



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Obstetrical and Gynecological Services

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Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"><li data-bbox="764 239 1073 388">• Updated <a href="#">Figure 1 – Example of Acknowledgement of Receipt of Hysterectomy Information</a></li></ul>	

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# Obstetrical and Gynecological Services

*Note: For policy information regarding coverage of obstetrical and gynecological services, see the [Medical Policy Manual](#) at [indianamedicaid.com](#).*

## Introduction

This document presents Indiana Health Coverage Programs (IHCP) billing, reimbursement, and coverage policies for gynecological and pregnancy-related services, including antepartum care, delivery, and postpartum care. Information about Notification of Pregnancy (NOP) procedures, high-risk pregnancy, hysterectomies, abortions, and birthing centers is also included in this document.

For information about sterilization, contraception, and sexually transmitted infection testing and treatment, see the [Family Planning Services](#) module.

*Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [indianamedicaid.com](#).*

## Cervical Cancer Screenings

The IHCP covers cervical cancer screening services including cytology (Pap smear) and human papillomavirus (HPV) testing, as well as medically necessary services such as the collection of the samples, screening by a cytotechnologist, and a physician's interpretation of the test results. Effective April 14, 2017, the IHCP follows the recommendations for cervical cancer screening set by the U.S. Preventive Services Task Force (USPSTF) and the American Society for Colposcopy and Cervical Pathology (ASCCP).

The USPSTF recommends the following guidelines for cervical cancer screenings:

- **Women younger than 21 years of age** – No screening for cervical cancer
- **Women 21 through 64 years of age** – Screening for cervical cancer with cytology (Pap smear) every three years
- **Women younger than 30 years of age** – No screening for cervical cancer with HPV testing, alone or in combination with cytology
- **Women 30 through 64 years of age** – Screening for cervical cancer with a combination of cytology and HPV testing every five years for women in this age range who want to lengthen the screening interval
- **Women with human immunodeficiency virus (HIV)** – Screening for cervical cancer within one year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology, with testing repeated six months later
- **Women who have had a hysterectomy** – No screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer

For repeat testing, cytological thresholds for further diagnostic testing (colposcopy) and treatments, and extended surveillance, the IHCP follows the recommendations of the ASCCP.

Detailed information regarding screening recommendations can be found on the [USPSTF website](#) at [uspreventiveservicestaskforce.org](#) and the [ASCCP website](#) at [asccp.org](#).

## Billing for Pregnancy-Related Services

Providers must indicate pregnancy and enter the date of last menstrual period (LMP) on all claims for pregnancy-related services. The IHCP does not process for payment any claims for pregnancy-related services submitted without an LMP.

Providers must indicate pregnancy and include the LMP on the professional claim as follows, depending on claim submission method:

- *CMS-1500* claim form – Enter the LMP date in field 14. Enter the pregnancy indicator **P** in field 24H for each service detail.
- Provider Healthcare Portal (Portal) professional claim – During Step 1 of the claim submission process, in the Claim Information section, select **Pregnancy** as the Date Type and enter the LMP in the Date of Current field.
- 837P electronic transaction – Indicate pregnancy by submitting **Y** in PAT09 in the 2000 loop. Submit LMP information in the DTP segment in the 2300 loop with a qualifier of 484.

When billing for pregnancy-related services on the professional claim, providers must indicate a pregnancy-related diagnosis code as the primary diagnosis (the first diagnosis code entered on the claim) and for each service detail, using diagnosis pointers. The IHCP limits payment for pregnancy-related services to ICD-10 diagnosis codes Z33 through Z36, subject to prior authorization (PA) restrictions and in accordance with *Indiana Administrative Code (IAC)*. See the *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a list of diagnosis codes for normal, low-risk pregnancy and for high-risk pregnancy.

Providers must enter the charged amount for each antepartum visit and for each postpartum visit. The charged amount is entered in field 24F (\$ Charges) on the *CMS-1500* claim form, the Charged Amount field in the Portal professional claim, or the Line Item Charge Amount field on the 837P electronic transaction.

Federal regulations allow providers to bill claims for certain prenatal services to the IHCP first, even if the member has insurance coverage through another carrier. For a list of relevant diagnosis codes, see *Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance* on the [Code Sets](#) page at indianamedicaid.com. For more information, see the [Third Party Liability](#) module.

See the [Claim Submission and Processing](#) module for general information about submitting professional claims, including step-by-step instructions for completing the *CMS-1500* claim form.

## Notification of Pregnancy

Early prenatal care can address potential health risks that contribute to poor birth outcomes. In addition, earlier enrollment of pregnant women in Medicaid case management programs is associated with better birth outcomes. The Family and Social Services Administration (FSSA) data shows that some low-income pregnant women do not seek prenatal services in the earliest stages of pregnancy, which often leads to untreated health risks. The FSSA Neonatal Quality Committee, made up of Indiana health professionals, has identified early prenatal care and the identification of health-risk factors of expectant mothers as an area of focus.

Within managed care programs, the FSSA uses the Notification of Pregnancy (NOP) form to improve the identification of health-risk factors of expectant mothers as early as the first trimester of pregnancy.



## ***Reimbursement for Notification of Pregnancy***

Providers may receive \$60 for one NOP per managed care member, per pregnancy. The following requirements must be met for a provider to be eligible for reimbursement for submitting an NOP:

- The NOP must be submitted via the Portal no more than five calendar days from the date of the office visit on which the NOP is based.
- The member's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based.
- The member must be enrolled with a managed care entity (MCE), including pregnant women enrolled in an MCE through HIP, Hoosier Care Connect, or Hoosier Healthwise, as well as presumptively eligible pregnant women enrolled with an MCE.
- The NOP cannot be a duplicate of a previously submitted NOP.

*Note: Duplicate NOPs (those for the same woman and the same pregnancy) do not qualify for the \$60 reimbursement. Only one NOP per member, per pregnancy is eligible for reimbursement. Recognized providers receive a systematic message if the NOP appears to be a duplicate.*

## ***Process for Completion of the Notification of Pregnancy***

Recognized providers complete and submit the NOP electronically using the Portal. After logging in, complete the following steps:

1. Select the **Eligibility** tab to verify the member's eligibility.
2. In the Eligibility Verification Request panel, enter any of the following three search criteria for the member:
  - Member ID
  - Social Security number (SSN) and birth date
  - Last name, first name, and birth date
3. Enter a date range for the inquiry or, at a minimum, enter an *effective from* date. If no date is entered in the Effective From field, the system defaults to the current date.
4. Click **Submit**.
5. In the Coverage column of the Eligibility Verification Information panel, click the link for the member's managed care plan to access the *Coverage Details* page.
6. Click [+] to expand the Managed Care Assignment Details panel and then click **Enter NOP** to begin the process of completing the NOP online. (The option to print a blank NOP is also available; however, note that only NOPs submitted online are reimbursable.)
7. Complete all information on the NOP form. An asterisk (\*) indicates a required field.
8. Click **Submit** to submit the NOP.
9. The Portal checks for potential duplicate NOPs. If a duplicate is identified, the recognized provider is asked to provide a reason why the new NOP is not a duplicate. The recognized provider can choose from three reasons related to the prior pregnancy:
  - Member abortion
  - Member preterm delivery
  - Member miscarriage

The provider can continue the process without identifying a reason; however, the duplicate NOP will not be reimbursed.

10. After submitting the NOP, click **Print NOP** to print the completed NOP for documentation purposes, or click **Close** to close the window without printing.

*Note: Submit the NOP within five calendar days from the date of the office visit. NOPs submitted more than five days from the date of the office visit are not reimbursed.*

## **Billing for Submitted Notifications of Pregnancy**

For NOP claims, bill using Current Procedural Terminology (CPT<sup>®1</sup>) code 99354 with modifier TH.

- 99354 – *Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour (list separately)*
- TH – *Obstetrical treatment/services, prenatal or postpartum*

The date of service on the NOP claim should be the date the provider completed the risk assessment during a visit with the pregnant woman.

**NOP claims should be submitted to the appropriate managed care entity.** Physicians can submit claims for NOP reimbursement using the *CMS-1500* claim form or the 837P electronic transaction. Hospitals can submit claims for NOP reimbursement using the *UB-04* claim form or the 837I electronic transaction. NOP claims from hospitals must be coded with revenue code 960 – *Professional fees– General*, in addition to CPT code 99354 with modifier TH.

## **Antepartum Care**

The IHCP reimburses up to 14 visits for normal antepartum care, one visit more than the 13 visits recommended by the American College of Obstetricians and Gynecologists (ACOG). The IHCP reimburses providers for the 14 visits in a normal pregnancy as follows:

- Three visits in trimester one
- Three visits in trimester two
- Eight visits in trimester three

Providers should bill antepartum care for pregnant members separately from the delivery and postpartum visits, using the following procedure codes:

- 99201–99215 – For the first antepartum visit, to accommodate the greater amount of work involved
- 59425 – Antepartum care only – for visits two through six
- 59426 – Antepartum care only – for the seventh and all subsequent visits

When billing an antepartum procedure code, providers should include the appropriate modifier from the following list:

- U1 – *Trimester one – 0 through 14 weeks, 0 days*
- U2 – *Trimester two – 14 weeks, one day through 28 weeks, 0 days*
- U3 – *Trimester three – 28 weeks, one day, through delivery*

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To identify antepartum visits in each trimester, providers must bill the appropriate U1, U2, or U3 modifier in conjunction with CPT procedure code 59425, 59426, or 99201–99215 with each specific date of service. If providers report an evaluation and management (E/M) code for the first visit, they must bill using the appropriate trimester modifier and expected date of delivery. See the *Antepartum Visit Procedure Codes and Billing Instructions* table in *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com for additional details.

*Note: CPT procedure codes 59425 and 59426 are not subject to National Correct Coding Initiative (NCCI) Column I/II editing when billed with modifiers U1, U2, or U3 and billed on the same date of service as the listed laboratory procedure codes.*

Providers should list each antepartum visit individually on the professional claim (CMS-1500 claim form or electronic equivalent) and submit claims after each individual visit or at the end of the respective trimester. The required antepartum tests and screenings for each trimester should be billed along with the trimester visits. Antepartum visits in the same trimester should be billed within 30 days of the end of the trimester.

See the [Billing Information for Pregnancy-Related Services](#) section for general billing information applicable to all pregnancy-related services.

## ***Antepartum Tests and Screenings***

The IHCP covers antepartum tests and screenings delivered according to standards established by the ACOG and the American Academy of Pediatrics (AAP).

Providers can bill antepartum tests and screenings with the appropriate visit code on the same CMS-1500 claim form, Portal professional claim, or 837P electronic transaction.

*Note: Providers are not allowed to bill separately for each component of the total obstetrical panel when all the tests listed in the panel are performed on the same date of service. For example, if the total panel of tests and screenings is performed on the same date of service, providers must bill the total obstetrical panel using the bundled laboratory procedure code 80055.*

## ***Placental Alpha Microglobulin-1 (PAMG-1) Test***

The IHCP provides coverage for CPT code 84112 – *Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg. placental alpha macroglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen.*

The IHCP reimburses for the placental alpha microglobulin-1 (PAMG-1) test when the test is considered medically necessary to confirm the diagnosis of premature rupture of membranes (PROM) or preterm premature rupture of membranes (PPROM). This test may be performed in a hospital setting (either inpatient or outpatient), or in a nonhospital setting (for example, a physician’s office or clinic). PA is not required for this testing; however, the use of the PAMG-1 test is closely monitored for appropriateness of use.

For reimbursement, providers should bill CPT code 84112 with the appropriate trimester modifier (U1, U2, or U3). One PAMG-1 test equals one unit of service.

## **Sonography**

The IHCP reimburses for sonography performed during pregnancy when warranted by one or more of the following conditions:

- Early diagnosis of ectopic or molar pregnancy
- Placental localization associated with abnormal bleeding
- Fetal postmaturity syndrome
- Suspected congenital anomaly
- Polyhydramnios or oligohydramnios
- Guide for amniocentesis
- Suspected multiple births
- Fetal age determination, if necessitated by the following:
  - Discrepancy in size versus fetal age
  - Lack of fetal growth or suspected fetal death

The IHCP reimburses for sonography for fetal age determination before therapeutic, nonelective abortions (in the case of fetal demise or for missed abortion) when the age of the fetus cannot be determined by the patient's history and physical examination. The information may also be essential for the selection of the abortion method when the member is considering a procedure and the conditions meet the requirements of *Indiana Code IC 16-34-1-8* for an elective abortion.

## **Echography**

The IHCP does not reimburse for routine echographies. A diagnosis of normal pregnancy does not explain the reason for the echography. Documentation in the patient's medical record must substantiate the medical need for the echography. Echographies performed to detect fetal malformations or intrauterine growth retardation should list an ICD-10 diagnosis code from the Z34 series (for normal pregnancy) or the O09 series (for high-risk pregnancy) as the **primary diagnosis** (see the *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com for complete lists of these codes), and ICD-10 diagnosis code Z36 – *Antenatal screening* as the **secondary diagnosis**. Pregnancy-related echographies billed without a secondary diagnosis to support medical necessity of the echography are subject to recoupment.

## **First-Trimester Fetal Nuchal Translucency Ultrasound**

The first-trimester fetal nuchal translucency ultrasound does not require prior authorization. However, the first-trimester fetal nuchal translucency ultrasound must be performed in conjunction with maternal serum-free beta human chorionic gonadotropin (hCG) and pregnancy-associated plasma protein A for the detection of chromosomal defects. The IHCP does not cover first-trimester fetal nuchal translucency testing when performed alone for the detection of chromosomal defects, as it is considered investigational. For optimal test results, the first-trimester fetal nuchal translucency ultrasound should be performed between 11 and 13 weeks of pregnancy. First-trimester fetal nuchal translucency ultrasounds are subject to the requirements found in *405 IAC 5-27-6*.

The IHCP does not provide reimbursement for routine ultrasounds or ultrasounds performed for gender determination. The diagnosis of a normal pregnancy does not substantiate the medical necessity for an ultrasound to be performed. Documentation must be maintained in the patient's medical record to support the medical need for an ultrasound.

Reimbursement is not available for CPT code 59072 – *Fetal umbilical cord occlusion, including ultrasound guidance*, as this procedure is designed to terminate a fetus.

See the *First-Trimester Fetal Nuchal Translucency Ultrasound Procedure Codes* table in *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

## ***Other Outpatient Office Visits during Pregnancy***

Providers can bill CPT procedure codes 99211–99215 for outpatient office visits rendered to pregnant members if the service is related to a concurrent medical condition requiring medical care or consultative referral. Providers must identify that concurrent condition as a primary or secondary condition by a valid ICD diagnosis code and indicate the appropriate diagnosis code in the diagnosis pointer field for the service billed. Additionally, providers can bill the first prenatal visit with E/M codes 99201–99215, the appropriate trimester modifier, and the expected date of delivery all indicated on the claim.

## **High-Risk Pregnancy**

A pregnancy may be considered *high risk* if at least one medical or psychosocial complication is identified in the current pregnancy or in the pregnant woman’s obstetrical history that places her at risk for preterm birth or a poor pregnancy outcome.

The IHCP does not determine conditions that may or may not complicate a pregnancy. Therefore, if a physician determines that an illness or injury could complicate a pregnancy or have an adverse effect on the pregnancy’s outcome, the IHCP allows billing for covered services provided to treat the illness or injury.

The IHCP covers compounded 17-alpha hydroxyprogesterone (17P) and Makena injections for the prevention of preterm delivery. For dates of service through June 30, 2017, both products must be billed through the pharmacy benefit process. See the [Pharmacy Services](#) module for billing instructions.

*Note: Effective July 1, 2017, coverage for Q9986 – Injection, Hydroxyprogesterone Caproate, (Makena), 10 mg is included under the IHCP medical benefit. Prior authorization is required. For dates of service on or after July 1, 2017, providers may bill for this service on professional and institutional claims. The product’s National Drug Code (NDC) must be included. Separate reimbursement is available in the outpatient setting when Q9986 is billed with revenue code 636 – Drugs requiring detailed coding for separate reimbursement in an outpatient setting.*

## ***Documenting High-Risk Pregnancies***

To document high-risk pregnancies for managed care members, providers may retain a copy of the submitted NOP in the patient’s record for retrospective review. NOPs can be completed at any time during the pregnancy, preferably during the initial visit, to document and monitor pregnancy conditions. If a normal pregnancy becomes high-risk at any time during the pregnancy, providers should use the NOP to document the change. See the [Notification of Pregnancy](#) section of this document for details.

*Note: NOPs can be submitted only for managed care members. For fee-for-service members, providers should retain other forms of documentation of high-risk pregnancy in the member’s medical records.*

## ***Increased Reimbursement and Additional Antepartum Visits for High-Risk Pregnancy***

Members with risk factors that may adversely affect the outcome of the pregnancy if not adequately treated are considered to have *high-risk pregnancies*. These complications, usually identified during the prenatal assessment, may place the member and the fetus in a high-risk pregnancy category that requires greater physician management.

Therefore, the IHCP reimburses physicians practicing obstetrics an additional \$10 per prenatal visit when the provider indicates a high-risk diagnosis code on the submitted claim and documents the specific medical high-risk factors in the member's medical records. Ensure that this information is easily identifiable on the medical record for audit purposes.

To be eligible for the higher reimbursement for prenatal office visits for patients who present with high-risk factors, providers must use a diagnosis code from the O09 series to signify high-risk pregnancy. (See the *ICD-10 Diagnosis Codes for High-Risk Pregnancy* table in *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com.) These codes, when billed with prenatal office visit procedure codes 59425 and 59426, increase the maximum fee allowed for these services by \$10 per visit.

In addition, members identified as high-risk patients may receive additional antepartum care visits, beyond the maximum of 14 allowed for a normal pregnancy. Claims must indicate one of the high-risk pregnancy diagnosis codes (from the O09 series), the LMP, the appropriate CPT code (procedure code 59425 for visits two through six, and procedure code 59426 for visits in excess of six), and the corresponding modifier.

*Note: The IHCP reimburses high-risk pregnancy care only when provided by physicians. Nonphysician providers that render pregnancy-related services to pregnant IHCP members must refer members identified as having high-risk pregnancies only to other appropriate physicians.*

## **Obstetrical Delivery and Postpartum Care**

Physicians should bill antepartum care separately from the delivery and postpartum care. The IHCP follows CPT guidelines for obstetrical delivery billing.

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean delivery. Medical problems complicating labor and delivery management may require additional resources, and physicians should identify related services by using the codes in the [Evaluation and Management Services](#) module, in addition to codes for maternity care.

The IHCP allows postpartum visits within 60 days after delivery. The IHCP may reimburse the physician for inpatient or outpatient postpartum visits using CPT code 59430, which is for postpartum care only.

The IHCP requires providers to bill the delivery and postpartum care services separately using the appropriate procedure codes. See the *Delivery-Only Procedure Codes* table and the *Postpartum-Care-Only Procedure Code* table in *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

## Early Elective Delivery Billing Information

The IHCP does not cover deliveries that are not medically indicated prior to 39 weeks and 0 days gestation, known as early elective deliveries (EEDs). This EED policy applies to all IHCP programs.

Table 1 – Approved Medical Indications for a Medically Necessary Delivery Prior to 39 Weeks and 0 Days

Maternal Indications	Fetal Indications	Obstetric Indications
Antiphospholipid syndrome	Abo isoimmunization	Abruption placenta
Chronic hypertension	Abnormal fetal heart rate	Abruption
Cardiovascular diseases	Chorioamnionitis	Antepartum hemorrhage/bleeding
Chronic pulmonary disease	Congenital heart defect/heart disease	Chronic hypertension with super imposed preeclampsia
Coagulopathy defect	Fetal abnormality	Chorioamnionitis
Coagulopathy disorders	Fetal chromosomal anomaly	Gestational diabetes
Congenital heart defect/heart disease	Fetal CNS anomaly	Gestational hypertension
Current cancer	Fetal damage due to disease	Hypertensive disorder
Diabetes mellitus	Fetal damage due to drugs	Increta
Epilepsy/seizure disorder	Fetal damage due to radiation	Maternal/fetal hemorrhage
Gastroenteric diseases/disorders	Fetal damage due to virus	Mild preeclampsia Severe preeclampsia/HELLP/eclampsia
Hematological disorder	Fetal demise-singleton	Multiple gestation/ multiple gestation with loss
HIV; asymptomatic HIV infection status	Fetal distress	Oligohydramnios
Hypertension non-specified	Fetal/maternal hemorrhage	Percreta
Liver disease	Intrauterine growth restriction	Placenta accreta
Maternal/fetal hemorrhage	Non-reassuring fetal antepartum testing	Placenta previa
Previous stillborn	RH isoimmunization	Placental previa hemorrhage
Prior classical cesarean delivery		Polyhydramnios
Prior myomectomy entering endometrial cavity		Premature rupture of membranes
Renal disease		Prolonged rupture of membranes
		Ruptured membranes
		Unstable lie; multiple gestation with malpresentation
		Vasa previa

The following modifiers are required on the professional claim (*CMS-1500* claim form or electronic equivalent) when billing fee-for-service (FFS) claims with CPT delivery codes 59409, 59514, 59612, or 59620. (Note that FFS does not cover CPT delivery codes 59410, 59515, 59614, or 59622.)

- **UA – Nonmedically necessary delivery prior to 39 weeks of gestation:** Deliveries at less than 39 weeks of gestation that do not meet the IHCP’s stated guidelines for approved medically necessary deliveries
- **UB – Medically necessary delivery prior to 39 weeks of gestation:** Deliveries resulting from:
  - Members presenting in labor and subsequently delivering before 39 weeks of gestation
  - Inductions or cesarean sections that meet the IHCP’s approved medical indications for a medically necessary delivery prior to 39 weeks and 0 daysDocumentation of the gestational age of the fetus and the medical indication for an early delivery must be completed and maintained in the member’s file. Suggested forms for documentation are the ACOG Patient Safety Checklists on the [ACOG website](http://acog.org) at [acog.org](http://acog.org) or the IPQIC Scheduling form on the [ISDH website](http://in.gov) at [in.gov](http://in.gov).
- **UC – Delivery at 39 weeks of gestation or later:** Delivery at 39 weeks of gestation or later regardless of method (induction, cesarean section, or spontaneous labor)

Condition codes are required on the institutional claim (*UB-04* claim form or electronic equivalent) when billing for FFS obstetric delivery services related to C-sections or inductions. Deliveries resulting from C-sections or inductions require one of the following condition codes (fields 18–24 of the *UB-04* claim form or equivalent fields of the electronic institutional claim):

- 81 – *C-sections or inductions performed at less than 39 weeks’ gestation for medical necessity*
- 82 – *C-sections or inductions performed at less than 39 weeks’ gestation electively*
- 83 – *C-sections or inductions performed at 39 weeks’ gestation or greater*

*Note: Deliveries that occur due to spontaneous labor do not require condition codes.*

For members enrolled in managed care programs, individual managed care entities (MCEs) establish and publish prior authorization, reimbursement, and billing criteria within their delivery systems. See the MCE’s policies for information regarding prior authorization, reimbursement, and billing for obstetric delivery services.

## **Multiple Births**

Multiple-birth deliveries are subject to multiple-surgery reimbursement. The current reimbursement policy indicated in *405 IAC 5-28-1(g)* for pricing multiple surgical procedures states that 100% of the global fee is reimbursed for the most expensive procedure. The second most expensive procedure is reimbursed at 50% of the global fee, and remaining procedures are reimbursed at 25% of the global fee. The IHCP reimburses for only one cesarean procedure, regardless of the number of babies delivered during the cesarean section. Therefore, only one detail line with one unit of service is billed for cesarean delivery procedure codes.

If billing for multiple births when all births are vaginal deliveries, providers bill the first birth using procedure code 59409 – *Vaginal delivery only (with or without episiotomy and/or forceps)* or 59612 – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)*. The second birth and any subsequent births are billed using procedure codes 59409 or 59612 with modifier 51 – *Multiple procedures*.

When billing for one vaginal birth and one or more births by cesarean section, the cesarean birth is billed with procedure code 59514 – *Cesarean delivery only* or 59620 – *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery*, and the vaginal birth is billed using procedure code 59409 or 59612 with modifier 51.



When billing for two or more vaginal births and one or more births by cesarean, the cesarean births are billed on one detail line with one unit of service using procedure code 59514 or 59620. The vaginal births are billed as separate details using procedure code 59409 or 59612 with modifier 51.

If an assistant surgeon aids in the cesarean delivery, the service is billed using modifiers 80, 81, or 82 to indicate that the service was performed by an assistant surgeon. The reimbursement for the assistant surgeon's services is 20% of the allowed amount for the cesarean delivery. Providers cannot bill the same rendering provider number for the surgeon and assistant surgeon details when billing for a cesarean delivery.

If billing for assistant surgery services provided by a physician assistant, providers can bill the same rendering provider number for the surgeon and physician assistant surgery details. The detail for the physician assistant is billed with the AS modifier to indicate the service was provided by the physician assistant. The reimbursement for the physician assistant's services is 20% of the allowed amount for the cesarean delivery.

## ***Reimbursement for Long-Acting Reversible Contraception Implanted During Delivery Stays***

The IHCP allows separate reimbursement for certain long-acting reversible contraception (LARC) devices implanted during an inpatient hospital or birthing center stay for a delivery. For applicable Healthcare Common Procedure Coding System (HCPCS) codes, see *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

To receive separate reimbursement for LARC devices implanted during inpatient hospital or birthing center stays for delivery, the appropriate HCPCS code should be billed on a professional claim (*CMS-1500* claim form or electronic equivalent). Separate reimbursement applies to the LARC devices only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital diagnosis-related group (DRG) or the birthing center all-inclusive reimbursement amount.

For more information about LARC devices, see the [Family Planning Services](#) module.

## ***Birthing Centers***

Per *IC 16-18-2-36.5*, a birthing center is a licensed, freestanding entity, place, facility, or institution where a woman is scheduled to give birth following a normal, uncomplicated (low-risk) pregnancy. Under *IC 16-21-2*, this term does not include a hospital, an ambulatory surgical center, or the residence of the woman giving birth. The IHCP created provider type 08 – *Clinic* and provider specialty code 088 – *Birthing center* to identify freestanding birthing centers.

Birthing centers must be licensed by the Indiana State Department of Health (ISDH) before enrolling in the IHCP. Birthing centers are assigned to the limited risk category and are not required to pay an application fee during enrollment or revalidation (see the [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#) for non-waiver providers at indianamedicaid.com). Providers should refer to the [IHCP Provider Type and Specialty Matrix](#) at indianamedicaid.com for other enrollment criteria.

Facility charges are billed on an institutional claim (*UB-04* claim form or electronic equivalent). Birthing center claims must report billing provider taxonomy code 261QB0400X (birthing) on the claim. Outpatient, outpatient crossover, and outpatient encounter claims are applicable claim types.

Birthing centers are paid at an all-inclusive rate. The services are billed using revenue code 724 – *Birthing center*. Only vaginal deliveries should be billed with this revenue code. Reimbursement rates are based on the revenue code 724 when the member delivers. When labor occurs but does not result in delivery, providers should bill revenue code 724 along with HCPCS code S4005 – *Interim labor facility global (labor occurring but not resulting in delivery)*.

Professional services rendered at birthing centers are billed on a professional claim (*CMS-1500* claim form or electronic equivalent). Services rendered by the following rendering provider types and specialty are payable when performed at birthing centers:

- Rendering provider type 09 – *Advanced practice nurse* with rendering provider specialty 095 – *Certified nurse mid-wife*
- Rendering provider type 31 – *Physician*

Professional charges are reimbursed directly to the practitioner at the applicable reimbursement rate. Other staff services, such as services provided by registered nurses (RNs) and licensed nurse practitioners (LPNs), are included in the delivery rate and not separately reimbursed.

Birthing center services are to be billed with place-of-service code 25 – *Birthing center*.

## Abortion and Related Services

The IHCP uses the word *abortion* to describe the early termination of pregnancy. The IHCP does not consider termination of an ectopic pregnancy to be an abortion. There are two types of abortion:

- *Spontaneous abortion* (or *missed abortion*) occurs for no apparent reason during early pregnancy and requires treatment to ensure the health of the mother. The IHCP reimburses for therapeutic treatment of spontaneous or missed abortion, and services relevant to this treatment, according to the IHCP-allowable amount. Providers should follow the coding guidelines included in this section.
- *Elective abortion* is an abortion that a doctor performs because the mother has chosen to terminate the pregnancy. *IC 16-34-1-2* prohibits the State from making payment from any fund under its control for an elective abortion, unless the elective abortion is necessary to preserve the life of the pregnant woman or unless federal law requires the State to cover it, such as in the case of rape or incest. Elective abortions performed for any other reason are noncovered services according to *405 IAC 5-28-7*. Providers must adhere to the procedures described in the following section to obtain payment for an elective abortion.

## Documentation Requirements

For spontaneous abortions, the IHCP requires no documentation from providers billing with the appropriate treatment code and following the guidelines described in this document.

For elective abortions, the physician must specify in writing the physical condition of the patient leading to the professional judgment that the abortion was one of the following:

- Necessary to preserve the life of the pregnant woman
- Due to rape or incest

The documentation must contain the name and address of the member, dates of service, physician's name, and physician's signature. Providers must attach this documentation to the paper claim form, upload it to the Portal claim, or send it separately as an attachment to the electronic claim transaction (as described in the *Paper Attachments with Electronic Claims* section of the [Claim Submission and Processing](#) module). The IHCP must receive correct documentation with claims before it will make payment for the elective abortion or any directly related service. The primary service provider should forward copies of the physician certification to the related service provider to bill for these services.

If providers submit a claim with a diagnosis code or procedure code indicating that a possible elective abortion was performed, the IHCP requires documentation for claim payment consideration. The IHCP suspends these claims for review of medical documentation. For lists of diagnosis codes and procedure codes that suspend for appropriate documentation supporting medical necessity, see the following tables in *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com:

- *ICD-10 Abortion Diagnosis Codes That Suspend for Appropriate Documentation Supporting Medical Necessity*
- *CPT and HCPCS Abortion Procedure Codes That Suspend for Appropriate Documentation Supporting Medical Necessity*
- *ICD-10 Abortion Procedure Codes That Suspend for Appropriate Documentation Supporting Medical Necessity*

## ***Medical Abortion by Oral Ingestion of Medication***

The IHCP reimburses mifepristone and misoprostol for use in medical abortion procedures based on the same coverage criteria applicable to surgical abortions.

### **Coverage and Reimbursement**

Mifepristone is also known as RU-486. By blocking progesterone, which is necessary to establish and maintain placental attachment, mifepristone disrupts the attachment of a fertilized egg to the uterus. Mifepristone was approved by the FDA in 2000 for use in medical abortions. Danco Laboratories (Danco) is responsible for manufacturing, marketing, distributing, and monitoring FDA compliance in the use of mifepristone in the United States.

Danco requires all physicians ordering mifepristone to sign a provider agreement about their responsibilities in providing this medication. This agreement requires that physicians report to Danco complications related to the administration of mifepristone. Danco then submits the information to the FDA. In addition, Danco requires the patient to sign a patient agreement, which the provider maintains in the medical record.

Misoprostol is a prostaglandin that softens the cervix and creates uterine contractions to release the fetus. Misoprostol has FDA approval for treatment of ulcers and is commonly used in labor induction to thin, relax, and open the cervix. When used in combination with mifepristone, physicians must administer misoprostol orally in the physician's office.

The IHCP reimburses only the FDA-approved regimen for medically induced abortions using orally administered mifepristone and misoprostol. The IHCP does not reimburse what is commonly known as the *evidence-based* regimen for medical abortion with mifepristone and misoprostol, which includes at-home or vaginal administration of misoprostol.

The FDA-approved regimen for these medications is as follows:

- Recommended gestational age – 49 days from last menstrual period
- Mifepristone dose – 600 mg orally administered on day-one office visit
- Misoprostol dose – 400 mcg orally administered on day-three office visit
- Misoprostol timing – 48 hours after receiving mifepristone

## Billing

Providers must use HCPCS code S0190 – *Mifepristone, oral, 200 mg* to bill mifepristone and HCPCS code S0191 – *Misoprostol, oral, 200 mcg* to bill misoprostol.

Medical abortion by oral ingestion of mifepristone and misoprostol requires three separate office visits to complete the procedure. The following list shows the billing guidelines for these office visits and the medications provided during the office visits. Providers must bill all claims for medical abortion by oral ingestion of mifepristone and misoprostol on the professional claim (*CMS-1500* claim form or electronic equivalent).

- Day 1:
  - Member reviews and signs the Patient Agreement.
  - Provider orally administers three 200 mg tablets of mifepristone.
  - Provider bills HCPCS code S0190 – *Mifepristone, oral, 200 mg*, three units.
  - Provider bills the appropriate E/M code for the office visit.
- Day 3:
  - Provider checks pregnancy status with clinical examination or ultrasound exam.
  - If an ultrasound is performed, provider bills the appropriate code for the service provided.
  - Provider orally administers two 200 mcg tablets of misoprostol.
  - Provider bills HCPCS code S0191 – *Misoprostol, oral, 200 mcg*, two units.
  - Provider bills appropriate E/M code for the office visit.
- Day 14:
  - Provider verifies pregnancy termination with clinical examination or ultrasound exam.
  - Provider bills appropriate E/M code for the office visit.
  - If an ultrasound is performed, the provider bills the appropriate code for the service provided.

Confirmation of pregnancy status must occur before the Day 1 office visit. The Day 1 office visit must occur after the 18-hour counseling and waiting period required by *IC 16-34-2-1.1(a)(1)*.

The IHCP suspends claims for Day 1 and Day 3 office visits pending submission of required documentation. To be reimbursed for services, the IHCP requires providers to submit all necessary documentation with claims for these office visits, as described in the [Documentation Requirements](#) section.

In addition, medical abortion by oral ingestion of mifepristone and misoprostol requires submission of the signed *Prescriber's Agreement* and *Patient Agreement*. These agreements are available from Danco, and Danco requires their use. Providers must attach documentation to the paper claim form, upload them to the Portal claim, or send them separately as an attachment to the electronic claim transaction (as described in the *Paper Attachments with Electronic Claims* section of the [Claim Submission and Processing](#) module). If providers fail to submit this documentation, the IHCP must deny the claims.

## Hysterectomy

The IHCP provides coverage for a medically necessary hysterectomy performed to treat an illness or injury. The IHCP does not cover a hysterectomy performed solely to render a member permanently incapable of bearing children, whether performed as a primary or secondary procedure. For information about sterilization services, see the [Family Planning Services](#) module.

Hysterectomy procedures must comply with *Code of Federal Regulations 42 CFR 441.250-441.259* and with *405 IAC 5-28-9*. Hysterectomy is subject to prior authorization.

## Informed Consent and Acknowledgement Statement for Hysterectomies

The IHCP covers hysterectomy **only** when medically necessary, and **only** when the member has given informed consent. The provider must have informed the member orally and in writing that the procedure will render the member permanently incapable of reproducing, and the member must have signed a written acknowledgement of receipt of that information.

The member or member's representative must sign an informed consent or acknowledgement, except when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible. However, the physician who performs the hysterectomy under these circumstances must complete the following requirements:

- Certify in writing that the individual was already sterile at the time the hysterectomy was performed.
- State the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a life-threatening emergency in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Claims billed with the CPT or ICD-10 procedure codes for hysterectomy services, shown in the *CPT Procedure Codes for Hysterectomy* and *ICD-10 Procedure Codes for Hysterectomy* tables in the *Obstetrical and Gynecological Services Codes* on the [Code Sets](#) page at indianamedicaid.com, require a document that includes the information necessary to satisfy documentation and certification requirements for hysterectomies, as shown in the example in [Figure 1](#). **Providers cannot use the *Consent for Sterilization* form for hysterectomy procedures under any circumstances.**

Providers must attach the appropriate documentation to the paper claim form, upload it to the Portal claim, or send it separately as an attachment to the electronic claim transaction (as described in the *Paper Attachments with Electronic Claims* section of the [Claim Submission and Processing](#) module). All providers of hysterectomy-related services must attach a photocopy of the appropriate acknowledgement or physician certification to the claim. This requirement extends to all providers: attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services. The primary service provider should forward copies of the acknowledgement or physician certification statement to the related service providers to ensure timely payment.

## Retroactive Eligibility for Hysterectomies

In accordance with *42 CFR 441.255*, the IHCP pays for hysterectomies performed during an individual's retroactive eligibility if the physician who performed the hysterectomy certifies one of the following in writing:

- The physician informed the individual before the operation that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy.
- The individual required a hysterectomy because of a life-threatening emergency. The physician determined that prior acknowledgement was not possible, and the physician who performed the hysterectomy did one of the following:
  - Certified in writing that the individual was already sterile at the time of the hysterectomy, and stated the cause of the sterility
  - Certified in writing that the hysterectomy was performed under a life-threatening emergency situation and prior acknowledgement was not possible, and included a description of the nature of the emergency

For more information about retroactive eligibility, see the [Member Eligibility and Benefit Coverage](#) module.

Figure 1 – Example of *Acknowledgement of Receipt of Hysterectomy Information*

<b>Acknowledgement of Receipt of Hysterectomy Information</b>	
Member Name: _____	
IHCP Member ID: _____	
Physician Name: _____	
NPI or IHCP Provider ID: _____	
AMA Education Number: _____	
It has been explained orally and in writing to _____ that the hysterectomy to be performed on her will render her permanently incapable of bearing children.	
<input type="checkbox"/> Signed before surgery	
<input type="checkbox"/> Signed after surgery (at the time of the hysterectomy, eligibility was not established).	
_____	_____
(Member or Representative Signature)	(Date)
<b>Physician Statement</b>	
The hysterectomy in the above case is being done for medically necessary reason(s), and the resulting sterilization is incidental and is not, at any time ever, the reason for this surgical operation.	
Diagnosis(es)	
_____	
_____	_____
(Physician Signature)	(Date)