Washington State Health Care Authority

Washington Apple Health (Medicaid)

Pregnancy-Related Services

October 1, 2024

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If the broken link is in the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide*

This new publication takes **effect October 1, 2024**. Information was moved out of HCA's *Physician-Related Services/Healthcare Professional Services Billing Guide* to this new guide. HCA's intent for this guide is to improve clarity and usability regarding pregnancy-related services payable by HCA when provided to eligible clients. Unless otherwise specified, the program in this guide is governed by the rules found in chapter 182-531 WAC.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

---

* This publication is a billing instruction.

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

Washington State Health Care Authority

Table of Contents

Resources Available

Topic	Contact
Policy or program questions	HCA Pregnancy-Related Services Program Manager (800) 562-3022 (toll free)
Information regarding family planning services, including immediate postpartum long-acting reversible contraceptive (LARC) insertion	See HCA's Family Planning Billing Guide.
Information regarding support services covered during and post pregnancy	See HCA's Maternity Support Services/Infant Case Management Billing Guide.
Information regarding childbirth education	See HCA's Childbirth Education Billing Guide.
Information on deliveries in a birthing center or in a home birth setting	See HCA's Planned Home Births and Births in Birthing Centers Billing Guide.
Information on detoxification services during pregnancy	See HCA's Substance-Using Pregnant Person (SUPP) Program Billing Guide.
Information on drug screening for medication for opioid use disorder during pregnancy	See HCA's Physician-Related Services/Health Care Professional Services Billing Guide.
Additional HCA resources	See HCA's Billers, providers, and partners webpage or contact the Medical Assistance Customer Service Center (MACSC).

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC and WAC 182-531-0050 for a complete list of definitions for Washington Apple Health.

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure.

Admitting diagnosis – The medical condition responsible for a hospital admission.

Antepartum – Relating to the period before birth. Also known as prenatal care.

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

HCPCS- See Healthcare Common Procedure Coding System.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

High-risk – Any pregnancy that poses a significant risk of a poor birth outcome.

Inpatient hospital admission – An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

Medically necessary – See WAC 182-500-0070.

Newborn or neonate or neonatal - A person younger than 29 days old.

Noncovered service or charge – A service or charge not reimbursed by HCA.

Provider – See WAC 182-500-0085.

Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care webpage for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to Step 2. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program benefit packages and scope of services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: HCA continues to pay for the following through fee-for-service (FFS):

- Professional fees for dental procedures using CDT® codes
- Professional fees using CPT® codes only when the provider's taxonomy starts with 12

See the Dental-Related Services Billing Guide or the Physician-Related Services/Health Care Professional Services Billing Guide, or both, for how to bill professional fees.

Managed care enrollment

Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to **HCA's Apply for or renew coverage webpage**, under *How to apply for or renew Apply Health (Medicaid) coverage*.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to the **Washington Healthplanfinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care webpage**.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care plan will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"Coordinated Care Healthy Options Foster Care."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit Apple Health Expansion.

See also **Apple Health expansion enrollees age 19 and 20** in this guide for coverage outside of HCA's contracted health plans.

Note: Clients who are pregnant or had a pregnancy end in the last 12 months are not eligible for Apple Health Expansion.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer?*

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

Pregnancy-Related Care

Confirmation of pregnancy

If a client presents with signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy and:

- The obstetrical (OB) record is not initiated, bill this visit using the appropriate level Evaluation & Management (E/M) code. Bill using the most appropriate diagnosis code(s) for the signs or symptoms, or both, the client is having [e.g., suppressed menstruation (ICD diagnosis code N92.5 or N93.8)]. Do not bill using the pregnancy diagnosis codes (e.g., Z33.1, Z34.00, Z34.80, or Z34.90).
- The OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately. The pregnancy diagnosis codes (e.g., Z33.1, Z34.00, Z34.80, or Z34.90) are used when billing the global OB package. See **Global (total) obstetrical (OB) care**.

If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E/M code if the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

Diagnostic testing to confirm pregnancy and gestational age

When testing to confirm pregnancy and gestational age, see the following:

- The clinical laboratory codes in HCA's **Physician-related/professional services fee schedule** for coverage of urine and blood testing for confirmation of pregnancy.
- **Obstetrical ultrasounds** in this guide.

Contraceptives

See HCA's **Family Planning Billing Guide** for information on coverage for contraceptives dispensed, injected, or inserted in an office/clinic setting, and additional instructions on billing.

Global (total) obstetrical (OB) care

Global OB care (CPT® codes 59400, 59510, 59610, or 59618) includes all the following:

- Routine antepartum care in any trimester
- Delivery
- Postpartum care

If the provider furnishes all the client's antepartum care, performs the delivery, and provides the postpartum care, the provider **must bill** using one of the global OB procedure codes.

Use HCPCS code 0500F along with the appropriate diagnosis code[†] on the first prenatal visit. HCA is tracking the date a client begins receiving obstetrical care (date the OB record is initiated). Note this date by entering HCPCS code 0500F with the appropriate ICD diagnosis codes Z33.1, Z34.00, Z34.80, or Z34.90 on the claim. When submitting claims with HCPCS code 0500F, use a billed amount of $0.01 (one cent), and the claim will pay at zero.

> **Note**: When billing global obstetrical services, the place of service code must correspond with the place where the child was born (for example: 25).

When more than one provider in the same clinic (same group NPI) sees the same client for global obstetrical care, HCA pays only one provider for the global (total) obstetrical care.

Providers who are in the same clinic who **do not** have the same group NPI **must not** bill HCA the global (total) obstetrical care procedure codes. In this case, the OB services must be unbundled and the antepartum, delivery, or postpartum care must be billed separately.

[†] HCA collects this code for quality measurement, tracking, and care coordination. Other payers use the code in the same way.

Audio-only visits as part of global obstetrical care

When billing for Global OB care (CPT® codes 59400, 59510, 59610, or 59618), HCA allows a total of three audio-only visits as follows:

- Up to two antepartum visits to be provided via audio-only telemedicine
- One early postpartum visit to be provided via audio-only telemedicine. An early postpartum visit is a postpartum visit up to two weeks after delivery.

The comprehensive postpartum visit typically scheduled at around six weeks after delivery may not be provided via audio-only telemedicine.

When two or three audio-only telemedicine visits have been used during Global OB care, bill the Global OB code with modifier 93.

When only one audio-only telemedicine visit has been used during Global OB care, no additional modifier is required.

Audio-only visits when Global OB care is unbundled

When billing audio-only visits when Global OB care is unbundled (see Unbundling obstetrical care), use the following guidelines:

- **Antepartum care only (CPT® codes 59425 and 59426)** - Up to two antepartum visits may be provided via audio-only telemedicine. When two audio-only telemedicine visits have been used during the antepartum period, bill either CPT® code 59425 or 59426 with modifier 93. When only one audio-only telemedicine visit has been used during the antepartum period, no additional modifier is required.
- **Postpartum care only (CPT® code 59430)** - One early postpartum visit may be provided via audio-only telemedicine. An early postpartum visit is a postpartum visit up to two weeks after delivery. The postpartum visit typically scheduled at around six weeks after delivery may not be provided via audio-only telemedicine. When an audio-only telemedicine visit has been used during the early postpartum period, no additional modifier is required.
- **Delivery with postpartum care (CPT® codes 59410, 59515, 59614, and 59622)** - One early postpartum visit may be provided via audio-only telemedicine. An early postpartum visit is a postpartum visit up to two weeks after delivery. The comprehensive postpartum visit typically scheduled at around six weeks after delivery may not be provided via audio-only telemedicine. When an audio-only telemedicine visit has been used during the early postpartum period, no additional modifier is required.
- **Delivery only (CPT® codes 59409, 59514, 59612, and 59620)** - This service requires in-person care and is therefore not eligible for audio-only or audio-visual telemedicine.

Note: **Do not** bill HCA for obstetrical services until all care is completed.

HIV/AIDS counseling/testing

HCA covers HIV testing for pregnant clients.

> **Note:** For more information on HIV/AIDS counseling/testing coverage policy, see HCA's **Physician-Related Services/Health Care Professional Services Billing Guide**.

HCA pays for counseling visits when billed with an E/M service on the same day when either of the following is true:

- The client is being seen for a medical problem and modifier 25 is used.
- The client is being seen for an antepartum visit and modifier TH is used.

HCA does not pay for a counseling visit if the client is being seen only to confirm pregnancy and an office visit is billed, because the counseling is considered part of the office visit.

Laboratory services

For information on billing for laboratory services, see HCA's **Physician-Related Services/Health Care Professional Services Billing Guide**.

Telemedicine

> **Note:** Refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth*, for more information on the following:
>
> - Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
> - Audio-only procedure code lists, under *Audio-only telemedicine*

Audio-visual telemedicine

HCA allows obstetrical services to be provided via telemedicine. When billing for audio-visual telemedicine, use the place of service (POS) relevant to the service provided on the date of service or the last date of service for a global or bundled code. **For example:**

- If the service was provided in-person in an office setting, use POS 11 (office).
- If the service was provided via audio-visual telemedicine, use either POS 02 (telehealth) or 10 (telehealth provided in patient home), whichever is appropriate.
- If the service was provided via audio-only telemedicine, refer to HCA's *Telemedicine Policy and Billing Guide*, under *Telehealth* on HCA's **Provider billing guides and fee schedules webpage**.

Audio-only telemedicine

Audio-only visits for pregnant clients must:

- Be utilized only when clinically appropriate for the individual client, based on current clinical guidance and standards of care from **ACOG** and **AAFP**.
- Not be used when client circumstances call for an in-person assessment or procedure.
- Be informed by client preference. Clients must have input on and choice regarding how services are delivered.
- Have documentation that complies with HCA's **telemedicine** policies. Must include start and stop time of audio-only interaction.

There is currently limited evidence on the safety and efficacy of audio-only telemedicine for maternity care. HCA monitors new and emerging evidence and adjusts this policy to align with best practices. See **Global (total) obstetrical (OB) care** for more details.

Unbundling obstetrical care

In the following situations, providers may not be able to bill HCA for global OB care as HCA may have paid another provider for some of the client's OB care, or a provider may have been paid by another insurance carrier for some of the client's OB care. In these cases, it may be necessary to unbundle the OB services and bill the antepartum, delivery, and postpartum care separately.

When a client transfers to a practice late in the pregnancy

- If the client has had antepartum care elsewhere, the subsequent provider must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that the provider performed. Otherwise, if the subsequent provider bills the global OB package, that provider is billing for some antepartum care that another provider has claimed.

- OR –

- If the client did not receive any antepartum care prior to coming to the provider's office, bill the global OB package.

  In this case, the provider may perform all the components of the global OB package in a short time. HCA does not require this provider to perform a specific number of antepartum visits to bill for the global OB package.

If a client transfers to another provider (not associated with the provider's practice), moves out of the area prior to delivery, or loses the pregnancy…

When provider A has seen the client for part of the antepartum care and has transferred the client to provider B for care, and provider B is billing separately for the antepartum care being delivered, provider B enters "transfer of care" in the *Claim Note* section of the electronic claim. Provider B bills only those services provided to these clients.

If a client changes insurance during pregnancy…

Sometimes, a client is fee-for-service at the beginning of pregnancy and enrolled in an HCA managed care organization (MCO) for the remainder of the pregnancy. HCA is responsible for paying only for those services provided to the client while the client is on fee-for-service. The MCO pays for services provided after the client is enrolled with the MCO.

HCA encourages early prenatal care and is actively enrolling new clients into managed care. If a client is on fee-for-service and is not yet enrolled in an MCO plan at the beginning of the client's pregnancy, consider billing the first visit as a secondary confirmation of pregnancy using the most appropriate ICD diagnosis code N92.5 or N93.8 with the appropriate level of office visit as described under Confirmation of Pregnancy.

When a client changes from one MCO plan to another, bill those services that were provided while the client was enrolled with the original MCO plan to the original carrier, and those services that were provided under the new coverage to the new MCO plan. The provider must unbundle the services and bill the antepartum, delivery, and postpartum care separately. For clients who move in and out of managed care and fee for service, use modifiers TH and CG to unbundle the codes.

Antepartum Care

Per CPT guidelines, HCA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation.
- Biweekly visits to 36 weeks gestation.
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history.
- Physical examination.
- Recording of weight and blood pressure.
- Recording of fetal heart tones.
- Routine chemical urinalysis.
- Pregnancy counseling, such as risk factor assessment and referrals.

Necessary prenatal monitoring, diagnostic, and laboratory tests may be billed in addition to antepartum care, **except for the following tests:** CPT® codes 81000, 81001, 81002, 81003, and 81007.

> **Note:** For audio-only visits as part of antepartum obstetrical care, see Audio-only visits as part of global obstetrical care.

Additional monitoring for high-risk conditions

Billing

When providing **additional monitoring** for high-risk conditions more than the CPT guidelines for normal antepartum visits, bill using the most appropriate E/M **codes 99211-99215 with modifier UA**. The office visits may be billed in addition to the global fee only after exceeding the CPT guidelines for normal antepartum care. Providers must bill with a primary diagnosis that identifies that the high-risk condition is pregnancy related.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care to qualify for additional payments. **The additional payments are intended to cover additional costs incurred by the provider because of more frequent visits.**

For example: Client A is scheduled to see a provider for the client's antepartum visits on January 4, February 5, March 3, and April 7. The client attends the January and February visits, as scheduled. However, during the scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants the client to come in on February 12 to be checked again. At the February 12 visit, the provider discovers the client's blood pressure is still slightly high and asks to see the client again on February 18. The February 12 and February 18 visits are outside of the client's regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since the client is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the most appropriate E/M codes with modifier UA, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e., Z33.1, Z34.00, Z34.80, or Z34.90) will be denied outside of the global antepartum care. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits if the extra visits are outside of the regularly scheduled visits**.

Assessment and treatment of high-risk conditions

Preterm labor and birth:

- HCA does not pay separately for CerviLenz. It is considered bundled into the practice expense.
- See fetal fibronectin.

Diagnostic and monitoring tests:

See obstetrical ultrasounds.

Coding for antepartum care only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E/M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.
- If the client had a **total** of four to six antepartum visits, bill using **CPT® code 59425** with a "1" in the *units* box. Bill HCA using the date of the last antepartum visit in the *to* and *from* fields.
- If the client had a **total** of seven or more visits, bill using **CPT® code 59426** with a "1" in the *units* box. Bill HCA using the date of the last antepartum visit in the *to* and *from* fields.

Do not bill antepartum care only codes in addition to other procedure codes that include antepartum care (i.e., global OB codes).

Do not bill using CPT E/M codes for the first three visits, then CPT® code 59425 for visits four through six, and then CPT® code 59426 for visits seven and on. These CPT® codes are used to bill only the **total** number of times the client was seen for all antepartum care during the client's pregnancy and **may not** be billed in combination with each other during the entire pregnancy period.

> **Note**: **Do not** bill HCA until all antepartum services are complete. Hospital care for pregnant clients can be billed concurrently.

Audio-only visits as part of antepartum obstetrical care

See Audio-only visits as part of global obstetrical care.

Consultations

If another provider refers a client during her pregnancy for a consultation, bill HCA using consultation CPT® codes 99241-99245. If an inpatient consultation is necessary, bill using CPT® codes 99252, 99253, 99254, and 99255 or for a follow-up bill using CPT® codes 99231-99233. The referring physician's name and NPI must be listed in the *Referring Physician* field on the claim.

If the consultation results in the decision to perform surgery (i.e., a cesarean section), HCA pays the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill HCA the appropriate consultation code.
- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill HCA the appropriate **consultation code with modifier 57** (e.g., 99241-57).

HCA does not pay the consulting physician if the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** HCA for the consultation in this situation.

Bill HCA for consultations using the most appropriate ICD diagnosis code. The medical necessity (i.e., sign, symptom, or condition) must be demonstrated. HCA does not pay providers for a consultation with a normal pregnancy diagnosis code (e.g., **Z33.1, Z34.00, Z34.80, or Z34.90**).

HCA pays consulting OB/GYN providers for an external cephalic version (CPT® code 59412) and a consultation when performed on the same day.

Early pregnancy loss and abortion services

- Pregnancy services include the assessment, management, treatment of pregnancy loss, and voluntary terminations. This includes spontaneous, incomplete, missed, induced, and elective abortions.
- Providers must bill using the most appropriate diagnosis codes for the type of abortion – elective, induced, spontaneous, incomplete, or missed. An elective termination of pregnancy requires ICD diagnosis code Z33.2.
- Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful treatment are covered.
- To bill for Rho(D) immune globulin, use the most appropriate HCPCS code. See **Physician-related/professional services fee schedule** and **Professionally administered drug fee schedule**.
- HCA covers abortion services through fee-for-service. Clients enrolled in an HCA managed care organization (MCO) may self-refer to any fee-for-service provider. Claims for abortion services must be submitted through ProviderOne—not the MCO.
- Clients on the Family Planning Only program are not covered for pregnancy care including induced abortions. For these services, they must apply for pregnancy medical coverage.
- **Medical abortions**:
    - HCA pays a bundled rate (HCPCS S0199) for medical abortions administered in an office or outpatient clinic setting.
        - HCPCS S0199 includes services rendered over an 18-day period, including office visits, ultrasounds, laboratory studies, and education/counseling. Day 1 of the 18-day period is the day medical abortion medications are provided, administered, or prescribed to the client.
        - Providers may bill HCPCS S0199 after the follow-up appointment or 18 days after the first visit, whichever comes first.
        - Reimbursement for HCPCS S0199 is limited to once every 5 weeks.
        - Providers must use the professional (J) claim when billing for HCPCS S0199.
        - Providers must bill for medical abortions using HCPCS S0199 unless there is a complication.
    - CPT® codes incorporated into the HCPCS S0199 rate include: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 76815, 76817, 76830, 85018, 86901, 36416, 36410, 36415, 99000, 99001, and 84702.

      The medical abortion provider must not bill these codes separately to either FFS or the client's MCO during the 18-day service period for HCPCS S0199.

Note:

- HCPCS S0199 does not include abortion medications, which must be billed on different lines. Rho(D) immune globulin is not included in the bundled rate and must be billed on a different line when administered.

- Do not use HCPCS S0199 when the client undergoes surgical abortion during the 18-day service period due to complications or incomplete medical abortion. Instead, bill separately for each individual service provided.

  - When a client does not present for a follow-up visit, use modifier TS when billing HCPCS S0199. The provider payment for HCPCS S0199 is unchanged when modifier TS is used.
  - HCA covers the following medications used according to nationally accepted guidelines issued by the Food and Drug Administration (FDA) and the American College of Obstetricians and Gynecologists (ACOG):
    - Methotrexate sodium, 50 mg (HCPCS J9260)
    - Mifepristone, oral, 200 mcg (HCPCS S0190)
    - Misoprostol, oral, 200 mcg (HCPCS S0191)
  - **Telemedicine**
    - When telemedicine is used to provide HCPCS S0199 bundled services, HCA does not pay any additional originating facility fees.

      Example: Client receives ultrasound(s), laboratory studies, and medication at Clinic A (originating site) and uses a telemedicine platform to meet with the medical abortion provider, who is at Clinic B (distant site). The provider may not bill for HCPCS Q3014 (originating facility fee). See **Telemedicine** for more information.
    - Medical abortion services provided via telemedicine to a client who does not receive ultrasound(s) and laboratory studies from the medical abortion provider are not eligible for the HCPCS S0199 bundled payment.

      Example: The client is at home and uses a telemedicine platform to meet with the provider for medical abortion education and counseling. The client then picks up the abortion medications at the clinic.
    - Medical abortion services provided via audio-only telemedicine are not eligible for the HCPCS code S0199 bundled payment.

      Example: The provider may only bill the appropriate evaluation and management (E/M) code, along with codes for the medications dispensed.

- **Surgical abortions**:

- HCA pays for surgical abortions that occur in an ambulatory surgical center (ASC), hospital, or HCA-approved and -contracted non-hospital-based center (abortion center).
- ASCs and hospitals must bill for surgical services according to their billing guides. See the **Ambulatory Surgery Centers Billing Guide**, the **Inpatient Hospital Services Billing Guide**, and the **Outpatient Hospital Services Billing Guide**.
- Abortion centers:
  - Abortion centers must be approved by and contracted with HCA to bill for facility fee payments for a surgical abortion. To become an approved abortion center, send a request to **familyplanning@hca.wa.gov**.
  - Abortion centers are reimbursed the facility fees only for surgical abortions. Abortion centers are not paid a facility fee for medical abortions not requiring surgical intervention.

Genetic counseling and genetic testing

General coverage and prior authorization

Coverage

HCA covers genetic counseling (CPT® 96040) when performed by a health care professional appropriately credentialed by the Department of Health (DOH).

Prior authorization

Certain genetic testing procedure codes require PA. Providers must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly. Providers must check the **Physician-related services fee schedule** for services that require either PA or EPA.

For procedure codes that require PA, use the *General Information for Authorization* form, HCA 13-835 and *Fax/Written Request Basic Information* form, HCA 13-756. See **Where can I download HCA forms?**

Prenatal genetic counseling

Coverage

HCA covers:

- In-person or audio-visual telemedicine encounters only.
- One initial prenatal genetic counseling encounter. This encounter must be billed in 30-minute increments and cannot exceed 90 minutes.
- Two follow-up prenatal genetic counseling encounters per pregnancy. The encounters must occur no later than 11 months after conception. These encounters must be billed in 30-minute increments and cannot exceed 90 minutes.

Prenatal procedures other than genetic counseling, such as laboratory or diagnostic testing, must be requested directly through the client's primary care provider (PCP) or PCCM.

Billing

Providers must follow the billing requirements listed in HCA's **ProviderOne Billing and Resource Guide**. The guide explains how to complete the claim. If you provide this service via telemedicine, see HCA's **Telemedicine Policy Billing Guide** for information on billing telemedicine claims.

> **Note**: Prenatal genetic clinics should submit billings within 120 days of the date of service to facilitate reconciliation of Department of Health's accounts.

Enter the following information in the listed fields on the claim:

Name	Enter
Diagnosis or nature of illness or injury	ICD diagnosis code Z31.5
Place of Service	The appropriate place-of-service code, which must be either: 11 (office), 21 (inpatient hospital), or 22 (outpatient hospital)
Rendering (Performing) Provider Taxonomy Code	The taxonomy for prenatal genetic counseling: 170300000X
Rending (Performing) Provide NPI	The genetic counselor's NPI number

Name	Enter
Billing Provider NPI	The approved HCA billing NPI
Billing Provider Taxonomy Code	The approved HCA billing taxonomy code, which cannot be 170300000X

Note: CPT® code 96040 must be billed using taxonomy 170300000X for both the initial visit and the two follow-up visits. To bill for genetic counseling, use an ICD diagnosis code for genetic counseling and the appropriate E/M code. CPT® code 96040 is a time-based code and each visit is limited to no more than 3 x 96040 (i.e., no more than 90 minutes per session).

Inpatient neonatal and pediatric critical care

For information on inpatient neonatal and pediatric critical care, see HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Newborn care

For information on newborn care, see HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Obstetrical ultrasounds

Based upon review of the evidence provided by HTCC, HCA considers routine ultrasounds to be medically necessary for pregnant clients as follows:

- One ultrasound in week 13 or earlier
- One ultrasound in weeks 16 through 22
- Other ultrasounds when medically necessary and clinically indicated for high-risk pregnancy or development of a specific, pregnancy-related condition.

HCA does not pay for:

- Ultrasounds when provided solely for the determination of gender.
- Third trimester ultrasounds unless a specific indication has developed, or the pregnancy is considered high-risk.

The above conditions and limitations do not apply to multiple gestation pregnancies and/or fetus with aneuploidy or known anomaly.

Note: Additional ultrasounds are subject to postpayment review.

Problem visits during pregnancy

If a client is seen for reasons other than routine antepartum or postpartum care, providers must bill using the appropriate Evaluation and Management (E/M) procedure code with a medical diagnosis code as the primary diagnosis. Claims with diagnosis codes Z33.1, Z34.00, Z34.80, or Z34.90 will be denied if listed as the principal diagnosis.

For those clients who have non-pregnancy-related issues and diagnosis(es), the provider should use the appropriate E/M code with the modifier GB.

> **Note:** Screening for perinatal mental health conditions is a covered service. See **Screening of mental health conditions during pregnancy and postpartum** for more information.

Screening exams

Fetal fibronectin

The semiquantitative measurement of fetal fibronectin may be considered as medically necessary with all the following conditions:

- Singleton or multiple gestation pregnancies
- Intact amniotic membranes
- Cervical dilation <3 cm
- Signs or symptoms suggestive of preterm labor (such as, regular uterine contractions, cramping, abdominal pain, change in vaginal discharge, vaginal bleeding, pelvic pressure, or malaise)
- Sampling that is performed between 24 weeks 0 days and 34 weeks 6 days of gestation
- Results available in less than 4 hours, for the test results to impact immediate care decisions for the pregnant client

HCA does not consider the use of fetal fibronectin assays to be medically necessary for the following indications:

- No symptoms of preterm birth (there is no clinical evidence that treating pregnant clients with no labor symptoms or high risk for premature delivery benefits pregnant client or baby)
- Routine screening or determination of risk of preterm delivery in asymptomatic pregnant clients
- Outpatient tests and the pregnant client awaits test results at home
- Monitoring of asymptomatic pregnant clients at high-risk for preterm labor (PTL)
- Pregnant clients not requiring induction due to likelihood of delivery within 24 to 48 hours
- Ruptured membranes or advanced cervical dilation (3 cm or more)

- Imminent birth

For all other indications, there is insufficient evidence to permit conclusions on efficacy and net health outcomes.

CPT® Code	Short Description
82731	Fetal fibronectin, cervicovaginal secretions, semi-quantitative

Examples of ICD diagnoses codes that support medical necessity are:

ICD Diagnosis Code	Short Description
N88.3	Incompetence of cervix
O34.32, O34.33	Cervical incompetence during pregnancy, childbirth, and the puerperium
O36.8190	Decreased fetal movement
O09.40, O09.529	Other indications for care or intervention related to labor and delivery
R10.9	Abdominal pain

Noninvasive prenatal diagnosis of fetal aneuploidy using cell-free fetal nucleic acids in birthing parent blood (NIPT)

HCA pays for noninvasive prenatal diagnosis of fetal aneuploidy using cell-free fetal nucleic acids in birthing parent blood (NIPT) (CPT® code 81507 and 81420) when it is medically necessary. Expedited prior authorization (EPA) is required. See EPA #870001344.

Screening of mental health conditions during pregnancy and postpartum

HCA covers screening for depression and anxiety during pregnancy and the postpartum period. Providers must screen pregnant and postpartum clients for depression and anxiety using a standardized, validated screening tool. Screening results are not equivalent to a diagnosis. Screening for perinatal depression and anxiety must occur at the initial prenatal/OB visit, at least once during the 2nd or 3rd trimester, and once in the postpartum period per American College of Obstetrics and Gynecology (ACOG) recommendation.

When billing HCA for perinatal depression and anxiety screening, use CPT® code 96127 or 96160. If the provider conducts a depression screening and anxiety screening on the same date of service using two different screening tools, the provider may bill separately for each screening using the appropriate CPT® code.

Submit the claim for the screening with the date the screening occurred. Perinatal mental health screening may be billed in addition to bundled or unbundled obstetric codes. If more frequent screening is needed, providers may submit a limitation extension (LE) request to HCA. See **Limitation extension (LE)**.

Note:

- Providers are responsible for having adequate training to administer and interpret screening tools, including determining screening outcome.
- Providers may use the Perinatal Psychiatric Consultation Line (PPCL) for recommendations and referrals related to perinatal mental and behavioral health. Providers may refer the client to Perinatal Support Washington Warmline for telephone support, professional referrals, and information about other resources.

Birthing parent depression screening

HCA considers depression screening for birthing parents to be medically necessary. Providers must follow standard coding practices when billing and follow applicable HCA rules.

When billing for clients age 21 and older, see HCA's **Physician-Related Services/Healthcare Professional Service Billing Guide**.

When billing for clients age 20 and younger, see HCA's **Early and Periodic Screening, Diagnosis, and Treatment Well-Child Program Billing Guide**.

What if a problem is identified as the result of a screening?

When a screening indicates a possible problem, the screening provider must ensure the client receives necessary services, including referring the client to an appropriate provider for an assessment where a diagnosis and plan of care are developed. Health care professionals may provide services for clients when services are within their scope of practice. To be reimbursed, providers must indicate the screening outcome by including one of the modifiers listed below. Providers must document in the client's record the name of the screening tool, the score, and what referrals were made.

Modifier	Description
U1	No need identified (negative screen). Indicates screening score within a normal range.
U2	Need identified (positive screen). Indicates risk, concern, impairment, or identification of a developmental and/or behavioral disorder.

Tobacco/nicotine cessation for pregnant clients

HCA pays for face-to-face counseling for tobacco/nicotine cessation for pregnant clients. Tobacco/nicotine cessation counseling complements the use of prescription and nonprescription tobacco/nicotine cessation products. These products are also covered by Medicaid.

Pregnant clients can receive provider-prescribed nicotine replacement therapy directly from a pharmacy. Prescription medications for tobacco/nicotine cessation may be obtained without going through the Washington State Quitline.

Face-to-face visit requirements for pregnant clients

Providers must document the client's pregnancy status and estimated date of delivery in the medical record. Additionally, the provider must establish and document the client's motivation to quit tobacco/nicotine use and provide an appropriate intervention based on client's readiness to change.

Provider types for providing face-to-face tobacco/nicotine cessation counseling for pregnant clients

The following may provide face-to-face tobacco/nicotine cessation counseling for pregnant clients: office-based practitioners (physicians, dentists, advanced registered nurse practitioners (ARNPs), physician-assistants-certified (PA-Cs), and naturopathic physicians), psychologists, pharmacists, certified nurse-midwives (CNM), and licensed midwives (LM).

Benefit limitations for providing face-to-face tobacco/nicotine cessation counseling for pregnant clients

A cessation counseling attempt occurs when a qualified physician or other Medicaid-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt.

Face-to-face cessation counseling attempts are defined and limited as follows:

- HCA allows two tobacco/nicotine cessation counseling attempts every 12 months.
- An attempt is defined as up to four tobacco/nicotine cessation counseling sessions.
- HCA covers one face-to-face tobacco/nicotine cessation counseling session per client, per day.

This limit applies to the client regardless of the number of providers a client may see for tobacco cessation. Providers can request a limitation extension by submitting a request to HCA.

Documentation requirements

Keep patient record information on file for each Medicaid patient for whom a tobacco/nicotine cessation counseling claim is made. Medical record

documentation must include standard information along with sufficient patient history to adequately demonstrate that Medicaid coverage conditions were met. The provider must keep written documentation in the client's file for each face-to-face tobacco/nicotine cessation counseling session for pregnant clients. Documentation must include the client's EDC.

Diagnosis codes should reflect that the client is pregnant and has a tobacco/nicotine use disorder.

Billing codes

CPT® Code	Short Description	Comments
99407	Behav chng smoking > 10 min (for pregnant clients only)	See Benefit limitations for providing face-to-face tobacco/nicotine cessation counseling for pregnant clients.

Vaccines/Toxoids (immunizations)

For information on vaccines/toxoids (immunizations), see HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Labor and Delivery

Anesthesia for labor and delivery

- HCA pays a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT® codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

> **Exception:** The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT® codes 01962-01966 or 01969.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).
- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.
- CPT® codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for CPT® code 01968 and an additional base of 5 is allowed for CPT® code 01969, in conjunction with the base of 5 for CPT® code 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code.

> **For example:** When a physician starts a planned vaginal delivery (CPT® code 01967) and it results in a cesarean delivery (CPT® code 01968), both procedures may be billed. However, if both an anesthesiologist and a certified registered nurse assistant (CRNA) are involved, each provider bills only for those services the provider performed. The sum of the payments for each procedure will not exceed HCA's maximum allowable fee.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

> **Note:** For more information on anesthesia, see HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Coding for deliveries without antepartum care

If it is necessary to unbundle the OB package and bill for the delivery only, bill HCA using one of the following CPT® codes:

- 59409 (vaginal delivery only)
- 59514 (cesarean delivery only)
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)]

If a provider does not furnish antepartum care, but performs the delivery and provides postpartum care, bill HCA using one of the following CPT® codes:

- 59410 (vaginal delivery, including postpartum care)
- 59515 (cesarean delivery, including postpartum care)
- 59614 (VBAC, including postpartum care)
- 59622 (attempted VBAC, including postpartum care)

Elective deliveries

HCA does not reimburse for early elective deliveries. An early elective delivery is a nonmedically necessary induction or cesarean section before 39 weeks of gestation. 39 weeks of gestation is greater than 38 weeks and 6 days.

HCA considers early elective deliveries to be medically necessary if the birthing parent or fetus has a diagnosis listed in the Joint Commission's current table of Conditions possibly justifying elective delivery prior to 39 weeks gestation (WAC 182-533-0400). If the client meets the medical necessity criteria, bill using EPA #870001375. **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**

If the early elective delivery does not meet medical necessity criteria, HCA will pay for the antepartum and postpartum professional services only. When billing, these services must be unbundled. HCA will not pay for the delivery services.

For all deliveries for a client equal to or over 39 weeks gestation, bill using EPA #870001378. This applies to both elective and natural deliveries for clients equal to or over 39 weeks gestation.

High-risk deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, HCA pays providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g., 59400 TG or 59409 TG).

The ICD diagnosis code **must clearly** demonstrate the medical necessity for the high-risk delivery add-on (e.g., a diagnosis of fetal distress). A normal delivery

diagnosis is not paid an additional high-risk add-on fee, even if the birthing parent had a high-risk condition during the antepartum period.

> **For example**: For cesarean delivery, the primary diagnosis is the condition that was responsible for the client's admission. If a particular condition resulted in the admission and the cesarean procedure, list **that condition's** ICD diagnosis code first on the claim[‡].

Bill only ONE line of service (e.g., 59400 TG) to receive payment for BOTH the delivery and the high-risk add-on. DO NOT bill the delivery code (e.g., 59400) on one line of the claim and the high-risk add-on (e.g., 59400 TG) on a second line of the claim.

A physician who provides stand-by attendance for high-risk delivery can bill CPT® code 99360 and resuscitation CPT® code 99465, when appropriate.

> **Note**: HCA **does not** pay an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Payment is limited to one per client, per pregnancy (even in the case of multiple births).

Coding for cesarean deliveries

The following apply to cesarean deliveries:

- HCA pays for multiple births by cesarean delivery at 100% for the first baby. No additional payment will be made for additional babies.
- Physician assistants-certified (PA-C) must bill for assisting during a C-section on their own claim using modifier 80, 81, or 82 to the delivery-only code (e.g., 59514-80). The claim must be billed using the PA-C's NPI.
- Physician assistants (PA) must bill for an assist by adding modifier 80, 81, or 82 to the delivery-only code (e.g., 59514-80).
- RNFAs assisting at C-sections may **only** bill using CPT® code 59514 or 59620 with modifier 80.

Coding for multiple births

HCA pays a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, bill using the delivery-only code (CPT® code 59409 or 59612) for each additional baby. Payment for each

---

[‡] HCA follows the American College of Obstetricians and Gynecologists (ACOG) guidelines on diagnosis when billing a high-risk delivery.

additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line.

Labor management

Labor management may be billed only when one provider (Provider A) admits the client to the hospital during labor, but another provider in a different group practice (Provider B) takes over the delivery. In this situation, the global OB care must be unbundled. Provider A must bill separately for the hospital admission and the time spent managing the client's labor. Provider B must bill for the delivery. The client must be in active labor and admitted to a hospital when Provider A refers the client to Provider B for delivery.

In this situation, the delivering provider (Provider B) or any provider within Provider B's group practice must not bill for labor management, even if the group practice does not have a group NPI.

Do not bill HCA separately for the hospital admission or for labor management if a provider or clinic where a group NPI is used did all the following:

- Performed all the client's antepartum care
- Admitted the client to the hospital during labor
- Delivered the baby
- Performed the postpartum care

These services are included in codes for global OB care.

To bill for labor management in the situation previously described, bill HCA using a hospital admission procedure code (CPT® codes 99221-99223) with modifier TH.

In addition to the hospital admission, HCA pays providers for up to 1 hour of labor management using prolonged services (CPT® code 99418) with modifier TH.

HCA limits payment for prolonged services to 1 hour per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management.

Note:

- HCA pays for prolonged services CPT® codes for labor management only when the provider performs the hospital admission and labor management services on the same day.

- The hospital admission code and prolonged services code(s) must be billed on the same claim with the same dates of services.

Postpartum Care

Coding for postpartum care only

If it is necessary to unbundle the OB package and bill for postpartum care only, bill HCA using CPT® code 59430 (postpartum care only).

If a provider furnishes all the antepartum and postpartum care, but does not perform the delivery, bill HCA for the antepartum care using the antepartum care only codes, along with CPT® code 59430 (postpartum care only).

Do not bill CPT® code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care. (i.e., global OB codes)

> **Note:** For billing purposes, postpartum care includes routine office visits for the 6-week period after the delivery. The codes for obstetric care (global payment or unbundled) apply only to the period up to and including the comprehensive postpartum visit, usually done at 6 weeks postpartum. Services provided after the 6-week postpartum visit are eligible for separate reimbursement. After Pregnancy Coverage (APC) is a 12-month Medicaid extension for clients who have been recently pregnant. Visit HCA's APC webpage for more information on APC coverage.

Treatment of postpartum hemorrhaging

Use of an intrauterine balloon to treat postpartum hemorrhage is reimbursable by billing CPT® code 58999 with modifier U3 and EPA #870001614.

> **Note:** For postpartum hemorrhaging requiring a hysterectomy, see HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Coverage Table

The following tables include information for billing HCA for pregnancy-related services.

Global (total) obstetrical (OB) care

Service	CPT® Code/ Modifier	Short Description	Limitations
Confirmation of pregnancy	99202-99215	Office visits	Code the sign or symptom (e.g., suppressed menstruation)
Global OB care	59400	Obstetrical care	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.
Global OB care	59510	Cesarean delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.
Global OB care	59610	Vbac delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.

Service	CPT® Code/ Modifier	Short Description	Limitations
Global OB care	59618	Attempted vbac delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.

Billing with modifiers for obstetric care

Nonsupervision, not part of global, medical diagnosis is always primary.

Modifiers	GB	CG	TH	UA
All these modifiers must be used with E/M only	**Nonsupervision** not part of global. Is a high-risk medical condition or condition unrelated to the pregnancy, which is always primary reason for the visit. Do not use a supervision diagnosis code.	Supervision when client is **in** and **out** of managed care	Supervision of the client when the provider treats client for less than four visits and unbundles care	Supervision with additional visits beyond global (for high-risk pregnancy)
Multiple providers for OB care		X		
Providers seeing client for medical reasons other than current pregnancy	X			

Modifiers	GB	CG	TH	UA
High risk pregnancy and all prenatal OB care				X
Client moves to/from managed care and FFS		X		
Perinatologist visit for preexisting condition and client is now pregnant (visit is outside of OB care/outside of OB bundle)	X			
Antepartum care and/or postpartum care if only 1-3 visits			X	

Antepartum care only

Note: Bill **only one** of these codes to represent the total number of times the client was seen for antepartum care.

Service	CPT® Code/ Modifier	Short Description	Limitations
Antepartum care	99202-99215 TH	Office visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Modifier TH must be billed.
Antepartum care	59425	Antepartum care only	Limited to one unit per client, per pregnancy, per provider

Service	CPT® Code/ Modifier	Short Description	Limitations
Antepartum care	59426	Antepartum care only	Limited to one unit per client, per pregnancy, per provider

Additional monitoring for high-risk conditions

Service	CPT® Code/ Modifier	Short Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 UA	Office/outpatient visit est	Must not be billed with a normal pregnancy diagnosis (**Z33.1, Z34.00, Z34.80, or Z34.90**); diagnosis must detail need for additional visits; must be billed with modifier UA.

Labor management

Note: Labor management may only be billed when another provider takes over and delivers the infant.

Service	CPT® Code/ Modifier	Short Description	Limitations
Labor management (hospital admit)	99221-99223 TH	Initial hospital care	Must not be billed by the same provider who bills for the delivery. **Note:** The admit code with modifier TH and the prolonged services code **must be billed on the same claim**.

Service	CPT® Code/ Modifier	Short Description	Limitations
Labor management (prolonged services)	+99418 TH **Limited to 4 units**	Prolonged service inpatient	Prolonged services are limited to 1 hour per client, per pregnancy; must be billed with modifier TH. Must not be billed by the same provider who bills for the delivery. **Note:** The admit code with modifier TH and the prolonged services code **must be billed on the same claim**.

Deliveries

Service	CPT® Code/ Modifier	Short Description	Limitations
Delivery only	59409	Obstetrical care	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
Delivery only	59514	Cesarean delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
Delivery only	59612	Vbac delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
Delivery only	59620	Attempted VBAC delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.

Service	CPT® Code/ Modifier	Short Description	Limitations
Delivery with postpartum care	59410	Obstetrical care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
Delivery with postpartum care	59515	Cesarean delivery	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
Delivery with postpartum care	59614	Vbac care after delivery	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
Delivery with postpartum care	59622	Attempted vbac after care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.

High-risk deliveries

Service	CPT® Code/Modifier	Short Description	Limitations
High-risk delivery [Not covered for assistant surgeons, co-surgeons, or RNFA]	Add modifier TG to the delivery code (e.g., 59400 TG)	Complex/high level of care	Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. Bill only **ONE** line of service (e.g., 59400 TG) for **BOTH** the delivery and high-risk add-on.

Postpartum care only

Service	CPT® Code/ Modifier	Short Description	Limitations
Postpartum care only	59430	Care after delivery	Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.

Authorization

Authorization is HCA's approval for covered services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), expedited prior authorization (EPA), and limitation extensions (LE) are forms of authorization**.

Prior authorization (PA)

What is prior authorization (PA)?

Prior authorization (PA) is the process HCA uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. PA does not guarantee payment.

For examples on how to complete a PA request, see HCA's **Billers, providers, and partners** webpage.

> **Note**: HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

HCA reviews PA requests in accordance with WAC 182-501-0165. HCA uses evidence-based medicine to evaluate each request. HCA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HCA reviews all evidence submitted and will either:

- Approve the request.
- Deny the request if the requested service is not medically necessary.
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HCA will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, HCA will deny the requested service.

When HCA denies all or part of a request for a covered service or equipment, HCA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action HCA intends to take.
- Includes the specific factual basis for the intended action.
- Includes references to the specific WAC provision upon which the denial is based.

- Is in sufficient detail to enable the recipient to learn why HCA's action was taken.
- Is in sufficient detail to determine what additional or different information might be provided to challenge HCA's determination.
- Includes the client's administrative hearing rights.
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Documentation requirements for PA or LE

PA documentation

How do I obtain PA or an LE?

For all requests for PA or LEs, the following documentation is required:

- A completed, TYPED *General Information for Authorization* form, 13-835. This request form MUST be the initial page when of the request.
- A completed *Fax/Written Request Basic Information* form, 13-756, if there is not a form specific to the service being requested, and all the documentation listed on the form with any other medical justification.

Fax the request to: (866) 668-1214.

See HCA's **Billers, provider, and partners** webpage.

See **Where can I download HCA forms?**

Requesting prior authorization (PA)

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's **prior authorization webpage** for details).

Fax

If providers choose to submit a faxed PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See **Where can I download HCA forms?** This form must be page one of the faxed request and must be typed.
- The program form, if available. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit faxed PA requests (with forms and documentation) to (866) 668-1214.

For a list of forms and where to send them, see **Documentation requirements for PA or LE**. Be sure to complete all information requested. HCA returns incomplete requests to the provider.

Limitation extension (LE)

What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides.

> **Note**: A request for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request an LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the **EPA criteria list** for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service.

The request must state all the following:

- The name and ProviderOne Client ID of the client
- The provider's name, NPI, and fax number
- Additional service(s) requested
- The primary diagnosis code and CPT® code
- Client-specific clinical justification for additional services

Expedited prior authorization (EPA)

What is expedited prior authorization (EPA)?

Expedited prior authorization (EPA) is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies the criteria

with specific codes, enabling providers to use those codes in lieu of requesting PA.

To bill HCA for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **use the 9-digit EPA number** (see **EPA criteria list** for numbers). Enter the EPA number on the billing form in the authorization number field, or in the **Authorization** or **Comments** section when billing electronically.

HCA denies claims submitted without a required EPA number.

HCA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to HCA on request. If HCA determines the documentation does not support the criteria being met, the claim will be denied.

> **Note**: HCA requires PA when there is no option to use an EPA number.

EPA documentation guidelines

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon HCA's request. If HCA determines the documentation does not support the EPA criteria requirements, the claim will be denied.

EPA criteria list

If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization).

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001344	Noninvasive prenatal diagnosis of fetal aneuploidy (NIPT)	**CPT® code**: 81507 and 81420	HCA considers NIPT for serum marker screening for fetal aneuploidy to be medically necessary in pregnant clients with high-risk singleton pregnancies, who have had genetic counseling, when one or more of the following are met: • Pregnant client is age 35 years or older at the time of delivery • History of a prior pregnancy with a trisomy or aneuploidy • Family history of aneuploidy (first degree relatives or multiple generations affected) • Positive first or second trimester standard biomarker screening test for aneuploidy, including sequential, or integrated screen, or a positive quadruple screen • Parental balanced Robertsonian translocation with increased risk for fetal T13 or T21 • Findings indicating an increased risk of aneuploidy
870001375	Early elective delivery or natural delivery prior to 39 weeks gestation	**CPT® code**: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	Client is under 39 weeks gestation and the birthing parent or fetus has a diagnosis listed in the Joint Commission's current table of Conditions possibly justifying elective delivery prior to 39 weeks gestation, or client delivers naturally

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001378	Elective delivery or natural delivery at or over 39 weeks gestation	**CPT® code**: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	Client is 39 weeks gestation or over 39 weeks gestation
870001614	Intrauterine balloon	**CPT® code:** 59899 **Modifier**: U3 **Dx:** 072, 072.0, 072.1, 072.2, 072.3	To treat postpartum hemorrhage

Payment

Fee Schedule Information

- Maximum allowable fees for all codes, including CPT® codes and selected HCPCS codes, are listed in the fee schedule.
- In the fee schedule, HCA identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in HCA billing guides and Washington Administrative Code (WAC) remain applicable.
- HCA's fee schedules are available for on HCA's **Professional billing guides and fee schedules** webpage and the **Hospital reimbursement** webpage.

Site-of service payment differential

For payment policies regarding professional services performed in facility and nonfacility settings, see HCA's **Physician-Related Services/Health Care Professional Services Billing Guide**.

General Billing

Note: All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's ProviderOne Billing and Resource Guide webpage and scroll down to *Paperless billing at HCA*. For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource*.

What are the general billing requirements?

Providers must follow HCA ProviderOne Billing and Resource Guide.

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill HCA for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

Billing claims electronically

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.