

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201976 DECEMBER 26, 2019

Note: A correction to this bulletin was made in IHCP Banner Page [BR202008](#): IHCP corrects updates to obstetrical and gynecological services policies

IHCP announces updates to obstetrical and gynecological services policies

Effective January 26, 2020, the Indiana Health Coverage Programs (IHCP) will update its policies for high-risk pregnancy, prior authorization (PA) for total or supracervical hysterectomies, and early elective deliveries.

These updates will be reflected in the next annual update to the [Obstetrical and Gynecological Services](#) provider reference module at in.gov/medicaid/ providers.



Additional changes to high-risk pregnancy services

As explained in *IHCP Bulletin* [BT201956](#), the IHCP amended the policy regarding high-risk pregnancy services. The bulletin stated that the IHCP will reimburse for high-risk pregnancy care when provided by a physician or an advanced practice registered nurse (APRN).

Effective January 26, 2020, the IHCP will reimburse for high-risk pregnancy care when provided by a **physician assistant** as well. For dates of service (DOS) on or after January 26, 2020, the IHCP will reimburse for high-risk pregnancy care when provided by physicians, APRNs, or physician assistants. Services must be deemed medically necessary or as preventive healthcare services, and provided within the scope of the applicable license and certification.

Physician assistants who are employed by physicians or are working in a physician-directed group or clinic under the supervision of a physician should bill using the physician's National Provider Identifier (NPI) as the rendering provider and include the appropriate modifier to indicate that a physician assistant performed the services.

PA for total or supracervical hysterectomy

The IHCP is revising its PA criteria for hysterectomies. Effective January 26, 2020, PA for total or supracervical hysterectomies will be granted for members with documentation supporting one of the following:

- Nonmalignant uterine tumor causing one of the following:
 - Enlarged uterus, with ill-defined adnexa
 - Postmenopausal enlargement with or without symptoms
 - Rapid uterine growth over the last 6 months
 - Pressure on adjacent organs
 - Abnormal bleeding (lasting longer than 8 days for more than two cycles, requiring additional bleeding protection, defined as large clots and gushes, limiting activity)
- Cervical intraepithelial neoplasia (CIN) III, diagnosed by cervical biopsy and/or endocervical curettage and confirmed by excisional biopsy (to exclude invasive disease), including cold knife conization, loop electrosurgical excision procedure (LEEP), large loop excision of the transformation zone (LLETZ), or loop surgical excision

- Fibroids in premenopausal woman with uterus greater than 12 weeks' gestational size or documentation of need for abdominal rather than vaginal approach; and one of the following:
 - Abnormal bleeding
 - Uterus size doubled within 1 year
 - Ureteral compression diagnosed by appropriate imaging modalities (for example, ultrasound, intravenous pyelogram [IVP], computerized tomography [CT] scan)
 - Other symptoms, such as urinary frequency or urgency, dyspareunia, or pelvic or abdominal pain or discomfort without other explanation
- Fibroids in postmenopausal woman with uterus greater than 12 weeks' gestational size or documentation of need for abdominal rather than vaginal approach; and one of the following:
 - Uterus size doubled within any time period
 - Ureteral compression diagnosed by appropriate imaging modalities (for example, ultrasound, IVP, CT scan)
 - Other symptoms, such as urinary frequency or urgency, dyspareunia, or pelvic or abdominal pain or discomfort without other explanation
 - Normal Pap or human papillomavirus (HPV) testing within 3 years
- Dysfunctional uterine bleeding in premenopausal woman with all of the following:
 - Abnormal bleeding uncontrolled by conservative therapy, such as hormonal therapy
 - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, or dilation and curettage (D&C)
 - No detectable structural or anatomic cause for the bleeding
 - Normal Pap or HPV testing within 3 years
- Postmenopausal bleeding (defined as bleeding more than 1 year after last menstrual period [LMP]) with all of the following:
 - Abnormal bleeding continued after change in or discontinuation of hormone replacement therapy, if previously used
 - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, or D&C
 - No detectable structural or anatomic cause for the bleeding
 - Normal Pap or HPV testing within 3 years
- Pelvic inflammatory disease (PID) with one of the following:
 - Suspected rupture or leakage of pelvic abscess
 - Unsuccessful management with antibiotics for 10 to 14 days
 - Surgery for residual, inactive but symptomatic disease, if conservative therapy is not possible
- Chronic PID with both of the following:
 - Chronic pelvic pain
 - Adhesions, scarring, or hydrosalpinx
- Recurrent abnormal uterine bleeding (lasting longer than 8 days for more than two cycles, requiring additional protection, defined as large clots and gushes, with limitations of normal activity) and benign endometrial biopsy after failed medication therapy – excluding members on birth control pills or those with intrauterine devices (IUDs)



- Chronic, incapacitating pelvic pain that is unresponsive to conservative therapy, such as analgesics, and evidence of normal gastrointestinal (GI)/genitourinary (GU) evaluations, as exhibited by the following:
 - A 4-to-6-month failed trial of oral contraceptives, diuretics, anti-inflammatories, or induced amenorrhea
 - Negative examinations of urinary tract (UT), GI tract, and musculoskeletal system
 - No etiology of pain revealed in psychological counseling
- Benign or malignant ovarian tumor or cyst in postmenopausal (more than 1 year) women
- Uncontrolled postpartum bleeding within 6 weeks of delivery, uncontrolled by drug therapy (for example, Pitocin, Methergine, or prostaglandin therapy) or D&C
- A diagnosis of placenta accreta, increta, or percreta
- Endometriosis uncontrolled by hormonal therapy (for example, depot medroxyprogesterone, oral contraceptives, gonadotropin-releasing hormone [GnRH] agonist, or danazol), surgical ablation, or excision
- Tubo-ovarian abscess
- Urinary or fecal incontinence due to fistula into vagina, uterus, perineum, or rectum; and fistula demonstrated by cystoscopy, proctoscopy, radiological examination, visual inspection, or probing
- Uterine prolapse, stage or grade 2 or higher, and one of the following:
 - Pain
 - Pelvic pressure
 - Stress incontinence
 - Ulceration of vaginal mucosa or cervix with bleeding or spotting
 - Vaginal splinting



The revised criteria above will replace the previously published criteria for total or partial hysterectomies.

Early elective deliveries

Effective for DOS on or after January 26, 2020, the IHCP will add the following conditions to the list of medical indications for a medically necessary delivery prior to 39 weeks of gestation (see [Table 1](#)):

- Prior uterine rupture
- Alloimmunization
- Intrahepatic cholestasis of pregnancy

For IHCP coverage of a delivery prior to 39 weeks' gestation, one of the approved medical indications in Table 1 must be present. The medical indications in Table 1 are compiled from lists released by the Indiana Perinatal Quality Improvement Collaborative (IPQIC), American College of Obstetricians and Gynecologists (ACOG), and the Joint Commission. This comprehensive list of medical indications is intended to ensure that all medically indicated deliveries prior to 39 weeks remain covered. The IHCP will continue to evaluate the list of approved medical indications to ensure that all medically necessary indications are covered.

For all early deliveries, documentation 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](#) at [acog.org](#) or the *IPQIC Scheduling* form on the [ISDH website](#) at [in.gov](#).

Providers are reminded that the IHCP does not cover early elective deliveries (EEDs), defined as deliveries performed prior to 39 weeks and 0 days gestation without medical indication. The IHCP does not reimburse for delivery Current Procedural Terminology (CPT^{®1}) codes submitted with the UA modifier, signifying deliveries at less than 39 weeks of gestation that do not meet the IHCP's stated guidelines for approved medically necessary deliveries. Additionally, the IHCP does not reimburse institutional claims submitted with condition code 82, signifying an elective C-section or induction performed at less than 39 weeks of gestation. This EED policy applies to all IHCP programs.

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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	Member presenting in labor
Chronic hypertension	Abnormal fetal heart rate	Abruptio placenta
Cardiovascular diseases	Chorioamnionitis	Abruption
Chronic pulmonary disease	Congenital heart defect/heart disease	Alloimmunization
Coagulopathy defect	Fetal abnormality	Antepartum hemorrhage/bleeding
Coagulopathy disorders	Fetal chromosomal anomaly	Chronic hypertension with super imposed preeclampsia
Congenital heart defect/heart disease	Fetal central nervous system (CNS) anomaly	Chorioamnionitis
Current cancer	Fetal damage due to disease	Intrahepatic cholestasis of pregnancy
Diabetes mellitus	Fetal damage due to drugs	Gestational diabetes
Epilepsy/seizure disorder	Fetal damage due to radiation	Gestational hypertension
Gastroenteric diseases/disorders	Fetal damage due to virus	Hypertensive disorder
Hematological disorder	Fetal demise-singleton	Increta
Human immunodeficiency virus (HIV); asymptomatic HIV infection status	Fetal distress	Maternal/fetal hemorrhage
Hypertension nonspecified	Fetal/maternal hemorrhage	Mild preeclampsia
Liver disease	Intrauterine growth restriction	Severe preeclampsia/HELLP/eclampsia
Maternal/fetal hemorrhage	Nonreassuring fetal antepartum testing	Multiple gestation
Previous stillborn	Rh isoimmunization	Multiple gestation with loss
Prior classical cesarean delivery		Oligohydramnios
Prior myomectomy entering endometrial cavity		Percreta
Prior uterine rupture		Placenta accreta
Renal disease		Placenta previa
		Placental previa hemorrhage
		Polyhydramnios
		Premature rupture of membranes
		Prolonged rupture of membranes
		Ruptured membranes
		Unstable lie; multiple gestation with malpresentation

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Note: Only the following medical indications in Table 1 are newly approved, effective for claims with DOS on or after January 26, 2020:

- *Prior uterine rupture*
- *Alloimmunization*
- *Intrahepatic cholestasis of pregnancy*

All other medical indications in Table 1 were previously approved.

For managed care questions

Information described in this bulletin applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish PA, reimbursement, and billing criteria within the managed care delivery system. Questions regarding prior authorization, reimbursement, and billing for obstetrical and gynecological services for members in the Healthy Indiana Plan (HIP), Hoosier Healthwise, and Hoosier Care Connect should be referred to the managed care entity (MCE) with which the member is enrolled.

QUESTIONS?

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