

Updates to Clinical Coverage Policy 1E-5 Obstetrical Services



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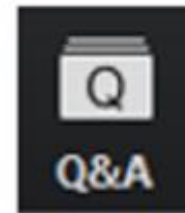
August 6, 2024

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Logistics for Today's Webinar

Question during the live webinar



Technical assistance

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Disclosures

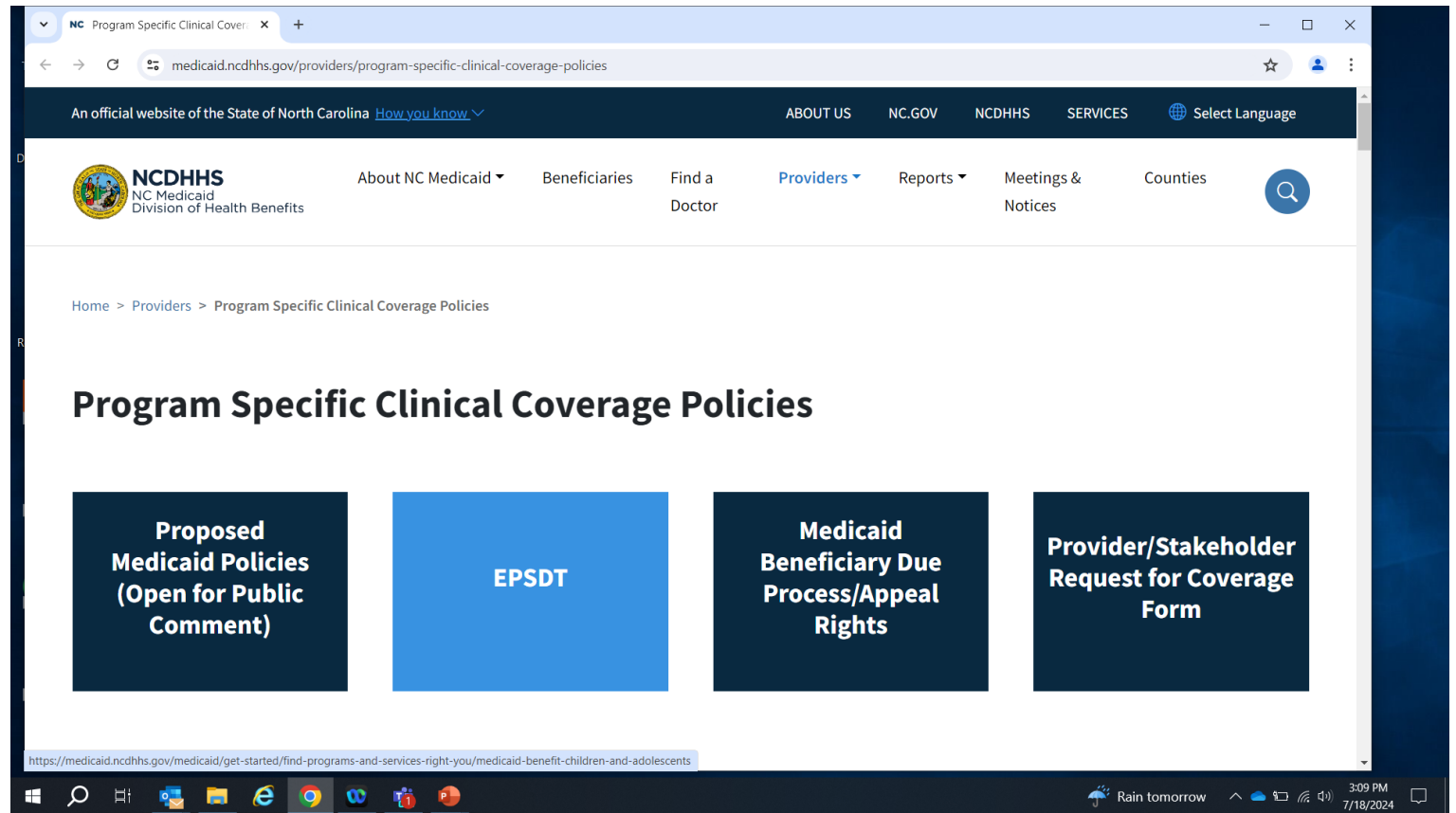
- None

Objectives

- This webinar will cover the updates that have occurred in the Obstetrical Clinical Policy 1E-5 over the last year:
 - Group Prenatal Care Incentive Payments
 - Vaginal Birth After Cesarean Delivery Codes (VBAC)
 - Postpartum Depression Screening
 - Pregnancy Management Program Updates
 - F codes

Source: [Program Specific Clinical Coverage Policies](https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies)

Program Specific Clinical Coverage Policies Homepage



Women's Health Clinical Policies

Medical Equipment

- [5A-1, Physical Rehabilitation Equipment and Supplies](#)
- [5A-2, Respiratory Equipment and Supplies](#)
- [5A-3, Nursing Equipment and Supplies](#)
- [5B, Orthotics & Prosthetics](#)

Obstetrics & Gynecology

- [1E-1, Hysterectomy](#)
- [1E-2, Therapeutic and Non-therapeutic Abortions](#)
- [1E-3, Sterilization Procedures](#)
- [1E-4, Fetal Surveillance](#)
- [1E-5, Obstetrics](#)
- [1E-6, Pregnancy Management Program](#)
- [1E-7, Family Planning Services](#)

What clinical policy are we focusing on during this webinar?

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): For questions about benefits and services available on or after implementation, please contact your PHP.

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Group Prenatal Care Incentive Payments

- NC Medicaid has always covered group prenatal care by paying for individual antepartum services, antepartum package services or global obstetrics packages. This will continue with no changes and applies to both individual patient visits or group prenatal care.
- Bill CPT code 99078 with modifier TH
- A practice may earn an additional \$250 incentive payment for the care of an individual pregnant person who attends group prenatal care when the following criteria are met:

3.2.3 Group Prenatal Care

Group Prenatal Care is an optional service that may be provided to pregnant beneficiaries. Medicaid shall pay an incentive for Group Prenatal Care when **five** or more visits are attended and documented in the health record.

Show Me The Money!

- If you have a group that starts every month with 10 members who complete at least 5 group visits, this will provide an additional \$2500 to your practice each month. This is an additional \$30,000 per year.
- If you have a group that starts every other month with 10 members who complete at least 5 group visits, this will provide an additional \$2500 to your practice every other month. This is an additional \$15,000 per year.
- If you have a group that starts every quarter with 10 members who complete at least 5 group visits, this will provide an additional \$2500 to your practice each quarter. This is an additional \$10,000 per year.



Vaginal Birth After Cesarean (VBAC) Codes

In addition, NC Medicaid is making the following updates to Clinical Coverage Policy 1E-5, Obstetrical Services:

- Adding coverage for the following new vaginal birth after cesarean (VBAC) codes, effective July 1, 2023:

Procedure Code	Code Description
59610	VBAC Delivery
59612	VBAC Delivery Only
59614	VBAC Care After Delivery
59618	Attempted VBAC Delivery
59620	Attempted VBAC Delivery Only
59622	Attempted VBAC After Care

Postpartum Depression Screening

- Obstetric, family practice, and pediatric providers may be reimbursed for *four* brief emotional behavioral assessments with scoring and documentation, per standardized instrument, during the first year after the delivery date or until the beneficiary eligibility ends, in addition to global obstetrics and postpartum package services. If a problem is identified, the beneficiary shall be referred to their primary care provider or other appropriate providers.

Postpartum Definition Dilemmas

- ACOG defines the postpartum period as the 12 weeks after delivery
- The *postpartum period* is defined by NC Medicaid as the period between delivery and the end of the month in which the 60th postpartum day falls. Postpartum package services are covered when the attending provider: a. performed the delivery and provided the postpartum care; or b. performed postpartum care only.
- Per [Clinical Coverage Policy 1E-6 Pregnancy Management Program](#), S0281 must be billed within 60 days of delivery.
- For the Prenatal and Postpartum (PPC) HEDIS measure, you must ensure comprehensive postpartum visits occur within 7-84 days of delivery.
- Medicaid for Pregnant Women (MPW) eligibility ends the last date of the month in which the 12-month post-pregnancy period ends.

Ideal Timing of the Comprehensive Postpartum Visit

- The ideal timing of the comprehensive postpartum visit should occur between 7 and 60 days post-delivery so that you can receive the incentive payment and get credit for the HEDIS measure.

Pregnancy Management Program Updates

- S0280 may be billed up to three times during a pregnancy.
- S0281 must be billed within 60 days of delivery.
- The PMP provider can only bill HCPCS codes S0280 a maximum of three times, and S0281 one time during the gestational period even if there are multiple births

The following table contains codes for the billing of the PMP Pregnancy Risk Screening Form and the PMP Postpartum plan maintenance:

HCPCS Code(s)	Guidelines	Telehealth Eligible Services
S0280	Providers shall bill this code after the pregnancy risk screening tool has been completed.	Yes
S0281	Providers shall bill this code after the postpartum visit is completed.	Yes

Note: Telehealth eligible services may be provided to new and established patients by the eligible providers listed within this policy.



What are these F Codes that everyone is talking about???

Prenatal and Postpartum Care (PPC) Quality Measure

- NC Medicaid has historically underperformed on the NCQA HEDIS® *Prenatal and Postpartum Care (PPC)* quality measure
 - Timeliness of Prenatal Care: The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
 - Postpartum Care: The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.

Figure 1. Comparison of Timeliness of Prenatal Care rates between the national average (Medicaid HMO) and NC Medicaid from 2017-2022.

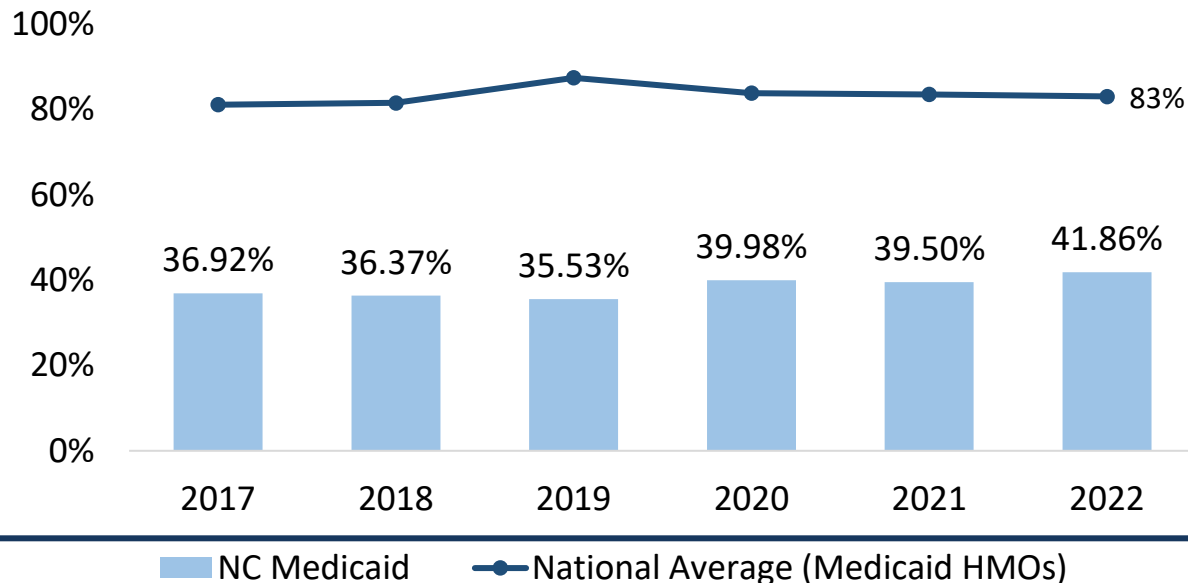
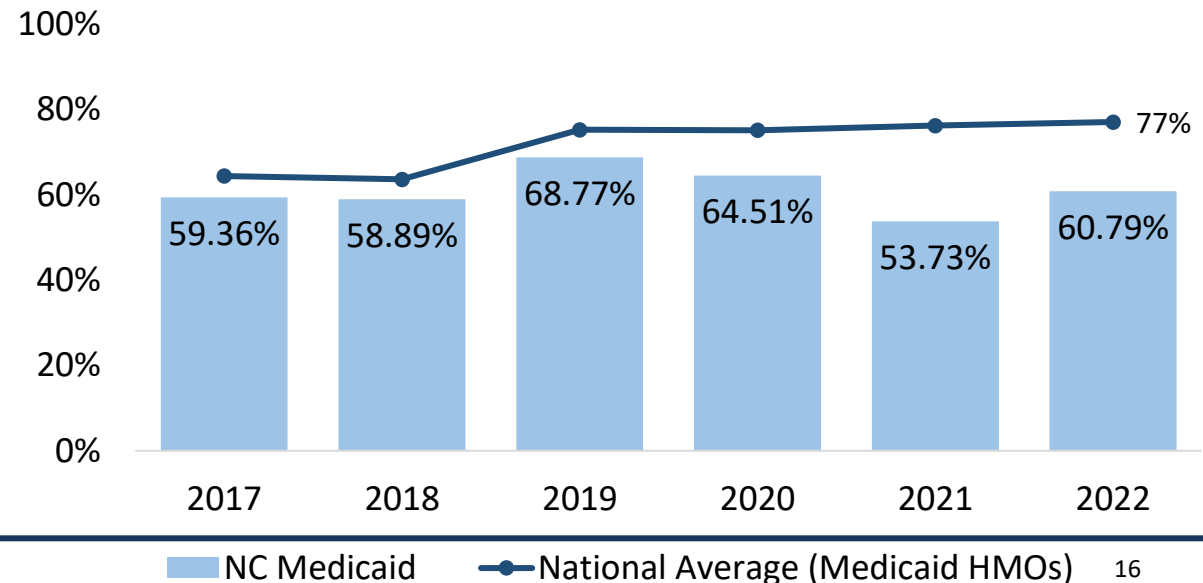


Figure 2. Comparison of Postpartum Care rates between the national average (Medicaid HMO) and NC Medicaid from 2017-2022.



The Problem

- These services are often recorded using global billing codes that are not billed until the end of the pregnancy, meaning the first instance of prenatal care and subsequent postpartum care are often not adequately captured in claims and encounters data

Table: Impact of Global Billing on HEDIS® Timeliness of Prenatal Care Numerator Compliance (June 2016-June 2023).

Presence of Global or Package Code	HEDIS Numerator Compliant	Number of (%) Distinct Medicaid IDs
Yes – Global or Package Code Found	Compliant	69,248 (25.53%)
	Not Compliant	137,825 (50.81%)
No – No Global or Package Code	Compliant	44,058 (16.24%)
	Not Compliant	63,487 (23.40%)

A higher proportion of people that were not numerator compliant had a global or package code for pregnancy-related services

The Solution: PPC F Codes

Two new F codes are being added to NC Medicaid’s clinical policy (revision of NC Medicaid Obstetrical Services Clinical Coverage Policy No: 1E-5):

- **0500F** for Initial Prenatal Visits and
- **0503F** for Postpartum Care Visits

Both codes are defined in the NCQA HEDIS® value sets and are meant to support more accurate and complete data collection

New F Codes for Capturing Prenatal and Postpartum Care			
CPT Code	Type	Description	Physician/NPP/LHD Services Guidelines
0500F	Individual	Initial Prenatal Care Visit	Code reported to identify initiation of prenatal care. Report at first prenatal encounter with an obstetrical provider or other prenatal care practitioner. Report date of visit and in a separate field the date of the last menstrual period (LMP).
0503F	Individual	Postpartum Care Visit	Code reported to identify the comprehensive postpartum care visit. Postpartum visit can be to an obstetrical provider or other postpartum care practitioner, or primary care provider (PCP). Do not include postpartum care provided in an acute inpatient setting or other urgent/emergency room setting.



Quality Management and Improvement Homepage

- The PPC F Codes Fact Sheet and FAQ Document can be found on our Quality Management and Improvement Homepage

Prenatal and Postpartum Care F Codes

NC Medicaid's [Obstetrical Services Clinical Coverage Policy No: 1E-5](#), updated June 15, 2024, requires the use of two new CPT billing codes for prenatal and postpartum care. These codes will assist in capturing information about the timeliness of prenatal and postpartum care provided to NC Medicaid members. The PPC F Codes Fact Sheet and FAQ document aim to give providers and practices more information about these new F codes, why they are important, and how they should be used.

- [PPC F Codes Fact Sheet](#) - July 2024
- [PPC F Codes FAQ Document](#) - July 2024

Prenatal and Postpartum Care F Code Requirement FAQ Document

Prenatal and Postpartum Care F Code Requirement: Frequently Asked Questions

BACKGROUND

NC Medicaid's [Obstetrical Services Clinical Coverage Policy No: 1E-5](#), updated June 15, 2024, requires the use of two new CPT billing codes for prenatal and postpartum care. These codes will assist in capturing information about the timeliness of prenatal and postpartum care provided to NC Medicaid members (see Table 1).

Table 1: F Codes for Capturing Prenatal and Postpartum Care Added to NC Medicaid's Clinical Policy

CPT Code	Type	Description	Physician/Non-Physician Provider/LHD Services Guidelines
0500F	Individual	Initial Prenatal Care Visit*	Code reported to identify initiation of prenatal care. Report at first prenatal encounter with an obstetrical provider or other prenatal care practitioner. Report date of visit and in a separate field the date of the last menstrual period (LMP).
0503F	Individual	Postpartum Care Visit	Code reported to identify the comprehensive postpartum care visit. Postpartum visit can be to an obstetrical provider or other postpartum care practitioner, or primary care provider (PCP). Do not include postpartum care provided in an

FAQ

Question

Highlights

20. Should providers still use S codes in addition to these new F codes?

a. Yes. These codes should be billed in addition to the 0500F and 0503F, respectively. The first visit should be billed with both codes (0500F and S0280) if the patient completes the Pregnancy Risk Screening Form. Providers should use the 0503F and S0281 codes after completing the comprehensive postpartum visit.

b. Per Clinical Coverage Policy 1E-6 Pregnancy Management Program, S0281 must be billed within 60 days of delivery and only after the postpartum visit has been completed. This code is to be billed once, even if there are multiple births. After this time, services for care management will end and those beneficiaries still requiring services should be referred to an appropriate provider.

Coding and Billing Examples

2. First Obstetric Visit with Prenatal Risk Screenings and Antepartum Package (Billed as a Single Claim)
 - a. LMP: 1/1/23
 - b. First Visit with Obstetric Provider (0500F): 2/14/23
 - c. Prenatal Risk Screenings at First Visit, 28 Weeks, and 36 Weeks
 - d. Antepartum Services (59426): Provided 2/14/23 - 10/7/23



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 01 01 23 QUAL.				15. OTHER DATE QUAL. MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN John Smith, MD						17a. NPI 1897657328		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. Z34.01 B. Z34.03 C. Z34.0 D. E. F. G. H. I. J. K. L.						ICD Ind.		22. RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPICR Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY														
02	14	23	02	14	23	11	0500F		A	0 00	1		NPI	1982476891					
02	14	23	02	14	23	11	S0280		A	50 00	1		NPI	1982476891					
07	16	23	07	16	23	11	S0280		B	50 00	1		NPI	1982476891					
09	10	23	09	10	23	11	S0280		B	50 00	1		NPI	1982476891					
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													NPI						

PHYSICIAN OR SUPPLIER INFORMATION

FAQ

Question

Highlights

3. Will all delivery claims be denied in the absence of these codes or only those that are globally billed?

a. The updated billing guidelines will deny all delivery billing claims that do not include 0500F, not just those that are globally billed. Claims will not be denied due to the absence of 0503F (postpartum care). However, the State may issue additional guidance or billing requirements if utilization does not mirror that of 0500F. As a reminder, global obstetric service claims are not to be submitted until postpartum care has been rendered.

FAQ Question Highlights

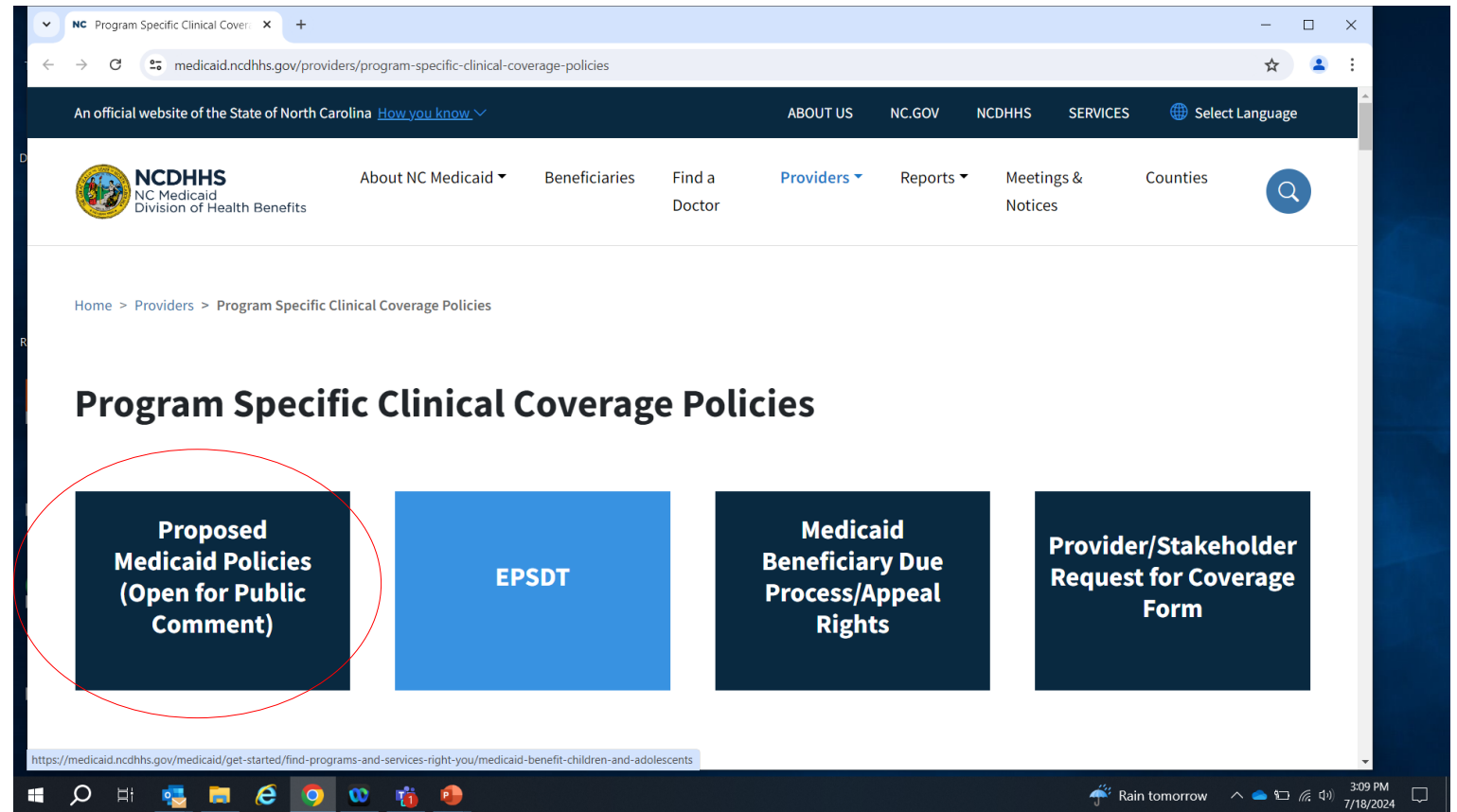
6. The revised policy was effective April 1, 2024, but claim denials will not begin until July 1, 2025. Will I be required to submit corrected claims to include 0500F for deliveries prior to July 1, 2025?

a. The State is in the process of updating NCTracks to mirror the language outlined in the updated policy and is also allowing time for providers to update their systems and become familiar with the new billing requirements. Providers will not be required to submit corrected claims for dates of service prior to July 1, 2025.

Other Resources

Source: Program Specific Clinical Coverage Policies

Program Specific Clinical Coverage Policies Homepage



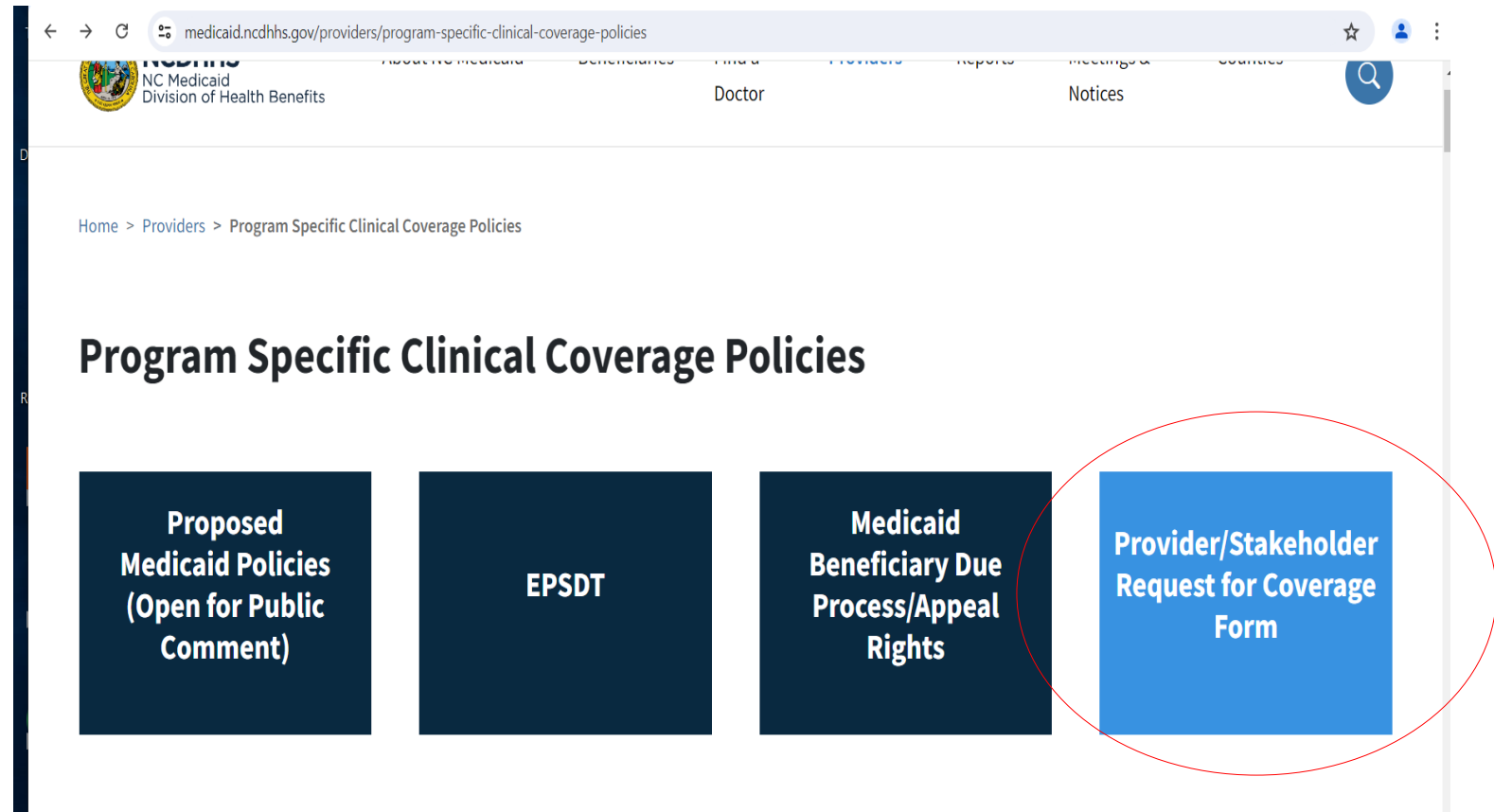
Public Comment Open Periods

NC Medicaid: 1E-5 x NC Proposed Medicaid Policies | NC x +

medicaid.ncdhhs.gov/meetings-notice/proposed-medicaid-policies

Proposed Policy	Date Posted	Ends
3L-1, State Plan Personal Care Services (PCS) Provided in Congregate Setting (New Policy)	06/07/2024	07/22/2024
3L, State Plan Personal Care Services (PCS) in In-Home Setting	06/07/2024	07/22/2024
1E-7, Family Planning Services	06/28/2024	08/12/2024
8D-3 Clinically Managed Low-Intensity Residential Treatment (New Policy)	07/08/2024	07/23/2024
8D-4 Clinically Managed Population Specific High Intensity Residential Treatment (New Policy)	07/08/2024	07/23/2024
8D-5 Clinically Managed		

Do you have changes or items that you would like for NC Medicaid's clinical coverage policies to cover?



The screenshot shows a web browser window with the URL medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies. The page header includes the NC Medicaid logo and navigation links for 'About NC Medicaid', 'Beneficiaries', 'Find a Provider', 'Reports', 'Meetings & Notices', and 'Contact Us'. The breadcrumb trail is 'Home > Providers > Program Specific Clinical Coverage Policies'. The main heading is 'Program Specific Clinical Coverage Policies'. Below the heading are four dark blue rectangular buttons with white text: 'Proposed Medicaid Policies (Open for Public Comment)', 'EPSDT', 'Medicaid Beneficiary Due Process/Appeal Rights', and 'Provider/Stakeholder Request for Coverage Form'. The last button is highlighted with a red circle.



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