



MATERNITY SERVICES BENEFIT COVERAGE STANDARD

Colorado Medicaid is committed to risk-appropriate maternal care and achieving optimal maternal and child health outcomes. The following standard includes best practice guidelines, such as early and continuous risk screening for pregnant women, early entry into prenatal care, prenatal care delivered by the provider/specialty level best suited to the risk level of the client, effective communication between providers regarding the client's perinatal plan of care and the establishment of a medical home following delivery to help ensure that the ongoing health care needs of the woman and child are met.

ELIGIBLE PROVIDERS

- Physician
- Osteopath
- Certified Nurse-Midwife
- Nurse Practitioner
- Clinical Nurse Specialist
- Physician Assistant
- Family Planning Clinic
- Public Health Agency
- Non-Physician Practitioner Group

Note: Not every provider and place of service listed above will be acceptable for every service (e.g., a family planning clinic may not be eligible for delivery reimbursement).

ELIGIBLE PLACES OF SERVICE

- Office
- Hospital
- Clinic
- Family Planning Clinic
- Public Health Agency
- Federally Qualified Health Center
- Rural Health Center
- Birthing Center



- Home

Note: Mental health providers and services for pregnant women with a covered mental health diagnosis are available through the client's regional Behavioral Health Organization.

ELIGIBLE CLIENTS

Medicaid-eligible women of childbearing age qualify for maternity services. Women remain eligible throughout their pregnancy and maintain eligibility until the end of the month in which 60 days have passed post-pregnancy. Income changes during pregnancy do not affect eligibility.

Pregnant women may apply for Medicaid and begin care under a period of presumptive eligibility. Presumptive Eligibility (PE) Medicaid is temporary Medicaid coverage for a six to eight week period of time so that prenatal care can begin while the official Medicaid application is being processed.

Only ambulatory care is covered during the PE period. Inpatient and labor and delivery services are not covered during the PE period. However, once approved for regular Medicaid by an official Medicaid eligibility determination, regular Medicaid coverage will be backdated to the date the initial application was signed by the client.

COVERED SERVICES

Pregnant women are eligible for all services determined by their provider to be medically necessary, including the services listed below.

Pregnant women age 20 and under are also eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, including dental care, vision care, and EPSDT health checkups.

Pregnant women age 21 and older are eligible for Healthy Communities outreach services provided by the Family Health Coordinator in their county/region. Family Health Coordinators are available to help clients navigate the Medicaid system, help clients find health care providers and community resources, and assist clients in obtaining Medicaid-covered transportation to health care appointments. Providers may also contact Family Health Coordinators to address specific client issues such as excessive missed appointments or assistance in finding a certain type of specialist who accepts Medicaid to whom the provider may refer clients. A link to general information about Healthy Communities can be found at this link:

www.colorado.gov/hcpf/healthy-communities.



Note: Pregnant women and women in the postpartum period are exempt from all copayments.

OFFICE VISITS:

- One initial, comprehensive prenatal visit including history and physical exam will be covered.
- Subsequent prenatal visits will be covered occurring at a frequency that follows generally accepted prenatal care practice guidelines based on client risk factors and complicating diagnoses.
- Postpartum visits are covered occurring at a frequency that follows generally accepted prenatal care practice guidelines. One to two postpartum visits are considered comprehensive in routine circumstances.

ROUTINE LAB SERVICES:

- Routine prenatal lab testing and screening (blood and cultures) supported by generally accepted prenatal care practice guidelines are covered.
- See also Genetics Screening, Testing, and Counseling below.

ULTRASOUNDS:

A maximum of two routine ultrasounds are covered per low-risk pregnancy. Women with high-risk pregnancies may receive more than two ultrasounds. Additional transvaginal or abdominal ultrasounds are covered when clinically indicated in accordance with generally accepted prenatal care practice guidelines for indication and frequency. Clinical indication must be clearly documented in the client record. Ultrasounds are not covered when performed solely to determine the sex of the fetus or to provide a keepsake picture.

ADDITIONAL SCREENING, DIAGNOSTIC, AND MONITORING SERVICES:

The following services are covered only when clinically indicated in accordance with generally accepted prenatal care practice guidelines for indications and frequency. The clinical indication must be clearly documented in the client record.

- Amniocentesis
- Fetal biophysical profile
- Fetal non-stress test
- Fetal echocardiogram
- Fetal fibronectin



- Chorionic villus sampling

GENETICS SCREENING, NON-INVASIVE DIAGNOSTIC TESTING, AND COUNSELING:
Genetic screening, non-invasive diagnostic testing, and counseling covered in accordance with generally accepted prenatal care practice guidelines. Screening coverage is available for women carrying a singleton gestation who meet ONE or more of the following conditions:

- Maternal age 35 years or older at delivery
- Fetal ultrasonographic findings indicated an increased risk of aneuploidy
- History of a prior pregnancy with a trisomy
- Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen
- Parental balanced robertsonian translocation with increased risk of fetal trisomy 13 or 21.

Note: Genetic screening, testing, and counseling must be billed by a Colorado Medicaid enrolled provider. Genetic Counselors cannot currently enroll in Medicaid, however they may render services under the supervision of an eligible provider.

GESTATIONAL DIABETES:

Diabetic supplies such as glucose meters and test strips are covered for women with gestational diabetes.

PRENATAL VITAMINS:

Prenatal vitamins are a benefit for pregnant women and during the postpartum period. A prescription indicating that the client is pregnant or in the postpartum period must be provided.

Note: For almost all pharmaceuticals and supplies, if a generic form of the prescribed pharmaceutical or supply exists, the generic alternative must be dispensed unless prior authorization is obtained for dispensing the brand-name pharmaceutical or supply.

HYDROXYPROGESTERONE CAPROATE INJECTIONS:

Hydroxyprogesterone caproate injections may be available for Medicaid clients between 16 and 36 weeks of gestation with a singleton gestation and a prior history of pre-term delivery before 37 weeks gestation due to:

- Spontaneous preterm labor; or
- Premature rupture of membranes and the absence of preterm labor within the current pregnancy.



Hydroxyprogesterone may be obtained through a pharmacy. Providers may also administer hydroxyprogesterone in an office setting.

LABOR AND DELIVERY:

Labor and delivery services including admission to the hospital, the admission history and physical examination, management of labor, and delivery are covered services.

HOME BIRTHS:

Home births may be performed by physicians and certified nurse-midwives carrying malpractice insurance that covers home births.

BREASTFEEDING/LACTATION SERVICES:

Breastfeeding/lactation office visits are for problem-specific care.

Note: Lactation consultants are not currently able to enroll as Colorado Medicaid providers.

BREAST PUMPS:

Colorado Medicaid clients who also participate in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) may be eligible to borrow a breast pump from the WIC program. Clients enrolled in WIC and Medicaid should contact the WIC program in their county for more information.

Manual breast pumps, including kit and supplies, are a covered benefit for use with premature infants and infants in critical care. They do not require prior authorization.

Electric breast pumps, including supplies, are a covered benefit as either a rental or for purchase and must be prior authorized.

- Purchase is available only for use with premature infants and infants in critical care, and only during a period of anticipated hospitalization lasting 54 days or more. Rental is available only for periods of infant hospitalization anticipated to last less than 54 days.

NON-COVERED SERVICES

- Home pregnancy tests
- Ultrasounds performed only for determination of sex of the fetus or to provide a keepsake picture
- Three and four dimensional ultrasounds
- Paternity testing



- Lamaze classes
- Birthing classes
- Parenting classes
- Home tocolytic infusion therapy

BILLING GUIDELINES

Refer to the Obstetrical Services Billing manual for billing guidelines.

DEFINITIONS

TERM	DEFINITION
Ambulatory Care	Any medical care delivered on an outpatient basis
High-risk pregnancy	Pregnancy that threatens the health or the life of the mother or her fetus. Risk factors can include existing health conditions, weight and obesity, multiple births, older maternal age, and other factors.
Singleton Gestation	Pregnancy with one fetus in the womb

LEGAL REFERENCES

REGULATION	REFERENCE
42 CFR 440.230	Amount, scope, and duration
CRS 25.5-5-102(2) and 25.5-5-202(3)	Amount, scope, and duration



REGULATION	REFERENCE
10 CCR 2505-10 § 8.200	Physician and certified nurse midwife services

POLICY IMPLEMENTATION/REVISION INFORMATION

ORIGINAL EFFECTIVE DATE: OCTOBER 2009

REVISION INFORMATION:

DATE	SECTION REVISED	CHANGE
10/29/2014	Maternity Services - Introduction	Added language clarifying the limitations of eligible providers and eligible places of service
10/29/2014	Eligible Clients	Grammatical edits
10/29/2014	Covered Services	Updated language pertaining to Healthy Communities
10/29/2014	Covered Services - Ultrasounds	Reduced coverage from 3 to 2 ultrasounds per uncomplicated or low-risk pregnancy
10/29/2014	Genetics Screening, Non-Invasive Diagnostic Testing, and Counseling	Added language to allow for coverage of non-invasive genetics testing
10/29/2014	Covered Services – Hydroxyprogesterone Caproate Injections	Updated coverage of hydroxyprogesterone to reflect current practice. The Department is working to add a rate to allow payment for Makena when administered in an office, however, if no rate is available by the time this document is completed, the reference will be removed. In that circumstance, the Department will add coverage for Makena to the standard when able to set the rate.
10/29/2014	Covered Services – Breastfeeding/Lactation Services	Added language clarifying Medicaid’s coverage of breast pumps for Medicaid clients.
10/29/2014	Non-Covered Services	Removed hydroxyprogesterone caproate injections as a non-covered service.
10/29/2014	Billing Guidelines	Removed detailed billing guidelines; information is available in published billing manuals.
10/29/2014		Removed reference to all specialty programs; they are governed by state rules and information is not appropriate for a coverage standard.



COLORADO

Department of Health Care
Policy & Financing

10/29/2014	Definitions	Removed definitions because they pertained to special programs that were also removed. Added definition of ambulatory care.
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Medicaid Director Signature

A handwritten date in black ink, "2/23/15".

Date