed
- Initial and subsequent histories
- Maternity counseling
- Risk assessments
- Physical exams
- Recording of weight
- Blood pressure recordings
- Fetal heart tones
- Lab work appropriate to the level of care including hematocrit and chemical urinalysis

Delivery

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee **may not** be billed for a multiple birth delivery. Delivery includes, but is not limited to, professional services, such as physician's services and anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number. Please refer to Chapter 28 for charges that are billable fee-for-service by physicians.

Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-04), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during hospitalization

Effective 01/01/10 inpatient and outpatient hospital services are to be billed fee for service by the performing provider utilizing the most appropriate CPT codes with the exception of the professional component for ultrasounds and anesthesia.

NOTE:

Sterilization procedures performed during delivery stays are included as covered services under the global fee and may not be billed separately by the hospital. Physician sterilization charges may be billed fee-for-service.

Effective 01/01/10 all outpatient hospital services associated with a pregnancy related condition for recipients assigned to the Maternity Care Program are excluded from the Primary contractor global capitated fee and are to be billed as fee for service by the Provider of service utilizing the most appropriate CPT code with the exception of the professional component for ultrasounds and anesthesia. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services.**

Postpartum Care

Postpartum care includes office visits, home visits, and in-hospital visits following delivery for routine care through the end of the month of the 60-day postpartum period. The postpartum exam should be accomplished four to eight weeks after delivery.

Care Coordination Services

The care coordinator arranges a coordinated system of obstetrical care for pregnant women based on specific guidelines for care coordination services.

Assistant Surgeon Fees

The global rate includes assistant surgeon fees for cesarean (C-section) deliveries.

Associated Services

The global fee includes all services associated with treatment of the pregnancy during the antepartum and postpartum period. Refer to table 24.5.4 for details.

Anesthesia Services

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

Home Visits

Postpartum Home visits are not skilled care nursing visits. Maternity Care Program home visits are for evaluation, assessment and referral and are accomplished by social workers or nurses at the discretion of the Primary Contractor. Home visits are optional, unless the required post partum care coordination encounter in the hospital is missed.

Ultrasounds

Medicaid pays for obstetrical ultrasounds for reasons of medical necessity. Ultrasound payment is limited to one per day. Payment will **not** be made to determine only the sex of the infant.

For recipients assigned to Maternity Care Primary Contractors the following applies:

Primary Contractors in each district are financially responsible for payment of medically necessary ultrasounds associated with each pregnancy. The primary contractor may have their own prior authorization system for those recipients that are required to participate in the Maternity Care Program. It is the Primary Contractor's responsibility to maintain a record of the dates of all ultrasounds for each pregnancy. The physician's professional-component for ultrasounds performed in the outpatient hospital is also the responsibility of the Primary Contractor and a component of the global associated capitated payment. The technical component for ultrasounds is to be billed fee for service by the performing provider utilizing the most appropriate CPT code. The exception is for ultrasounds performed in a teaching facility (i.e. UAB and USA Maternal Fetal Medicine) as designated in the State Plan (See Section 24.6).

For recipients not required to participate in the Maternity Care Program and not assigned to a primary Contractor in the Maternity Care Program (Fee for Service Billing) the following applies:

A limit of two ultrasounds will be approved without requiring a prior authorization. PA requests shall be submitted to HP following normal PA procedures for ultrasounds exceeding two.

The following information is required for all ultrasound requests for authorization:

- Prior Authorization Request Form
- Date of the requested ultrasound
- Date of the request
- A list of **all dates and diagnoses of prior ultrasounds** for the current pregnancy
- Recipient's date of birth and Medicaid number
- EDC-Estimated Date of Confinement

- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

Requests for authorization should be submitted prior to the service being rendered. However, certain extenuating circumstances necessitate a retroactive authorization for OB ultrasound services provided. These circumstances include TPL claims, miscarriages not known to providers, and Maternity Care Program dropouts. In these limited cases (supportive documentation required), the time limit for obtaining authorization is not applicable. However, the claim time-filing-limit, 1 year from date of service, does apply.

Separately Billable Services

Services provided outside the scope of the global fee that may be billed separately are listed below:

Separately Billable Service	***Description***
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. In addition, women on Plan First have the option of obtaining oral contraceptives, the contraceptive ring, or the contraceptive patch, with a prescription from a private provider, at a Medicaid-enrolled community/outpatient pharmacy. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron). Smoking cessation products for pregnant women will be covered after prior authorization through the Pharmacy Administrative Services contractor. Refer to Appendix Q Tobacco Cessation for additional information. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline. Approval will be granted up to 3 months at a time.
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests. The professional component for radiology services is a component of the primary contractor global fee and should be billed separately to the primary contractor with the exception of teaching hospitals.
Dental	Dental services are covered for recipients under 21 years of age. For Maternity Care -eligible recipients, services must be pregnancy-related.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, standby and infant resuscitation may be billed under the mother's name and number on a fee-for-service basis.
Family Planning Services	Any claim with a family planning procedure code or indicator, with the exception of hospital claims for sterilization procedures performed during the delivery stay may be billed on a fee-for-service basis. Women on Plan First will continue to have the option of receiving family planning services from the Alabama Department of Public Health or a Federally qualified Health Center, along with oral contraceptives, the contraceptive ring, or the contraceptive patch.
Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the global fee. Access to emergency services will not be restricted by the Maternity Care Program.

Separately Billable Service	***Description***
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.
Fees for Dropouts	All services provided to dropouts should be billed fee-for-service. However, the provider of service must submit the claims to the Primary Contractor for Administrative Review. Appropriate claims will then be referred to Medicaid by the Primary Contractor.
Mental Health	**S**creening, **B**rief Intervention, and **R**eferral to **T**reatment (SBIRT) are services designed to identify individuals who are at risk for development of substance use disorders, assist individuals in implementing strategies to reduce the potential for development of substance use disorders, and refer individuals who have identified needs for substance abuse treatment to specialized substance abuse treatment providers. Note: The intent of SBIRT is referral for Substance Abuse to include alcohol and drug abuse as smoking cessation is covered in the Maternity Care Program under Care Coordination Services. <u>Screening</u>: A full screen, as reimbursable through this benefit, is a structured process used to identify an individual whose current use of alcohol and/or other drugs creates a clearly defined risk for harm in some life dimension. A non-reimbursable pre-screening process must provide documentation of the need for a full screen. The pre-screening process may consist of, as few as, one to two brief questions incorporated into a general health questionnaire; a valid and reliable short screening tool; observations of attending medical personnel; interview and self-report; laboratory results; and/or concerns expressed by significant others. The full screen must be conducted utilizing an authorized, evidence-based screening tool with established reliability and validity in the identification of individuals who are at risk for developing substance use disorders. The tool must also provide enough information to establish an appropriate level of intervention in relation to each individual's identified risk factors. Authorized tools that may be used to conduct the full screen include the following: • Alcohol, Smoking, and Substance Involvement Test (ASSIST) • Drug Abuse Screening Test (DAST) • Alcohol Use Disorders Identification Test (AUDIT) • Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) Questionnaire • Problem Oriented Screening Instrument for Teenagers (POSIT) Additional tools that conform to the criteria specified above may be utilized to provide the full screen. Prior to use, however, each tool not listed above must be reviewed and authorized for use by the Alabama Medicaid Agency. The full screening process includes the provider's evaluation of the results and an explanation of these results to the individual who has been screened. The provider must clearly explain the level of risk associated with the identified alcohol and/or drug use pattern, and describe the corresponding implications within the context the individual's health and other life dimensions. The provider's response to low risk substance use shall be provided during the screening process as according to the identified needs of the individual. This may include, but is not limited to, the dissemination of material that provides information on the risks associated with drinking and drug use, for example:

Separately Billable Service	*Description*
	• Potential alcohol and drug interactions with medications the individual is taking. • The potential for exacerbation of a health condition with alcohol and drug use. • The potential impact of alcohol or drug use on pregnancy. If the individual has a positive full screen, indicative of a moderate to high risk for a substance use disorder, the provider must be prepared to conduct or obtain brief intervention services during this same visit. **BRIEF INTERVENTION** A brief intervention is an organized encounter that includes, at a minimum, a provider and an individual who has been identified through a full screening process as being at moderate to high risk for development of a substance use disorder. Through the use of motivational strategies with demonstrated effectiveness, the goals of a brief intervention are to increase the individual's awareness and insight regarding current alcohol and/or drug use; to establish acceptance of a need for change; and to support the individual in development and implementation of a plan for change. The brief intervention may consist of a single brief (15 minutes) session or multiple brief sessions dependent upon the unique needs of each individual. Referrals for specialized substance abuse treatment services are provided in conjunction with brief interventions. During any brief intervention, including the first session, the provider must be prepared to make a direct referral to a specialized substance abuse treatment provider for individuals who are at high risk for severe substance use and related consequences. Referrals must be initiated as soon a need for such is established. **SERVICE UNITS/LIMITS** **Screening:** H0049 **Service Unit:** Episode **Limit:** One per pregnancy Providers may bill for time that is spent face-to-face administering an authorized screening tool, discussing the screening results, and providing recommendations for further actions. Providers may not bill for the time during which an individual self-administers a screening tool. **Brief Intervention:** H0050 **Service Unit:** 15 minutes **Limit:** 1/day, 2/pregnancy Providers may bill for time that is spent face-to-face implementing strategies to assist individuals with moderate to high risks for development of substance use disorders in behavior modification that supports risk reduction. Allowable strategies include efforts made by the provider to assist the individual in accessing specialty substance abuse treatment services when there is an identified need for such. **Restrictions:** SBIRT services are not a covered benefit for: • Smoking and tobacco abuse. • Individuals who have been diagnosed with a substance use disorder. • Individuals who have had previous and/or are now receiving treatment for a substance use disorder.

Separately Billable Service	***Description***
	Service Documentation: Documentation of services provided shall incorporate the following: • The need for and method of identification of the need for SBIRT as established during a pre-screening process. • Identification of the screening tool used to conduct the full screening process. • The results of the full screening process. • Brief intervention goals unique to each individual. • Summary report of each brief intervention session conducted, including the implementation of established motivational strategies. • Referrals made and outcomes. • Follow-up services provided. **Approved Providers:** Coverage of Screening, Brief Intervention, and Referral for Treatment (SBIRT) for pregnant women is covered in conjunction with antepartum care provided by physicians, physician employed nurse practitioners, nurse midwives, physician-employed physician assistants and FQICs. Prior to offering the services health care professionals must complete an online tutorial which can be accessed at http://www.mh.alabama.gov/SATR/AlabamaSBIRT/Default.aspx . The Mental Health and Substance Abuse Services Division of the Alabama Department of Mental Health will notify the Medicaid Maternity Care Program of health care professionals' successful completion of the tutorial. Procedure codes H0049 (screening for substance use) and H0050 (brief intervention and referral to treatment) will then be billable for the health care professional who has successfully completed the online tutorial. A diagnosis code of V222 must be billed by the provider on the claim form.
Miscarriages less than 21 weeks	All services may be billed fee-for-service. If the claim does not contain the miscarriage diagnosis code, it must be sent to the Primary-Contractor, who must submit an Administrative Review Form to the Alabama Medicaid Agency prior to the services being billed fee-for-service.
Referral to Specialists	Services provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner is not considered a specialty provider. A Board Certified Perinatalogist is considered a specialty provider and may bill fee-for-service for high risk patients only. Refer to the Chapter 28, Physicians Chapter, for billing information.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service. The Primary contractor must submit an Administrative Review Form to the Alabama Medicaid Agency and get approval for the exemption prior to the claims being billed.
Non-Pregnancy Related Care	Services provided that are not pregnancy-related are the responsibility of the beneficiary unless she is eligible under regular Medicaid benefits.

Separately Billable Service	***Description***
Tobacco Cessation Face-To-Face Counseling	Effective January 1, 2014, the Alabama Medicaid Agency cover a new smoking cessation benefit for Medicaid-eligible pregnant women. Medicaid will reimburse for up to four face- to-face counseling sessions in a 12-month period. The reimbursement period will begin in the prenatal period and continue through the postpartum period (60 days after delivery or pregnancy end). Documentation must support each counseling session. Face-to-face counseling services must be provided: • By or under the supervision of a physician; • By other health care professional who is legally authorized to furnish such services under State law and within their scope of practice and who is authorized to provide Medicaid coverable services other than tobacco cessation services. Refer to Appendix Q Tobacco Cessation for additional information.
Long Acting Reversible Contraception (LARC)	Effective April 1, 2014, the Alabama Medicaid Agency will cover long acting birth control in the inpatient hospital setting **immediately** after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting **immediately** after discharge from the inpatient hospital. The cost of the device or drug implant will be captured in the hospital's cost. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement. Refer to Chapter 19 Hospital for additional information.

24.3 Prior Authorization and Referral Requirements

A prior authorization is required for fee-for-service recipients (recipients not required to participate in the Maternity Care Program and not assigned to a primary Contractor in the Maternity Care Program) receiving ultrasound number three and above (refer to ultrasound section 24.1.2.) Referrals to specialty providers for a pregnancy related care (i.e., Cardiology, Endocrinology, etc.) are paid fee-for-service, if the condition is pregnancy related for the Maternity Care recipients and are billable fee-for-service for any medical condition covered by Medicaid for full-Medicaid recipients.

24.4 Cost Sharing (Copayment)

Copayment does not apply to services provided for pregnant women.

24.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Primary Contractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

24.5.1 Time Limit for Filing Claims

Medicaid requires all claims from Primary Contractors to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

24.5.2 Diagnosis Codes

Primary Contractors are to bill all claims to HP utilizing the appropriate CPT code. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services**.

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

24.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Claims for maternity care services are limited to the following five procedure codes and modifiers:

Code	*Modifier*	*Description*
59400	U9	Routine obstetric care including antepartum care, vaginal delivery **(delivery at 39 weeks of gestation or later)** (with or without episiotomy or forceps) and postpartum care
59400	UD	Routine obstetric care including antepartum care, vaginal delivery **(medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care
59400	UC	Routine obstetric care including antepartum care, vaginal delivery **(non-medically necessary prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care
59410	U9	Vaginal delivery **(delivery at 39 weeks of gestation or later)** and postpartum care only
59410	UD	Vaginal delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care only
59410	UC	Vaginal delivery **(non-medically necessary prior to 39 weeks of gestation)** and postpartum care only
59510	U9	Routine obstetric care including antepartum care, cesarean delivery **(delivery at 39 weeks of gestation or later)** and postpartum care
59510	UD	Routine obstetric care including antepartum care, cesarean delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care

Code	*Modifier*	*Description*
59510	UC	Routine obstetric care including antepartum care, cesarean delivery **(non-medically necessary prior to 39 weeks of gestation)** and postpartum care
59515	U9	Cesarean delivery **(delivery at 39 weeks of gestation or later)** and postpartum care only
59515	UD	Cesarean delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care only
59515	UC	Cesarean delivery **(non-medically necessary delivery prior to 39 weeks of gestation)** and postpartum care only
99199		Maternity Care Drop-Out Fee. Patient must have enrolled with the Primary Contractor for their district of residence prior to delivery.

NOTE:

Effective for dates of service on or after **April 1, 2014**, benefit criteria for obstetric delivery services will change for Alabama Medicaid Agency. Claims that are submitted for obstetric delivery procedure codes **59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, or 59622** will require one of the following modifiers:

U9-Delivery at 39 weeks of gestation or later

UD-Medically necessary delivery prior to 39 weeks of gestation

UC-Non-medically necessary delivery prior to 39 weeks of gestation

Claims for deliveries that are submitted without one of the required modifiers will be denied.

Appropriate Use of Modifiers

Please refer to this CMS link for more information regarding NCCI edits:http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)

It may be necessary to indicate that on the day a procedure or service identified by CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full. **Recipients may not be billed for any services covered under this program.** Delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full for all services provided from the time of delivery through the postpartum period. Recipients may be billed for services provided prior to the time of delivery.

For recipients who receive total care through the Primary Contractor network, a global fee should be billed.

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period.

Drop-out fees may be billed using procedure code 99199 for women who have enrolled into the MCP in her county of residence. This code is used when the recipient miscarries or moves out of district and changes her county code. Once this code is billed primary contractors are to send hard copy claims with an Administrative Review Form to Alabama Medicaid Agency, P. O. Box 5624, Montgomery, Alabama 36103-5624. These claims for prenatal visits, or other services will be stamped with an override stamp in order to pay fee-for-service.

Billing for other districts—this policy will apply when the recipient moves to another county outside of the district for which she is eligible and DOES NOT CHANGE HER COUNTY CODE, the billing district will bill the global using her/his own global rate. The biller of the global will keep $100 for an administrative fee and send all of the bills from her/his district and the global less $100 to the district for which she billed. The district receiving the global less $100 will pay the bills from both districts. You may not bill a drop out and use this policy.

24.5.4 Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	Description
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium)
00942	Anesthesia for colpotomy, vaginectomy, colporrhaphy, and open urethral procedures)
00948	Anesthesia for cervical cerclage)
00950	Anesthesia for culdoscopy)
00952	Anesthesia for hysteroscopy and/or hysterosalpingography)
01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for; vaginal delivery only
01961	Anesthesia for; cesarean delivery only
01965	Anesthesia for incomplete or missed abortions
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for c-section delivery following neuraxial labor
01996	Daily hospital management of continuous epidural
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56441	Lysis of labial adhesions
56820	Coloscopy of the vulva
56821	Coloscopy of the vulva with biopsy
57000	Colpotomy; with exploration
57010	Colpotomy
57020	Colpocentesis (separate procedure)
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57150	Irrigation of vagina and/or application of medicament

Procedure Code	Description
57400	Dilation of vagina under anesthesia
57410	Pelvic examination under anesthesia
57460	Colposcopy of the cervix including upper/adjacent vagina
59000	Amniocentesis, any method
59001	Therapeutic amniotic fluid reduction
59012	Cordocentesis (intrauterine), any method
59020	Fetal contraction stress test
59030	Fetal scalp blood sampling
59150	Removal of ectopic pregnancy
59160	Curettage, postpartum
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin)
59300	Episiotomy or vaginal repair by other than attending physician
59320	Cerclage of cervix, during pregnancy
59325	Cerclage of cervix, during pregnancy; abdominal
59350	Hysterorrhaphy of ruptured uterus
59400-U9	Routine obstetric care includes antepartum care, vaginal delivery **(delivery at 39 weeks of gestation or later)** (with or without episiotomy and/or forceps) and postpartum care
59400-UD	Routine obstetric care including antepartum care, vaginal delivery **(medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care
59400-UC	Routine obstetric care including antepartum care, vaginal delivery **(non-medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy or forceps) and postpartum care
59409-U9	Vaginal delivery only **(delivery at 39 weeks of gestation or later)** (with or without episiotomy and/or forceps)
59409-UD	Vaginal delivery only **(medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy and/or forceps)
59409-UC	Vaginal delivery only **(non-medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy and/or forceps)
59410-U9	Vaginal delivery only **(delivery at 39 weeks of gestation or later)** (with or without episiotomy and/or forceps), including postpartum care
59410-UD	Vaginal delivery only **(medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy and/or forceps), including postpartum care
59410-UC	Vaginal delivery only **(non-medically necessary delivery prior to 39 weeks of gestation)** (with or without episiotomy and/or forceps), including postpartum care
59412	Delivery; external Cephalic
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only (4 to 6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
59510-U9	Routine obstetric care including antepartum care, cesarean delivery **(delivery at 39 weeks of gestation or later)**, and postpartum care
59510-UD	Routine obstetric care including antepartum care, cesarean delivery **(medically necessary delivery prior to 39 weeks of gestation)**, and postpartum care
59510-UC	Routine obstetric care including antepartum care, cesarean delivery **(non-medically necessary delivery prior to 39 weeks of gestation)**, and postpartum care
59514-U9	Cesarean delivery only **(delivery at 39 weeks of gestation or later)**
59514-UD	Cesarean delivery only **(medically necessary delivery prior to 39 weeks of gestation)**

Procedure Code	Description
59514-UC	Cesarean delivery only **(non-medically necessary delivery prior to 39 weeks of gestation)**
59515-U9	Cesarean delivery only **(delivery at 39 weeks of gestation or later);** including postpartum care
59515-UD	Cesarean delivery only **(medically necessary delivery prior to 39 weeks of gestation)** including postpartum care
59515-UC	Cesarean delivery only **(non-medically necessary delivery prior to 39 weeks of gestation)** including postpartum care
59610-U9	Routine obstetric care including antepartum care, vaginal delivery **(delivery at 39 weeks of gestation or later)** (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59610-UD	Routine obstetric care including antepartum care, vaginal delivery (**medically necessary delivery prior to 39 weeks of gestation**) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59610-UC	Routine obstetric care including antepartum care, vaginal delivery (**non-medically necessary delivery prior to 39 weeks of gestation**) (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612- U9	Vaginal delivery only (**delivery at 39 weeks of gestation or later)**, after previous cesarean delivery (with or without episiotomy and/or forceps)
59612-UD	Vaginal delivery only **(medically necessary delivery prior to 39 weeks of gestation)**, after previous cesarean delivery (with or without episiotomy and/or forceps)
59612-UC	Vaginal delivery only **(non-medically necessary delivery prior to 39 weeks of gestation)**, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614- U9	Vaginal delivery only **(delivery at 39 weeks of gestation or later)**, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59614-UD	Vaginal delivery only **(medically necessary delivery prior to 39 weeks of gestation),** after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59614-UC	Vaginal delivery only **(non-medically necessary delivery prior to 39 weeks of gestation),** after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618- U9	Routine obstetric care including antepartum care, cesarean delivery **(delivery at 39 weeks of gestation or later)** and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59618-UD	Routine obstetric care including antepartum care, cesarean delivery **(medically necessary delivery prior to 39 weeks of gestation)** and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59618-UC	Routine obstetric care including antepartum care, cesarean delivery **(non-medically necessary delivery prior to 39 weeks of gestation)** and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620- U9	Cesarean delivery only **(delivery at 39 weeks of gestation or later),** following attempted vaginal delivery after previous cesarean delivery
59620-UD	Cesarean delivery only **(medically necessary delivery prior to 39 weeks of gestation),** following attempted vaginal delivery after previous cesarean delivery
59620-UC	Cesarean delivery only **(non-medically necessary delivery prior to 39 weeks of gestation),** following attempted vaginal delivery after previous cesarean delivery
59622- U9	Cesarean delivery only **(delivery at 39 weeks of gestation or later),** following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59622-UD	Cesarean delivery only (**medically necessary delivery prior to 39 weeks of gestation**), following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59622-UC	Cesarean delivery only (**non-medically necessary delivery prior to 39 weeks of gestation**), following attempted vaginal delivery after previous cesarean delivery; including postpartum care
59871	Removal of cerclage suture under anesthesia

Procedure Code	Description
59899	Unlisted procedure, maternity care and delivery
76801	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76802	Ultrasound, pregnant uterus, real time image documentation, with fetal and maternal evaluation
76805	Ultrasound, pregnant uterus, B-scan and/or real time with imagine documentation; complete
76810	Ultrasound, complete, multiple gestation, after the first trimester
76811	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76812	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76813	Ultrasound pregnant uterus, real time with image documentation, 1st trimester
76814	Ultrasound for each additional gestation use in conjunction with 76813
76815	Ultrasound, limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76816	Ultrasound, follow-up or repeat
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velcocimetry, fetal, umbilical artery
76821	Doppler velocimetry, fetal, middle cerebral artery
76825	Echocardiography, fetal
76826	Echocardiography, fetal, follow-up or repeat study
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal, follow-up or repeat study
81000	Urinalysis, by dipstick or tablet reagent
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dip stick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, glycated
85013	Spun micro-hematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
99058	Office services provided on an emergency basis
99201	Office or other outpatient visit for E&M
99202	Office or other outpatient visit for E&M
99203	Office or other outpatient visit for E&M
99204	Office or other outpatient visit for E&M
99205	Office or other outpatient visit for E&M
99211	Office or other outpatient visit for E&M
99212	Office or other outpatient visit for E&M
99213	Office or other outpatient visit for E&M

Procedure Code	Description
99214	Office or other outpatient visit for E&M
99215	Office or other outpatient visit for E&M
99217	Observation care discharge day management
99218	Initial observation care, per day, for E&M
99219	Initial observation care, per day, for E&M
99220	Initial observation care, per day, for E&M

NOTE:

The global fee includes the associated codes and the maternity care codes.

24.5.5 Place of Service Codes

The following place of service code applies when filing claims for maternity care services:

POS Code	*Description*
21	Inpatient Hospital

24.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

24.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Long Acting Reversible Contraception (LARC)	Chapter 19
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Tobacco Cessation	Appendix Q