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.

Table of Contents

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)*
1E-4, *Fetal Surveillance*
1E-7, *Family Planning Service*s
1H, *Telehealth, Virtual Patient Communications, and Remote Patient Monitoring*
1L-1, *Anesthesia Services*
1M-2, *Childbirth Education*
1M-3, *Health and Behavioral Intervention*
1M-5, *Home Visit for Postnatal Assessment and Follow-up Care*
1M-6, *Maternal Care Skilled Nurse Home Visit*
4A, *Dental Services*
8A*, Enhanced Mental Health and Substance Abuse Services*
1-I, *Dietary Evaluation and Counseling and Medical Lactation Services*
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 pregnant beneficiary.

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 pregnant beneficiary or the 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 pregnant 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 incision through the pregnant beneficiary's abdomen and uterus.

f. Certified Registered Nurse Anesthetist (CRNA)
An advanced practice RN specializing in the administration and monitoring of anesthesia for medical and surgical procedures.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid 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.

2.1.2 Specific

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

a. <u>Medicaid</u>

1. Regular Medicaid
In addition to antepartum, labor and delivery, and postpartum care, a beneficiary in this eligibility category is eligible for full Medicaid coverage. This coverage shall extend through at least the last day of the month in which the 12-month postpartum period ends.

2. Medicaid for Pregnant Women
A beneficiary with Medicaid for Pregnant Women (MPW) coverage is eligible for antepartum, labor and delivery, and postpartum care in addition to full Medicaid coverage. 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].

3. Population Groups Without State Coverage
For a population group for whom the state cannot provide coverage, Medicaid for care and services shall be provided for the treatment of an emergency condition. Services are authorized for actual dates that the emergency services are provided up to a maximum of five calendar days.

Note: The local department of social services in the county where the individual 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 beneficiary who is determined by a qualified provider to be presumptively eligible for Medicaid, to receive ambulatory antepartum care while the beneficiary's eligibility status is being determined. Presumptive eligibility is determined based on evidence of pregnancy and income only.

The pregnant beneficiary must apply for Medicaid no later than the last day of the month following the month the beneficiary is determined presumptively eligible. If the pregnant beneficiary applies for Medicaid within this time frame, they remain presumptively eligible for Medicaid until the local department of social services makes a determination on the beneficiary's application.

If the pregnant beneficiary fails to apply for Medicaid within this time period, the beneficiary is eligible only through the last calendar day of the month following the month the beneficiary is determined presumptively eligible.

In the case of a beneficiary 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.

5. **Retroactive Eligibility**
   Retroactive eligibility applies to this policy.

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; so 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/

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 there is 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

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 here: Refer to https://medicaid.ncdhhs.gov

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 Initial Prenatal Care Visit

To capture the initial prenatal care visit, providers must use CPT code 0500F (Initial prenatal care visit).

Note: Report at the first prenatal encounter with the health care professional providing obstetrical care. This would be the first visit with the obstetrical provider. Report the date of visit and in a separate field, the date of the last menstrual period (LMP) in addition to the customary services billed for this initial visit.

3.2.2 Routine Antepartum Visits

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

a. Initial prenatal history and physical exam, subsequent prenatal history, and physical exams. Each antepartum visit routinely consists of the recording of weight, blood pressure 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:
    1. Monthly visits up to 28 weeks
    2. Biweekly visits from 28 to 36 weeks gestation; and
    3. Weekly visits from 36 weeks until delivery.

Note: The pregnant beneficiary may be seen more frequently if the beneficiary's condition warrants.

Routine antepartum care is normally billed using a package procedure code in which all antepartum services are combined into one billing code.

3.2.3 Group Prenatal Care

Group Prenatal Care is an optional service that may be provided to pregnant beneficiaries. Medicaid shall pay an incentive for Group Prenatal Care when **five** or more visits are attended and documented in the health record.

3.2.4 Non-Routine Individual Antepartum Services

Medicaid shall cover individual evaluation and management codes for antepartum services when one of the following criteria is met:

a. A routine, uncomplicated pregnancy that requires more than the current ACOG recommended number of antepartum visits;
b. All prenatal visits after a high-risk diagnosis (at the initial visit or during the pregnancy); or

c. Less than four antepartum care visits are rendered before delivery or termination of provider-patient relationship.

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.

3.2.5 Pregnancy Risk Screening

a. The pregnancy risk screening form must be used to identify a pregnant beneficiary in need of pregnancy care management services at the initial prenatal encounter.

b. Providers shall complete the pregnancy risk screening form as current indications dictate.

c. A Medicaid beneficiary shall be referred for pregnancy care management assessment if a risk factor is identified. A copy of the pregnancy risk screening form must be provided to the high-risk case management agency.

d. A beneficiary shall be eligible to receive pregnancy care management services at any time during pregnancy or the post delivery period which ends on the last day of the month during which the 60th day post-delivery occurs.

Note: The Care Management Pregnancy Risk Screening Form can be found on the following web site: https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp

3.2.6 Counseling

Refer to clinical coverage policy 1M-3, *Health and Behavioral Intervention* at https://medicaid.ncdhhs.gov/ or information on counseling services for behavioral intervention including substance use.

Refer to clinical coverage Policy, IE-7*, Family Planning Services* 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.

3.2.6.1 Tobacco Cessation Counseling

Tobacco use screening shall be provided to all pregnant beneficiaries and an appropriate referral made for those willing to quit and a brief motivational intervention for those not ready to quit. The pregnant beneficiary who uses tobacco should be referred to Quitline NC for assistance.

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

3.2.7 Fetal Surveillance Testing

Medicaid shall cover medically necessary fetal surveillance testing. Refer to clinical coverage policies 1E-4*, Fetal Surveillance,* at https://medicaid.ncdhhs.gov/ for additional information.

3.2.8 Case Management

Case management services for pregnant beneficiaries are covered through NC Medicaid's clinical coverage policy 1E-6, *Pregnancy Management Program (PMP)* for beneficiaries assessed as high-risk and clinical coverage policy 12B, *Human Immunodeficiency Virus (HIV) Case Management* policy.

3.2.9 Vaccinations

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

3.3 Package Services

3.3.1 Antepartum Care Package Services

Medicaid shall cover antepartum package services 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 pregnant beneficiary before delivery.

3.3.2 Global Obstetrics Package Services

Antepartum care, labor and delivery, and postpartum care are covered as an all-inclusive service when:

a. at least 4 antepartum care visits were rendered before the delivery; and
b. the same provider who renders the antepartum care performs the delivery and postpartum care.

Note: E/M services provided to a pregnant beneficiary, in addition to global or package obstetric codes, in excess of three visits must require submission of health record documentation to support medical necessity.

3.3.3 Postpartum Care Package Services

The postpartum period is defined by Medicaid as the period between delivery and the end of the month in which the 60th postpartum day falls. Postpartum package services are covered when the attending provider:

a. has not provided any antepartum care, but performed the delivery, and provided the postpartum care; or
b. has not provided any antepartum care, and did not perform the delivery, but performs all postpartum care.

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. The postpartum delivery period should not be confused with the twelve-month postpartum MPW coverage.

3.4 Consultations

Medicaid shall cover inpatient and outpatient consultations when health records support that the services are medically necessary. This applies to a pregnant 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.
The *Maternal Care Skilled Nurse Home Visit* policy requires that the client be referred by their prenatal care physician or advanced practice provider (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, the placenta, membranes, and umbilical cord from the uterus to the outside world. This includes vaginal delivery with or without episiotomy, or Cesarean delivery. Assisted vaginal delivery includes help with the use of forceps or vacuum device when necessary.

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

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 pregnant beneficiary shall 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/providers/program-specific-clinical-coverage-policies for information on anesthesia and obstetrics.

3.5.2 Complications Related to Delivery

Medicaid shall cover complications related to delivery when the diagnosis substantiates medical necessity.

3.5.3 Multiple Gestation Deliveries

If the pregnant beneficiary delivers multiple babies, vaginally or by C-section, the appropriate modifiers and diagnosis codes 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 pregnant beneficiary can be billed. The service must be requested by a physician, and a diagnosis substantiating the high risk must be documented on the claim Health records documenting the high-risk delivery and the need for stand-by services are not required with the claim submission but must be available for NC Medicaid or DHHS fiscal contractor upon request.

Medicaid shall cover stand-by services for:

a. care provided to the pregnant beneficiary during a high-risk delivery; and
b. attendance at delivery and initial stabilization of the newborn during a high-risk delivery.

3.6 Postpartum Care

To capture the postpartum visit, providers must use CPT code 0503F Postpartum care. **Report this code at the postpartum visit.** Postpartum care services encompass management of the beneficiary immediately after delivery and during the four to twelve-week period following delivery. From the latest ACOG publication, components of this service must consist of an interaction within the first 3 weeks of delivery with the obstetrical/gynecological provider concluding with a comprehensive postpartum examination and contraceptive counseling no later than 12 weeks post-delivery. (Contraceptive counseling is a component of the postpartum visit and is not separately reimbursable). For a beneficiary with chronic medical conditions or pregnancy-related

complications, transition and coordination of medically necessary primary or specialty care shall be implemented as soon as possible.

Medicaid covers medically approved family planning methods to prevent conception for beneficiaries with traditional Medicaid or 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 a pregnant beneficiary 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.

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

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 that care is administered in a timely manner to improve quality of care and long-term outcomes for both beneficiary and child. Maternal depression screening identifies a beneficiary 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 four 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 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.

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 visit to the beneficiary's private residence 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 (it is within delegated staff person's scope of practice to administer vaccinations) and may conduct other tests or screenings, as appropriate.

3.8 United States Preventive Services Task Force (USPSTF) Recommendations

NC Medicaid encourages screening for all current United States Preventative Services Task Force (USPSTF) recommendations in all pregnant beneficiaries.

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.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

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;
f. Home tocolytic infusion therapy; and
g. More than 3 pregnancy risk screenings per pregnancy.

4.2.2 Non- Emergency Services for Population Groups Without State Coverage

a. Medicaid shall not cover specific antepartum and postpartum services for any individual without state coverage 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.

4.3 Stand-by Services

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

Refer to clinical coverage policies at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies for specific requirements for prior approval for non-Obstetric services.

5.2 Limitations

The following limitations apply to obstetric care services:

a. Labor Antepartum care package services are covered once during the beneficiary's pregnancy. In special circumstances (such as when the pregnant beneficiary moves), up to three different providers may bill for antepartum care 4–6 visits. This does not apply to different providers in the same group.

b. Postpartum coverage will extend through the end of the month in which the 12-month postpartum period ends after the end of the birth event.

c. Stand-by services related to a pregnant beneficiary for a high-risk delivery are limited to two hours per day.

d. 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.

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).

8.0 Policy Implementation and History

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.

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.
04/01/2022	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)

Date	Section Revised	Change
04/01/2022	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.
04/01/2022	Section 1.1	Added Definitions section to policy and added pertinent definitions.
04/01/2022	Section 2.0	Updated heading from “Eligible Beneficiaries” to “Eligibility Requirements”
04/01/2022	Section 2.1	Removed “General” from “General Provisions” in subheading.
04/01/2022	Section 2.1.1	Updated subheading from “Regular Medicaid” to “General” and added general criteria to this section.
04/01/2022	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.
04/01/2022	Section 2.1.2.1	Section 2.1.1 became Section 2.1.2.1 “Regular Medicaid”
04/01/2022	Section 2.1.2.2	Section 2.1.2. became Section 2.1.2.2 “Medicaid for Pregnant Women.” Removed 42 CFR 447.53(b)(2). 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.
04/01/2022	Section 2.1.2.3	Section 2.1.3 became Section 2.1.2.3 “Undocumented Aliens.” Removed 10A NCAC 21B.0302; added 10 A NCAC 23E.0102(C)(1)(2).
04/01/2022	Section 2.1.2.4	Section 2.1.4 became Section 2.1.2.4 Presumptive Eligibility.
04/01/2022	Section 2.1.2.5	Section 2.1.5 became Section 2.1.2.5 “Retroactive Eligibility.” Included information related to NCHC eligible beneficiaries.

Date	Section Revised	Change
04/01/2022	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.
04/01/2022	Section 3.2.1	Added "Routine" to subheading. Added clarifying language for uncomplicated pregnancy, removed unnecessary language.
04/01/2022	Section 3.2.2	Added "Non-Routine" to subheading. 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.
04/01/2022	Section 3.2.3	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*
04/01/2022	Section 3.2.3.1	Added coverage guidelines for Tobacco Cessation Counseling.
04/01/2022	Sections 3.2.4	Removed reference to CCP 1K-7, Prior Approval for Imaging Procedures;
04/01/2022	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.
04/01/2022	Sections 3.3.1, 3.3.2	Added "Care" to subheading of 3.3.1. Added "Package" to subheading of 3.3.2. 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.
04/01/2022	Section 3.3	Note added to clarify that a telehealth visit will count as a visit in a global or package service.
04/01/2022	Section 3.3.3	Added "Care" to subheading. Removed CPT codes found in these sections. Clarified length of postpartum period of 6 to 8 weeks following delivery.
04/01/2022	Sections 3.4, 3.5, 3.5.1, 3.5.2, 3.5.3 and 3.5.4	Added language to further define services covered in Labor and Delivery. Added Maternal Skilled Nurse home visit policy reference for consultations.

Date	Section Revised	Change
04/01/2022	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.
04/01/2022	Section 3.5 Note	Changed "attending physician" to "delivery provider" to include certified nurse midwives.
04/01/2022	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.
04/01/2022	Section 3.6	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.
04/01/2022	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.
04/01/2022	Section 3.7	Added Section "Hybrid Telehealth Visit with Supporting Home Visit" for coverage and corresponding guidelines.
04/01/2022	Section 3.8	Added United States Preventive Services Task Force (USPSTF) Recommendations
04/01/2022	Section 4.0	Moved information related to non-emergency services for undocumented aliens to this section.
04/01/2022	Section 4.2	Modified subheading from "Emergency Services for Undocumented Aliens" to "Specific Non-Covered Criteria."
04/01/2022	Section 4.2.1	Added Section 4.2.1 Added subsection "Non-Emergency Criteria" and added non-covered criteria.
04/01/2022	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.
04/01/2022	Section 5.1	Due to 12-month postpartum expansion and increased MPW benefit coverage, removed PA requirements for non-obstetrical services.
04/01/2022	Section 5.2	Removed CPT codes from this section

Date	Section Revised	Change
04/01/2022	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.
04/01/2022	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.
04/01/2022	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.
04/01/2022	Attachment A, Letter C	Added section (c.) for billing guidance within table that follows; added NPP/LHD, as needed to table headings. 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.
04/01/2022	Attachment A, Letter D	Added Modifier GT criteria for Telehealth Claims for Global/Package Billing and Individual Visit Billing.
04/01/2022	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).
04/01/2022	Attachment B	Removed description for CPT codes and removed CPT codes for services that are not considered part of global package and cannot be billed separately. Rearranged format for ease of readability.
04/01/2022	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 billing scenarios and instructions for billing individual perinatal visits. Changed CPT code 99201 to 99202 as 99201 is an end dated code.
04/01/2022	Attachment B, Letter B	Added Section "Billing for Observation and Inpatient Services" and corresponding billing guidance.
04/01/2022	Attachment B, Letter C	Added Section "Postpartum Services" and corresponding billing guidance.
04/01/2022	Attachment B, Letter D	Added Section "Billing Prenatal and Postpartum Services Via Telehealth" and corresponding billing guidance.
04/01/2022	Attachment B, Letter E	Added Section "Billing for Hybrid Telehealth Visit with a Supporting Home Visit" and corresponding billing guidance.

Date	Section Revised	Change
04/01/2022	Attachment B, Letter F	Added Section "Billing for Tobacco Cessation Counseling" and corresponding billing guidance.
02/01/2023	Throughout the policy	Changed text to a neutral gender text.
02/01/2023	Subsection 3.2.3	Added text regarding Pregnancy Risk Screening.
02/01/2023	Subsection 4.2.1. g.	Added the text: No more than 3 pregnancy risk screenings per pregnancy.
02/20/2023	Attachment A; Section C	Corrected wording from Letter C to Section C. Amended date not changed.
04/15/2023	All Sections All Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.
04/01/2024	Index pg ii	Removed B of Attachment B Billing for Obstetrical Services A.-F.
04/01/2024	Throughout policy	Removed "female" and changed to "beneficiary" or "individual".
04/01/2024	Throughout policy	Updated references to Attachment B
04/01/2024	Section 1.1	Added a more detailed definition of Certified Registered Nurse Anesthetist (CRNA
04/01/2024	Section 2.1.2	Replaced definition of **Undocumented Aliens** to **Population Group Without State Coverage** and defined. Used this new title throughout policy to replace Undocumented Aliens.
04/01/2024	Section 2.1.2. 4.	Added that presumptive eligibility beneficiaries have emergency coverage until their status is determined
04/01/2024	Section 3.2.1	**Added Initial Prenatal Care Visit** and the addition of LMP and 0500F codes for capturing maternal data.
04/01/2024	Section 3.2.3	Added the coverage of Group Prenatal Care and defined.
04/01/2024	Section 3.2.4	Added criteria for Evaluation and Management codes for antepartum services.
04/01/2024	Section 3.2.5	Added that a beneficiary shall be referred for Pregnancy Care Management if a risk factor is found through the Pregnancy Risk Form
04/01/2024	Section 3.3.1	Removed Note

Date	Section Revised	Change
04/01/2024	Section 3.3.2	Added billing guidance for Global Obstetrics Package Services
04/01/2024	Section 3.3.3	Added and defined the postpartum period post-delivery and clarified it is separate from the 12-month postpartum extension
04/01/2024	Section 3.4	Removed physician extender and added new reference advanced practice provider
04/01/2024	Section 3.5	Added "even if a cesarean was performed during a primary" for defining vaginal plan
04/01/2024	Section 3.5.4	Removed reference to Attachment A
04/01/2024	Section 3.6	Added" To capture the postpartum visit, providers must use CPT code 0503F Postpartum care. **Report this code at the postpartum visit** and ACOG's guidelines for postpartum care post-delivery
04/01/2024	Section 3.6.1	Changed postpartum depression screenings from three to four
04/01/2024	Section 3.8	Removed specific criteria for United States Preventive Services Task Force (USPSTF) Recommendations and changed to "current"
04/01/2024	Section 5.2	Removed the Note under **Limitations** and added language for clarification of when the coverage will occur during the postpartum period.
04/01/2024	Attachment A Section C	Added codes 59610, 59612, 59614, 59618, 59620 and 59622. Removed codes S0280 and S0281 and referenced that they are covered in policy 1E-6 . Removed specific billing guidance for Local Health Departments pertaining to those that only deliver antepartum services, postpartum care or high risk antepartum care. Removed all Routine Obstetrical Procedure Codes
04/01/2024	Attachment B	Removed Sections A. B. C.;
04/01/2024	Attachment B	Added under A. "with EP modifier";
04/01/2024	Attachment	Added under E. "Append modifier GT if performed via telehealth". Removed CPT description code chart Removed and added guidance for conducting and billing telehealth services. Changed CC4C to CMARC

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.

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.

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.

b. Information for PMP reimbursement of care coordination can be found in clinical coverage policy 1E-6, Pregnancy Management Program at https://medicaid.ncdhhs.gov/

c. Indian Health Service PMP providers bill RC 510, S0280, and S0281 for reimbursement for PMP services.

d. 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, 59610, 59612, 59614, 59618, 59620, and 59622. Please note that Postpartum visits are billed with global codes or postpartum package codes.

e. External cephalic version with or without tocolysis, may be billed in addition to delivery codes. FHQC and RHC 's will use the "C" suffix provider number.

f. Attendance at delivery may not be billed with newborn resuscitation.

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 12 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 3.2.4** 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**

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.

F. Place of Service

Inpatient hospital, Outpatient hospital, Office, Birthing Center

Telehealth claims shall 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/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

Attachment B: Billing for Obstetrical Services

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

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

B. 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 (for example, telephone conversations). 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 must be conducted in person within the first trimester of pregnancy.

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

1. Providers Billing Global OB or Package Codes:

i. 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 for each telehealth visit conducted with a supporting visit. The originating site fee shall be billed in addition to the pregnancy global package codes.

ii. To be reimbursed for the originating site facility fee for this care model, all of the listed requirements must be met for each home visit:

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

B. The fee must be billed with the date of service for which the home visit is conducted.

C. The telehealth originating site facility fee must be appended with the GT modifier and billed with a place of service "12" to designate that the originating site was the home.

D. 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 shall bill the appropriate level Home Service evaluation and management code for each telehealth visit with a supporting home visit made by an appropriately trained delegated staff person.

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

D 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. Append modifier GT if performed via telehealth.

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 Management for At-Risk children (CMARC) visit but the service must be offered and the 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.