



Benefits Collaborative Policy Statement

MATERNITY SERVICES

Colorado Medicaid is committed to risk-appropriate care that will enhance optimal maternal and child health outcomes. Best practice guidelines include 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 of the client, effective communication regarding the perinatal plan of care between each provider, and the establishment of a medical home following delivery to facilitate the ongoing health care needs of the woman and child.

Eligible Providers

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

* 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 Places of Service

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

Eligible Clients

Medicaid-eligible women of childbearing age qualify for maternity services. Eligible pregnant women are entitled to continuous eligibility. The woman remains eligible throughout her pregnancy and until the end of the month in which the 60th day following the end of her pregnancy occurs. 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

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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 and women in the postpartum period are exempt from all copayments. 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 EPSDT outreach services provided by the EPSDT Outreach Coordinator in their county/region. EPSDT Outreach 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 EPSDT Outreach 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 EPSDT and contact information for EPSDT Outreach Coordinators can be found at www.colorado.gov/hcpf by clicking on “Clients and Applicants” and then “Medical Assistance Programs.”

Office Visits:

- One initial, comprehensive prenatal visit including client 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. Seven to thirteen subsequent prenatal visits for a routine pregnancy are considered comprehensive.
- 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.
- See **Billing Guidelines** below for prenatal care billing information.

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 three routine ultrasounds are covered per pregnancy. 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.

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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, Testing and Counseling:

Genetic screening, testing and counseling is covered in accordance with generally accepted prenatal care practice guidelines. Colorado Medicaid does not currently recognize “Genetic Counselor” as an eligible provider type.

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.

* For almost all pharmaceuticals and supplies, if a generic form of the prescribed pharmaceutical or supply exists, then the generic alternative must be dispensed unless prior authorization is obtained for dispensing the brand-name pharmaceutical or supply. (See pharmacy policy for details on how to obtain prior authorization for pharmaceuticals.)

Labor and Delivery:

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

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 covered using Evaluation and Management (E+M) procedure codes for problem-specific care. Most E+M require services to be rendered by a physician, physician assistant, or advanced practice nurse. There are a small number of E+M codes that allow services to be provided by a registered nurse. Lactation consultants are not currently able to enroll as Colorado Medicaid providers.

Manual breast pumps are a covered benefit and do not require prior authorization. Electric breast pumps must be prior authorized.

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Special Programs

Prenatal Plus Program:

The goal of the Prenatal Plus program is to improve birth outcomes by reducing the prevalence of low birth weight infants among Medicaid-eligible women in Colorado. Prenatal Plus provides case management, nutrition, and psychosocial services to pregnant women who are assessed to be at high risk for delivering low birth weight infants. These services complement medical prenatal care by addressing the lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect her pregnancy.

Only providers who have received training for the Prenatal Plus Program and meet the service requirements determined by the Colorado Department of Public Health and Environment are eligible for reimbursement for Prenatal Plus services. The provider must demonstrate how they meet the specified service requirements including:

- Identify and target pregnant women with risk factors potentially requiring the Prenatal Plus service package
- Deliver Prenatal Plus services to eligible pregnant women who complete the Risk Assessment and are found to be at high risk for delivering a low birth weight baby
- Refer clients for other services as necessary and coordinate with other community agencies
- Track, document and report risk resolution and pregnancy outcome for women who remain in the program through delivery

Application review and provider selection is conducted at the Colorado Department of Public Health and Environment.

Reimbursable Prenatal Plus services are limited to:

- Risk Assessment - Identification and documentation of client medical, psychosocial, nutritional and behavioral strengths and risk factors that could negatively impact pregnancy outcome.
- Prenatal Care Coordination - Services provided by a Prenatal Plus provider that includes service planning and coordination, referral, follow-up and monitoring.
- Home visitation - A 30-90 minute face-to-face contact with a client at the client's residence or alternative non-provider site by the Prenatal Plus provider to address issues identified through the Risk Assessment.
- Nutrition counseling - Nutrition intervention services provided by a registered dietitian including ongoing nutrition assessment, client counseling and referral to other health professionals as needed.
- Psychosocial counseling - Services provided by a mental health professional including ongoing assessment of the client's psychological and social situation, brief psychotherapy, crisis intervention and referral to additional mental health treatment as needed.

Contact the local EPSDT Outreach Coordinator for information on how to enroll or refer a client. A link to general information about EPSDT and contact information for EPSDT Outreach Coordinators can be found at www.colorado.gov/hcpf by clicking on "Clients and Applicants" and then "Medicaid Programs."

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Nurse Home Visitor Program:

The Nurse Home Visitor Program is a program available to first-time (defined as no previous live births), pregnant women or women whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level. (Medicaid only reimburses for services for Medicaid-eligible clients.) Participating providers shall be certified by the Colorado Department of Public Health and Environment and provide targeted case management services that include:

- Assessment of the first-time pregnant woman and her first child's needs for health, mental health, social services, education, housing, childcare and related services
- Development of care plans to obtain the needed services
- Referral to resources to obtain the needed services, including medical providers who provide care to a first-time pregnant woman and her first child
- Routine monitoring and follow-up visits with the women where progress in obtaining the needed services is monitored, problem-solving assistance is provided and the care plans are revised to reflect the woman's and child's current needs

Contact the local EPSDT Outreach Coordinator for information on how to enroll or refer a client. A link to general information about EPSDT and contact information for EPSDT Outreach Coordinators can be found at www.colorado.gov/hcpf by clicking on "Clients and Applicants" and then "Medicaid Programs."

Special Connections Program:

The Special Connections Program is a Medicaid program for pregnant women with substance use disorders. The program is administered jointly with the Colorado Department of Human Services' Division of Behavioral Health. Services available to participating women include:

- Risk assessment
- Individual, group, and family counseling
- Case management
- Group health education sessions

Services are provided on an outpatient or residential basis depending upon the level of severity of the disorder, and client need. Services may be provided throughout the pregnancy and up to one year following the birth (if the birth resulted in a live-born infant of whom the woman will retain custody). All providers of Special Connections services must be licensed by and contracted with the Division of Behavioral Health.

Contact the local EPSDT Outreach Coordinator for information on how to enroll or refer a client. A link to general information about EPSDT and contact information for EPSDT Outreach Coordinators can be found at www.colorado.gov/hcpf by clicking on "Clients and Applicants" and then "Medicaid Programs."

State-Only Prenatal Program:

The State-Only Prenatal Program is a state-funded program for pregnant women who are legal permanent resident immigrants who entered the United States after August 22, 1996 and are not eligible for Medicaid due to their alien status but meet categorical eligibility requirements.

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Only services related to the pregnancy including prenatal, labor and delivery, and postpartum care are covered. The prenatal, labor and delivery, and postpartum care in the State Only Prenatal Program are the same as those in traditional Medicaid.

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
- 17 alpha hydroxyprogesterone caproate injections for the prevention of preterm labor

Billing Guidelines*

Office Visits, Labor and Delivery, and Postpartum Care:

Prenatal care provided at places other than Federally Qualified Health Centers or Rural Health Centers should be billed using the global or bundled system.

- Providers should bill all antepartum visits, the labor and delivery, and postpartum care on one claim using procedure codes specific to the number of antepartum visits provided, whether the delivery was vaginal or by cesarean section, and other specific circumstances.
- A bundled procedure code should also be used when only the delivery and postpartum care were provided, or when only a limited number of antepartum visits were provided.
- Prenatal visits should only be billed singly if three or fewer visits were provided before delivery or termination of care.

* Consult the Current Procedural Terminology (CPT®) manual and the provider billing manuals for global procedure codes and specific requirements regarding claim submission.

Additional Services (Ultrasounds, Labs, etc.):

Ultrasounds, labs, anesthesia, services in Special Programs, and other additional services should be billed separately from and in addition to the global prenatal care.

Lab tests performed in the office may be billed as a separate charge by billing the appropriate 80000 range CPT code allowed by the laboratory's CLIA certification category.

Medicaid does not reimburse the prenatal care practitioner for tests performed at an independent lab. If the practitioner sends a specimen to an independent lab, the lab will bill for their services.

- The collection of a urine specimen is included in the office visit
- Finger/heel/ear stick for collection of specimens are included in the office visit
- Collection of a Pap test or other culture when sent to an independent lab is billable

Obstetrical Anesthesia:

General or regional anesthesia by the delivering physician or an anesthesiologist is covered. Epidural anesthesia by a provider other than the delivering practitioner is covered. Direct patient contact time must be documented. Claims for more than 120 minutes (eight or more 15 minute units) of direct patient contact epidural time require documentation verifying the extended direct patient contact. Standby anesthesia is a benefit in conjunction with deliveries.

Definitions

At-risk is used to describe a pregnant woman who requires additional prenatal care services due to factors that increase the probability of a preterm delivery, a low birth weight infant or a poor birth outcome.

Low Birth Weight is a birth weight less than 2,500 grams.

Risk Assessment is a standardized prenatal assessment tool, or equivalent, for identification of the medical, genetic, life-style and psychosocial factors that put a client “at-risk” for preterm delivery, a low birth weight infant or a poor birth outcome.

Postpartum Period, for the purposes of this policy, means the period of time starting on the date the pregnancy ends and continuing through the end of the month in which the 60th day after the end of the pregnancy occurs.

Legal References

- 42 CFR 440.230 - Amount, scope, and duration
- CRS 25.5-5-102(2) and 25.5-5-202(3) - Amount, scope, and duration
- CRS 25.5-5-205(B) – Continuous eligibility
- 10 CCR 2505-10 § 8.200 – Physician and certified nurse midwife services
- 10 CCR 2505-10 § 8.748 – Prenatal Plus Program
- 10 CCR 2505-10 § 8.749 – Nurse Home Visitor Program
- 10 CCR 2505-10 § 8.745 – Special Connections Program
- CRS 25.5-5-201(4) – State Only Prenatal Program



Medicaid Director Signature

9/3/15

Date