Section 2

Women's Services

Services for Pregnant Women, Certified Nurse-Midwife Services, and Birthing Center Hospital Services

Table of Contents

Introduction 3
Fee-for-Service or Managed Care 3
Member Eligibility 3
Procedure Codes 4
Billing 4
Prior Authorization 4
References 4
Part I - Services for Pregnant Women 5
1 General Information 5
1-1 General Policy 5
1-2 Fee-for-Service or Managed Care 5
1-3 Definitions 5
1-4 Procedure Codes 5
2 Provider Participation Requirements 5
2-1 Provider Enrollment 5
2-2 Credentials 5
3 Member Eligibility 6
4 Program Coverage 6
4-1 Covered Services 6
4-2 Services by Physician, Certified Family Nurse Practitioner, and Certified Nurse-Midwife 10
5 Non-Covered Services and Limitations 13
6 Billing 13
6-1 Prior Authorization 13
Part II - Certified Nurse-Midwife Services 14

1 General Information 14
1-1 General Policy 14
1-2 Fee-for-Service or Managed Care 14
1-3 Definitions 14
2 Provider Participation Requirements 14
2-1 Provider Enrollment 14
2-2 Credentials 14
3 Member Eligibility 14
4 Program Coverage 15
4-1 Covered Services 15
5 Non-Covered Services and Limitations 15
5-1 Non-Covered Services 15
5-2 Limitations 16
6 Billing 16
Part III - Birthing Center - Hospital Services 17
1 General Information 17
1-1 General Policy 17
1-2 Fee-for-service or managed care 17
1-3 Definitions 17
2 Provider Participation Requirements 18
2-1 Provider Enrollment 18
3 Member Eligibility 18
4 Program Coverage 18
4-1 Covered Services 18
5 Non-Covered Services and Limitations 19
5-1 Non-Covered Services 19
5-2 Limitations 19
6 Billing 19
6-1 Prior Authorization 20
Index 21

Introduction

This manual is divided into three parts: Services for Pregnant Women, Certified Nurse-Midwife Services and Birthing Center. The manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*) and the *Physician Services Utah Medicaid Provider Manual*.

Fee-for-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid beneficiaries. A Medicaid member enrolled in an MCP (health, behavioral health, or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid Member Services hotline at 1(844)238-3091 for further information.

Refer to the provider manual, *Section I: General Information*, for information regarding MCPs.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid beneficiary enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a beneficiary enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a beneficiary's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a beneficiary before providing services. *Therefore, if a Medicaid beneficiary is enrolled in a plan, a fee-for-service claim will not be paid unless the claim is for a "carve-out service"*. Eligibility and plan enrollment information for each beneficiary is available to providers from several sources.

Eligibility and plan enrollment information for each member is available to providers from these sources:

- The Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility
- AccessNow: (800) 662-9651
- Member Services hotline at (844) 238-3091

Member Eligibility

A Medicaid beneficiary is required to present the Medicaid Member Card before each service, and every provider must verify each beneficiary's eligibility each time and before services are rendered. For more information regarding verifying eligibility refer to the provider manual, *Section I: General Information, Verifying Medicaid Eligibility*.

Procedure Codes

Effective January 1, 2013, most procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov.

Billing

Visits may be billed by the provider or by the agency employing the provider either electronically or on paper, according to CMS standards.

Further billing instructions are found in the provider manual, *Section I: General Information*.

Prior Authorization

Prior authorization may be required for certain services. Failure to obtain prior authorization may result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the beneficiary is retro-eligible for the dates of service requested.

Prior authorization (PA) information is provided in the provider manual, *Section I: General Information.* Code specific coverage and prior authorization requirements are provided on the Medicaid website, Coverage and Reimbursement Lookup Tool at: https://medicaid.utah.gov.

References

Current Procedural Terminology (CPT Manual) *(including procedure codes, nomenclature, descriptions and other data contained therein), copyright American Medical Association. All rights reserved.*

Social Security Act 1891(gg) and 42 CFR 440.165.

Part I - Services for Pregnant Women

1 General Information

1-1 General Policy

The services described in this section are available to pregnant women eligible for Medicaid or for the Presumptive Eligibility (PE) Program. These services are in addition to those normally provided in uncomplicated maternity cases as defined in *Current Procedural Terminology* (CPT) and in addition to Certified Nurse-Midwife (CNM) services listed in the CNM section of this manual.

1-2 Fee-for-Service or Managed Care

Refer to the Introduction of this Manual for Fee-for-Service or Managed Care information.

1-3 Definitions

There are no definitions specific to Part I.

1-4 Procedure Codes

Refer to the Introduction of this Manual for Fee-for-Service or Managed Care information.

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to the provider manual, Section I: General Information, for provider enrollment information.

2-2 Credentials

To be eligible for Medicaid reimbursement for services described in *Chapter 4, Covered Services*, the provider must be qualified as described in this chapter and enrolled with the Utah Medicaid Program.

Required qualifications:

Certified Family Nurse Practitioner
Must be currently licensed in accordance with the Nurse Practice Act of the State of Utah.

Certified Nurse-Midwife
Must be currently licensed in accordance with the Certified Nurse Midwifery Practice Act of the State of Utah.

Certified Pediatric Nurse Practitioner
Must be currently licensed in accordance with the Nurse Practice Act of the State of Utah.

Certified Social Worker

Must have a minimum of a Master's Degree in Social Work and currently licensed according to the Social Work Licensing Act of the State of Utah.

Licensed Practical Nurse (LPN)
Currently licensed in accordance with the Nurse Practice Act of the State of Utah. Additional training and experience required to meet the expectations for a Perinatal Care Coordinator and must work under the supervision of a registered nurse.

Registered Dietitian (RD)
Must be currently licensed in accordance with the Dietitian Practice Act of Utah.

Registered Nurse (RN)
Currently licensed in accordance with the Nurse Practice Act of the State of Utah.

Social Service Worker
A minimum of a Bachelor's Degree in Social Work and currently licensed according to the Social Work Licensing Act of the State of Utah.

3 Member Eligibility

Refer to the Introduction of this Manual for member eligibility information.

4 Program Coverage

4-1 Covered Services

Enhanced services

Enhanced services include perinatal care coordination, prenatal and postnatal home visits, group prenatal and postnatal education, nutritional assessment and counseling, and prenatal and postnatal psychosocial counseling.

4-1.1 Perinatal Care Coordination

The referral for enhanced services must be made by the beneficiary's Perinatal Care Coordinator or prenatal care provider. Medicaid covers enhanced services up to the end of the month in which the date 60-days post-delivery occurs. Providers should encourage beneficiaries who have not applied for Medicaid benefits to do so.

The Baby Your Baby web site is a resource available to providers and beneficiaries. (www.babyyourbaby.org)

4-1.2 Perinatal Care Coordination

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psychosocial, nutritional, educational and other services for the pregnant woman.

Perinatal care coordination services are available to the pregnant woman throughout pregnancy and up to the end of the month in which the sixty days following pregnancy ends.

This coordination process requires the skill and expertise of professionals who have broad knowledge of perinatal care, interviewing and assessment techniques, alternative community resources, and referral systems required to develop an individual service plan.

The Perinatal Care Coordinator serves as a liaison between beneficiaries and individuals or agencies involved in providing care, as a contact person for the beneficiary and family, and as a resource to prepare and counsel the beneficiary regarding essential services which are determined necessary and scheduled for the beneficiary.

Needs of pregnant women are individual and influenced by varying medical, personal, socioeconomic and psychosocial factors. A plan of care with intervention(s) to meet identified needs or resolve problems may be indicated on a limited, intermediate, or comprehensive basis. The initial assessment made by the Perinatal Care Coordinator will be the basis for determining the level of care and the extent of coordination and monitoring necessary for each individual.

Monitoring of the individual plan of services by the Perinatal Care Coordinator is essential to minimize fragmentation of care, reduce barriers, link beneficiaries with appropriate service and assure that services are provided consistent with optimal perinatal care standards.

Monitoring involves contact with the beneficiary through clinic visits, home visits, or telephone contact. A contact is a covered service when it results in the beneficiary gaining access to an essential service identified through the contact. Monitoring includes a contact resulting in assessment, planning of care and services, and reevaluation of the plan of care. Monitoring may also include consultation with care providers to assess the need for further follow up or coordination and arrangement of necessary services.

The number, duration, scope and interval between contacts will vary among beneficiaries and even across one beneficiary's pregnancy. At a minimum, contacts, including telephone contacts with the beneficiary, must include: assessment and documentation of current physical, psychosocial, socioeconomic, and nutritional status. Follow up on the outcome of previous referrals must be included along with documentation of any referrals arranged for additional services. Anticipatory guidance regarding pregnancy and parenting must also be documented.

A record of contacts made with the beneficiary or with providers on behalf of the beneficiary, and services arranged or provided by the Perinatal Care Coordinator is documented and maintained in the medical record, and typically includes:

- Name of recipient
- Date of service
- Name of provider agency and person providing the service
- Place of service
- Intake assessment
- An individualized care plan, including risk factors and proposed referrals
- Documentation of current physical, psychosocial, socioeconomic, and nutritional status
- Documentation of new referrals and outcome of previous referrals
- Documentation of anticipatory guidance regarding pregnancy and parenting
- Changes made to the care plan indicated through contact with the beneficiary or providers

Perinatal Care Coordination Service Providers must be a licensed provider in Utah and one of the provider types listed below.

- Registered Nurse
- Certified Nurse-Midwife
- Certified Family Nurse Practitioner
- Social Service Worker
- Certified Social Worker
- Licensed Practical Nurse

The provider bills either electronically or on paper, according to CMS standards. The service is reimbursed monthly, based on a maximum of four - 15 minute time units, regardless of the number or duration of contacts during the 30-day billing cycle.

4-1.3 Prenatal and Postnatal Home Visits

Home visits can be included in the management plan of pregnant beneficiaries when there is a need to assess the home environment and its implications for the management of prenatal and postnatal care; to provide direct care; to encourage regular visits for prenatal care; to provide emotional support; and to determine educational needs.

Each home visit is documented in the beneficiary's record and typically includes:

- Date and purpose of the visit
- Provider or agency making the visit
- Evaluation of the physical environment
- Interactions among household members noted during the visit
- Findings of the physical evaluation of mother and/or baby, if indicated
- Lactation support
- Referrals or recommendations for continuing care, and
- Signature of the individual making the visit.

Medicaid limits prenatal and postnatal home visits to a total of six (6) during any 12-month period (Post payment review). Visits may be provided by one of the following qualified providers, as described in *Chapter 2-1, Credentials*.

- Perinatal Care Coordinator
- Registered Nurse employed by a Certified Home Health Agency or Community Health Agency
- Certified Nurse-Midwife
- Certified Family Nurse Practitioner
- Certified Pediatric Nurse Practitioner
- Licensed Practical Nurse (as of 7/01/95).

4-1.4 Group Prenatal and Postnatal Education

Group prenatal and postnatal education is classroom learning experience for the purpose of improving the knowledge of pregnancy, labor, childbirth, parenting and infant care. The objective of this planned educational service is to promote informed self-care, to prevent development of conditions which may complicate pregnancy, and to enhance early parenting and child care skills. This service includes printed material and/or instructional media. Classes are limited to 10 couples or 20 individuals per qualified

instructor. Group education is limited to eight (8) units during any 12-month period (Post payment review). One unit is one class at least one hour in length.

Group Education may be provided by one of the following qualified providers as described in *Chapter 2-1, Credentials* of this manual.

- Registered Nurse
- Certified Nurse-Midwife
- Certified Family Nurse Practitioner
- Certified Pediatric Nurse Practitioner
- An individual with current certification by one of the following organizations:
  - International Childbirth Education Association (ICEA)
  - Association for Psychoprophylaxis in Childbirth Instructor Preparation/Lamaze Instructor Preparation Program (ASPO/Lamaze)
  - Bradley Instructor Preparation Program
  - Birth Educators Special Training Course (BEST)
  - University of Utah, College of Nursing Childbearing Year Instructor Preparation Class

4-1.5 Nutritional Assessment and Counseling

Nutritional assessment and counseling is an individually designed service which provides an assessment of the pregnant women's nutritional needs and food patterns, and the planning for the provision of food and drink appropriate for the pregnant woman's conditions, or the provision of nutrition education, and counseling to meet normal and therapeutic needs.

In addition, these services may include:

- Assessment of nutritional status and food preferences
- Planning for the provision of appropriate dietary intake within the recipient's home environment and cultural considerations
- Nutritional education regarding therapeutic diets as part of the development of a nutritional treatment plan
- Regular evaluation and revision of nutritional plans

All pregnant beneficiaries are referred by the Perinatal Care Coordinator to the Women, Infants and Children Nutritional Program (WIC) for the initial nutritional assessment and counseling. No additional payment is made for this service.

The WIC program may refer some woman to a Registered Dietitian. This referral would be for a woman with complex nutritional or related medical risk factors, who may require intensive nutrition education, counseling, monitoring and frequent consultations beyond the scope of service of the WIC program.

Medicaid allows 2 nutritional counseling visits to be provided by a Registered Dietitian or qualified provider. In addition, Medicaid limits nutritional counseling for pregnant women by a Registered Dietician to a maximum of fourteen (14) units during any 12-month period. (One unit equals one-half hour). The 14 nutritional units are to be billed under code S9470. The clients individual nutritional plan must be documented in the beneficiary's record (Post payment review).

4-1.6 Prenatal and Postnatal Psychosocial Counseling

Psychosocial evaluation is provided as a prenatal and postnatal service to identify beneficiaries and families with high psychological and social risk. The professional providing the service must document each visit, develop a psychosocial care plan and provide or coordinate appropriate intervention, counseling or referral necessary to meet the identified needs of each family.

Medicaid limits this counseling to ten (10) units during any 12 month period. A unit is a therapeutic exchange between beneficiary and therapist lasting 20 to 50 minutes (Post payment review).

Counseling may be provided by one of the following licensed Medicaid providers.

- Licensed Clinical Social Worker
- Clinical Psychologist
- Marriage and Family Therapist

4-2 Services by Physician, Certified Family Nurse Practitioner, and Certified Nurse-Midwife

4-2.1 Risk Assessment

Risk assessment is the systematic review of relevant beneficiary data to identify potential problems and determine a plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contributes significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality.

A care plan for high risk beneficiaries, in addition to standard care, includes referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the particular risk factor(s) involved. A care plan for low risk beneficiaries includes primary care services and additional services specific to the needs of the individual.

The provider completing the risk assessment must use consultation standards and be consistent with the Utah Medical Insurance Association guidelines.

Medicaid limits risk assessment to two assessments during any 10-month period. One assessment should occur at intake and another at 36-38 weeks gestation or earlier as problems arise. Document the assessment in the patient's record and indicate whether the beneficiary is determined to be low or high risk (Post payment review).

Risk assessment may be provided by a physician, Certified Nurse-Midwife, or Certified Family Nurse Practitioner, as described in *Chapter 2-1, Credentials*.

4-2.2 Prenatal Assessment Visit (Initial Visit Only)

A prenatal assessment visit is a single prenatal visit for a new beneficiary. The initial visit provides an in-depth evaluation of a beneficiary with a confirmed pregnancy. This procedure requires the collection of medical data and the assessment of the beneficiary's current mental and physical condition. This service includes family history, past medical history, personal history, system review, a complete physical

examination, the ordering of appropriate diagnostic tests and procedures, development of the medical record and initiation of a plan of care.

Medicaid limits the prenatal assessment visit to one visit in any 10-month period (Post-payment review).

This service can be billed only when the beneficiary is referred immediately to a community practitioner or lost to follow-up because the beneficiary does not return. This service cannot be billed when complete antepartum, delivery and postpartum services are provided by the same provider. (The assessment visit is included in the global fee.)

Service may be provided by a physician, Certified Nurse-Midwife, or Certified Family Nurse Practitioner, as described in *Chapter 2-1, Credentials*.

4-2.3 Single Prenatal Visit(s) Other than Initial Visit

A single prenatal visit other than the initial visit is a single prenatal visit for an established beneficiary who does not return to complete care for unknown reasons. The initial assessment visit was completed, a plan of care established, one or two follow-up visits completed, without further care provided.

Medicaid limits this service to a maximum of 3 visits in any 10-month period. The service may be billed only when the beneficiary is lost to follow up for any reason. This service cannot be billed when complete antepartum, delivery and postpartum services are provided by the same provider. (The visits are included in the global fee.) (post payment review)

Service may be provided by a physician, Certified Nurse-Midwife, or Certified Family Nurse Practitioner, as described in *Chapter 2-1, Credentials*.

4-2.4 Total Maternity Care

Total maternity care includes ALL services normally provided in uncomplicated maternity cases during the period of pregnancy. Services include the initial visit, antepartum care, labor, delivery and postpartum care as defined below. These may not be billed as separate services.

Antepartum care
Antepartum care includes usual prenatal services. The initial visit must be included as part of antepartum care and not billed as a separate service. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical analysis, hematocrit, maternity counseling, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Also included is the treatment of routine complaints that accompany almost every pregnancy including, but not limited to, nausea, vomiting, backache, headache, cystitis, malaise, mild anemia, etc.

Labor and delivery services
Labor and delivery services include admission to the hospital, admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy and with or without forceps or breech delivery), cesarean section delivery, and resuscitation of newborn infant when necessary.

Postpartum care

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, a six-week postpartum visit, and obtaining a Pap smear. Medicaid covers postpartum services up to the end of the month in which the 60 days post-delivery occurs.

Laboratory work

Laboratory work, such as hematocrit and urinalysis, provided during routine visits is included in the total global care fee. Non-routine laboratory work and other antepartum and postpartum diagnostic services for which there is medical indication can be charged and billed separately or as a laboratory "profile" by the direct provider of service (laboratory). Non-routine tests include but are not limited to blood group and RH, antibody screen for irregular antibodies, rubella titer, varicella titer, cervical cytology, Hepatitis B, HIV, serology for syphilis, GC culture, Chlamydia culture, TSH and CBC with Differential.

Complications of pregnancy

When complications or risk factors pose a risk significant enough to compromise the pregnancy, the mother or the fetus during the prenatal, labor, or delivery period, and warrant consideration for additional payment the follow must be completed:

- Provide detailed documentation of the circumstances
- Submit the risk assessment form for billing to assure payment for services

Billing for the standard risk assessment must be received before a high risk delivery can be billed. To warrant consideration for additional payment, such complications should be of major significance, separately identifiable by an ICD-9-CM or ICD-10-CM diagnosis code, requiring separate and distinct therapy from the routine services of pregnancy, and be clearly identified in the record.

4-2.5 Global Maternity Care - Physicians

Global maternity care includes the initial visit, antepartum care, labor, delivery and postpartum care services as defined in *Chapter 4-2.4, Total Maternity Care* in this manual.

Note: Rural physicians are paid an additional 12% fee on any of these codes billed.

4-7.6 High Risk Pregnancy Services

High risk pregnancy global care services are provided by physicians according to the Utah Medical Insurance Association guidelines. In addition to the codes for Maternity Care found in the CPT Manual, H1001, Risk Assessment is also available for use. This code may be billed twice per pregnancy.

Additional applicable global high risk services are to be appended with a 22 modifier.

4-2.7 Global Maternity Care - Certified Nurse Midwives

Global maternity care includes the initial visit, antepartum care, labor, delivery and postpartum care services as defined in *Chapter 4-7.4, Total Maternity Care*.

Even when a Certified Nurse Midwife cares for some psychosocially or demographically high risk women according to written agreements with consulting physicians and admitting hospitals, they receive the regular global fee payment.

5 Non-Covered Services and Limitations

For non-covered services and limitations refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov.

6 Billing

Refer to the provider manual, *Section I: General Information,* for detailed billing instructions.

6-1 Prior Authorization

Refer to the introduction of this manual for prior authorization information.

Part II - Certified Nurse-Midwife Services

1 General Information

1-1 General Policy

Services of a Certified Nurse-Midwife are provided to women eligible for or receiving Medicaid. The services are available to the extent that the nurse-midwife is authorized to practice under state law or regulation at Utah Code Annotated Title 58-44a. Direct reimbursement is available to the midwife as a payment option.

1-2 Fee-for-Service or Managed Care

Refer to the introduction to this manual for the Fee-for-Service or Managed Care information.

1-3 Definitions

There are no definitions specific to Part II.

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to the provider manual, *Section I: General Information,* for provider enrollment information.

2-2 Credentials

To be eligible for Medicaid reimbursement for services described in *Chapter 4, Covered Services*, the provider must be qualified as described in this chapter and enrolled as a Utah Medicaid provider.

Required qualifications:

Certified Nurse-Midwife (CNM) must be

- Currently licensed to practice in the state as a registered professional nurse;
- Legally authorized by the state or regulations to practice as a nurse-midwife; and has successfully completed a program of study and clinical experience for nurse midwives, as specified by the state.

Nurse-Midwife services are services within the scope of practice authorized by state law for the nurse-midwife to include care for women during the maternity cycle and care for women's health problems beyond the maternity cycle. Services also include care for the infant through the first year of life.

3 Member Eligibility

Refer to the Introduction of this Manual for member eligibility information.

4 Program Coverage

Refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov for additional covered services information.

4-1 Covered Services

Ambulatory, non-institutional type services directed toward management of health care for women and infants are covered services for the CNM. Some limited inpatient services, related to labor and delivery are covered if authorized in hospital policy. CPT codes will be used by the CNM to code and bill for services provided. To account for program utilization and differentiate between CNM services and physician services, editing will be done with the designated provider type.

Laboratory Procedures

Laboratory procedures must be provided in compliance with CLIA laboratory guidelines, and based on the status of the laboratory and the certification obtained. This applies to all office labs.

Medicaid policy for laboratory services states that the laboratory performing the test must bill Medicaid directly for the service. A provider cannot send a specimen to a laboratory, bill Medicaid for the test, and pay the laboratory.

Newborn Screening

Newborn screening (36) tests sponsored through the state laboratory are covered under the hospital DRG.

On occasion, an infant may be born in a non-clinical setting. The code S3620 submitted with the BL modifier is to be used by certified nurse midwives or clinics to bill for the state laboratory newborn screening kit when the procedure is completed outside of a hospital setting. The state laboratory newborn screening kit code includes the initial lab tests and a follow-up test about two weeks from birth. The venipuncture code may be billed in addition to S3620 - BL.

Rural Services

Services performed in rural areas will be reimbursed 12% higher than the regular fee for global maternity care. The higher fee is available only when the CNM practices or travels to the rural setting. Payment is based on the place of service.

5 Non-Covered Services and Limitations

5-1 Non-Covered Services

For non-covered services in addition to those listed below, refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov.

- Infertility diagnosis or therapy
- Pre-pregnancy counseling
- Premenstrual syndrome care

- Routine, preventive medicine obstetrics
- Certified Nurse Midwife consultations, especially where risk to a patient is involved. This is a physician service

5-2 Limitations

Certified Registered Nurse Midwives must work within their scope of licensure and in association with an Obstetrician/Gynecologist or other physician to whom they refer patients with high risk conditions or complications.

Additional limitations:

- Pap smear is not a separate billable service, but is considered as part of an office call. The laboratory completing the service bills for the service.
- Problems encountered during pregnancy must not be billed as separate services unless they are severe, unusual complications and require specific separate therapy which can be coded with a specific diagnosis code.
- All office calls must be related to a specific, identifiable service in relation to a medical condition which can be coded using an appropriate ICD-9-CM or ICD-10-CM diagnosis code.

Emergency services only beneficiaries - services for labor and delivery

Only labor and delivery codes are billable for an individual with an Emergency Services Only Medicaid Member Card. Other maternity care services (prenatal and postpartum) are not payable for an emergency services only beneficiary.

A Certified Nurse-Midwife may be reimbursed for a delivery for an individual with an Emergency Services Only Medicaid Member Card if described by the following procedure code: 59409, Vaginal delivery only, with or without forceps.

For more information on the Emergency Services Program, refer to the provider manual, *Section I: General Information*.

6 Billing

Refer to the provider manual, *Section I: General Information,* for detailed billing instructions.

Part III - Birthing Center - Hospital Services

1 General Information

1-1 General Policy

Birthing centers are not specifically identified in federal regulation under medical assistance for Medicaid beneficiaries. However, such facilities have value as specialty units or freestanding facilities specifically designed to provide a low cost alternative to the traditional hospital childbirth experience for a select, low risk population of healthy maternal patients expected to have an uncomplicated pregnancy, labor, delivery and recovery. Birthing Centers must assure quality care and a safe environment and must be in compliance with all federal, state and local laws, rules and regulations.

Birthing center services are intended to be short term, but procedures must be identified for consultation, back-up services, transfer and transport of the mother and newborn to a hospital for continuing care when necessary. Clinical staff, licensed staff and support personnel must be sufficient in number to meet patient needs, ensure patient safety and quality of care. The clinical staff must be in compliance with applicable professional practice laws and written birthing center protocols, and must be trained in emergency and resuscitation measures for infants and adults.

Authority for Birthing Center Services is found in Section 1901 ET. Seq. and Section 1905 of the Social Security Act, and by 42 Code of Federal Regulations 440.90 [October 1, 1996 edition] which is adopted and incorporated by reference. The birthing center must be in compliance with rules found in the Utah Administrative Code R432-550.

1-2 Fee-for-service or managed care

Refer to the introduction to this manual for the Fee-for-Service or Managed Care information.

1-3 Definitions

Birthing Center
A freestanding facility, providing maternal patients prenatal care, labor and delivery services as well as postpartum recovery.

Birthing Room
A room and environment designed, equipped and arranged to provide for the care of a woman and newborn and to accommodate a support person(s) during the process of vaginal birth.

Free-standing
Existing independently or physically separated from another health care facility by fire walls and doors and administered by separate staff with separate records.

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to the provider manual, *Section I: General Information,* for provider enrollment information.

3 Member Eligibility

Refer to the Introduction of this Manual for member eligibility information.

4 Program Coverage

Refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov for additional covered services information.

4-1 Covered Services

Reimbursement is considered to cover the services listed below in sufficient amount, duration and scope to provide appropriate, safe quality care to the maternal mother and infant being served in a Birthing Center.

Clinical Staff and Personnel

- A physician or certified nurse-midwife present at each birth to assess, monitor, and facilitate the labor and delivery process and evaluate and provide care to the maternal patient and newborn into the recovery period.
- Physicians available by contractual agreement and willing to provide back-up, consultation, and accept referrals on a 24 hour a day basis.
- Nursing care services planned and delivered by licensed nursing personnel.
- Licensed personnel and support staff to meet patient needs, ensure patient safety, and assure that patients in active labor are attended.

Pharmacy Services

Provided in compliance with the Pharmacy Practice Act, Board of Pharmacy Rules, Controlled Substances Act; and other applicable state and federal laws, rules and regulations.

Anesthesia Services

Facilities and equipment commensurate with the obstetrical procedures provided in the facility.

Laboratory and Radiology Services

Direct or contract laboratory, radiology and associated services to meet the needs of patients. Laboratory services must be provided by a CLIA certified laboratory which meets the requirements of R444 and R432-100-26, Utah Administrative Code. Radiology services must comply with applicable sections of R156-54 and Radiation Control, R313-12, Utah Administrative Code.

5 Non-Covered Services and Limitations

5-1 Non-Covered Services

For non-covered services refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov.

5-2 Limitations

Birthing center maternal patients are limited to women determined to be at low maternity risk for a poor pregnancy outcome. Maternal patient risk for obstetric complications is assessed by the clinical provider through careful prenatal screening throughout the pregnancy and upon admission to the facility. Risk assessments must be documented in the medical record.

Service in a birthing center is limited to maternal patients who do not show symptoms of any of the following:

- Severe anemia or blood dyscrasia
- Insulin dependent diabetes
- Symptomatic cardiovascular disease, including active thrombophlebitis
- Compromised renal function
- Substance abuse
- Hypertension to include moderate to severe pregnancy-induced hypertension; preeclampsia and toxemia
- Genital herpes - suspected or confirmed
- Viral infection during pregnancy with potential adverse effects to the fetus
  Previous obstetrical complications, previous C-section, or any uterine surgery
- Multiple gestation
- Pre-term labor (36 weeks or less) or post-term gestation
- Prolonged rupture of membranes
- Intrauterine growth restriction
- Suspected congenital anomaly
- Fetal presentation other than vertex
- Oligohydramnios, polyhydramnious, or choriomnionitis
- Abruption placenta or placenta previa
- Fetal distress
- Need for general anesthesia or other than that normally used in the facility
- Any condition identified prenatally with the potential for adverse effects on the maternal patient or infant.

6 Billing

Refer to the provider manual, *Section I: General Information,* for detailed billing instructions.

6-1 Prior Authorization

Prior authorization (PA) may be required for certain services. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the beneficiary is retro-eligible for the dates of service requested.

Prior authorization information is provided in the provider manual, *Section I: General Information.* Code specific coverage and prior authorization requirements are provided on the Medicaid website, Coverage and Reimbursement Lookup Tool at: https://medicaid.utah.gov.

Index

AccessNow 3
Anesthesia Services 18
antepartum care 11, 12
Antepartum care 11
assessment 7, 11
billing 8, 12
Billing 4, 12
Birthing Center 18
care plan 10
Certified Family Nurse Practitioner 5, 8, 9, 10, 11
certified nurse-midwife 18
Certified Nurse-Midwife 3
Certified Pediatric Nurse Practitioner 5
Certified Registered Nurse-Midwife ... 5, 8, 9, 10, 11, 14, 16
Certified Social Worker 5, 8
CLIA 15, 18
Clinical Psychologist 10
Clinical Social Worker 10
Clinical Staff and Personnel 18
complications 12, 16, 19
Complications of pregnancy 12
contact 7, 8
counseling 6, 10, 11, 15
Counseling 9, 10
Coverage and Reimbursement Lookup Tool 4, 15, 19, 20
defined 11
demographically high risk 13
diagnosis code 12, 16
Eligibility 3
Emergency services only 16
Emergency Services Only 16
Fee for Service 3
fee-for-service 3
Fee-for-Service 5, 14, 17
global maternity care 15
Global Maternity Care 12
group prenatal and postnatal education 6
Group Prenatal and Postnatal Education 8
Gynecologist 16
high risk 10
High Risk Pregnancy Services 12
home visits 6, 7, 8
Home visits 8
Infertility 15
initial assessment 7
Initial Visit 10
labor 11, 12
labor and delivery 15, 16, 17
Labor and delivery services 11
Laboratory 15, 18
Laboratory work 12
licensed 14
Licensed Practical Nurse 6, 8
limitations 16
low risk 10
Managed Care 5, 14, 17
Marriage and Family Therapist 10
Member Services hotline 3
Newborn screening 15
non-clinical setting 15
non-covered services 15, 19
nutritional assessment 6
Nutritional Assessment 9
nutritional status 7
Obstetrician 16
Perinatal Care 7
perinatal care coordination 6
Perinatal care coordination 7
Perinatal Care Coordination 6
  assessment 6
Perinatal Care Coordination Service Providers 8
Perinatal Care Coordinator 7
Pharmacy Services 18
physician 15, 16
plan of care 7, 11
Postnatal 8
postpartum care 11, 12
Postpartum care 12
Prenatal 8
Prenatal and Postnatal Home Visits 8
Prenatal Assessment 10
prenatal care 17
prenatal care provider 6
Pre-pregnancy counseling 15
Presumptive Eligibility 5
prior authorization 3
Prior Authorization 4
procedure codes 4
provider enrollment 5
psychosocial 6, 7
Psychosocial 10
psychosocial counseling 6
psychosocially 13
Radiology 18
Registered Dietitian 6
registered nurse 6
Registered Nurse 6, 8, 9
risk assessment 12
Risk assessment 10
Risk Assessment 10
Rural physicians 12
Rural Services 15
Single Prenatal Visit 11
Single Prenatal Visit(s) Other than Initial Visit 11

Social Service Worker 6, 8
socioeconomic 7
state laboratory 15
Total Maternity Care 11