Pregnancy: Early Care and Diagnostic Services 1

This section contains information for billing obstetrical (OB) early care and diagnostic services, including sonography, genetic testing and cordocentesis.

Note: For assistance in completing claims for pregnancy services, refer to the *Pregnancy Examples* section in this manual.

Presumptive Eligibility for Pregnant Women Program

The Presumptive Eligibility for Pregnant Women (PE4PW) program allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending a decision of their formal Medi-Cal application. See the *Presumptive Eligibility for Pregnant Women Program Process* section of this manual for more information.

Prenatal Care Guidance Program

The Prenatal Care Guidance (PCG) program is integrated into the existing Maternal and Child Health (MCH) programs in local health departments. The PCG seeks to educate Medi-Cal-eligible patients about the importance of prenatal care as well as assist them in obtaining and continuing prenatal care. There are several well-established benefits of prenatal care for Medi-Cal recipients: reduced incidence of low-birthweight babies, improved health of the mother before and after birth, and the ultimate cost savings related to decreased utilization of expensive health services.

Welfare departments are responsible for informing all mothers who apply for and are currently eligible for welfare that publicly funded medical care is available for their children. The integration of PCG and MCH activities will avoid duplicate effort and cost because information about prenatal and well-baby care is usually given to the same people.

Individual PCG programs have been developed at the county level and therefore differ among counties. At a minimum, however, MCH workers contact maternity care providers to assist staff in making appointments for their clients and contacting providers on a follow-up basis to ensure that clients have kept their appointments. Providers may also contact their local MCH program for assistance when they have high-risk clients who do not keep their appointments. The success of this program depends on providers' assistance in cooperating with MCH staff when they call.

For further information, contact the local MCH program through the local county health department.

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program (CPSP) is a benefit of the Medi-Cal program. The program offers a wide range of services to pregnant Medi-Cal recipients from the day that pregnancy is medically established and postnatally to the end of the month in which the 60-day period following termination of pregnancy ends. For information about this program, refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* sections in this manual.

Tobacco Cessation

Providers must offer one, face-to-face smoking/tobacco cessation counseling session and a referral to a tobacco cessation quitline to pregnant and postpartum recipients as recommended in *Treating Tobacco Use and Dependence: 2008 Update*, a U.S. Public Health Service Clinical Practice Guideline. Such counseling and referral services must be provided to pregnant and postpartum recipients without cost sharing. These services are required during the prenatal period through the postpartum period (the end of the month in which the 60-day period following termination of the pregnancy ends).

Prenatal and Postpartum Care

Pregnancy care includes prenatal, pregnancy-related services, and postpartum services as described in this section.

Medically necessary prescribed medications, laboratory services, radiology, tobacco cessation services, mental health services, substance use disorder services and dental services as defined in the *Denti-Cal Manual of Criteria* are among the covered services of the Medi-Cal program during pregnancy and the postpartum period for all pregnant patients.

Pregnancy Care: Billing:

When billing any medically necessary service during pregnancy or the postpartum period, include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

Gender Override

Instructions for overriding gender limitations for procedures are in the *Transgender Services* section in the appropriate Part 2 provider manual.

Pregnancy Care Office Visit: Antepartum Initial

HCPCS code Z1032 (initial office visit occurring within 16 weeks of last menstrual period [LMP]) is used to bill for a comprehensive office visit related to pregnancy. This code is comparable to a high complexity Evaluation and Management (E&M) code as described in the CPT-4 code book, and must include a comprehensive history, physical examination and medical decision-making of high complexity. If these components are not performed and documented in the medical record, code Z1034 (antepartum follow-up office visit) should be billed instead of code Z1032. The initial pregnancy care comprehensive office visit must conform to current standards equivalent to those defined by the American Congress of Obstetricians and Gynecologists (ACOG).

Code Z1032 is used for either global or per-visit billing and must be billed with an ICD-10-CM pregnancy associated diagnosis (O09.00 – O26.93, O29.011 – O48.1, O98.011 – O9A.519, Z34.00 – Z34.93). Reimbursement for HCPCS code Z1032 is limited to one visit in six months unless care is transferred to another physician during the same pregnancy or the provider certifies in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that pregnancy has recurred within a six-month period. Claims exceeding this limitation without certification are denied. Consultants who co-manage a pregnancy without complete transfer of care should not bill with code Z1032. Instead, E&M consultation codes 99241 – 99245 should be used.

These claims are subject to the six-month billing limit and recipient eligibility for the month of service as on all other claims.

Pregnancy Care Office Visits: Antepartum Follow-Up

Code Z1034 is used for an antepartum follow-up visit. Documentation for primary obstetrical providers must conform to current standards equivalent to those defined by ACOG for antepartum visits. Documentation by consultants, including those involved in co-management of a pregnancy, should be consistent with CPT-4 guidelines for consultation services and document the appropriate history, physical examination and medical decision making. These services must be separately identifiable from the professional and/or technical components of any diagnostic study performed. Code Z1034 may not be used to bill obstetric consultation services by a nurse practitioner or certified nurse midwife for high-risk referrals. High-risk consultation services must be provided by a perinatologist and billed with E&M consultation codes 99241 – 99245.

For more information, refer to the *Non-Physician Medical Practitioners (NMPs)* section in this manual.

Pregnancy Care Office Visit: Postpartum

Code Z1038 is used for a postpartum visit. While an office visit 7 to 14 days after delivery may be advisable after a cesarean delivery or to follow up on a complicated gestation, this care is part of the delivery follow-up and is not separately reimbursable. The postpartum visit normally occurs 4 to 6 weeks after delivery and must conform to the current standards equivalent to those defined by ACOG in the latest edition of the *Guidelines for Perinatal Care*. Providers may render and be reimbursed for more than one postpartum visit in six months if there is documentation of a postpartum complication on the claim form in the Remarks field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or an attachment for reimbursement.

Pregnancy-Related Services:

Pregnancy-related services are services required to assure the health of the pregnant patient and the fetus, or that have become necessary as a result of the patient having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, family planning services and services for other conditions that might complicate the pregnancy. Services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postnatally to the end of the month in which the 60-day period following termination of pregnancy ends.

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum patient for specialty or other medically necessary care, providers should advise the specialist or other provider that the referral is for a medically necessary service and remind the specialist to include a pregnancy diagnosis code on the claim form to ensure reimbursement. Claims should be billed with either CPT-4 Evaluation & Management (E&M) consultation codes 99241–99245 or the most appropriate billing code for the service provided. These visits must not be billed with either procedure code Z1034 (antepartum office visit) or E&M procedure codes 99201–99215 (new or established outpatient visits), or the claim may be denied.

Urinalysis (Routine)

Reimbursement for individual antepartum visits and global obstetrical service includes routine urinalysis. Claims for routine urinalysis with a diagnosis related to pregnancy are denied. Claims for urinalysis, when billed with an ICD-10-CM pregnancy diagnosis, may be reimbursed if billed in conjunction with another diagnosis code other than Z00.00, Z00.8, Z01.00 – Z01.01, Z01.10, Z01.110, Z01.118, Z01.89, Z02.1 or Z02.89. A pregnancy diagnosis code must be present on the claim form for reimbursement. A diagnosis code that establishes the medical necessity of the urinalysis must also be present on the claim form to allow reimbursement, as outlined above.

Genetic Testing

Refer to the *Genetic Counseling and Screening* section in this manual.

Glucometers for Gestational Diabetics

HCPCS code E0607 (home blood glucose monitor) is a benefit for recipients with gestational diabetes. Medical justification of this condition must be present on the claim, using ICD-10-CM diagnosis codes O24.011 – O24.919 or documentation attached to the claim that indicates the recipient is a gestational diabetic. Reimbursement is limited to one glucometer every five years, per recipient, for any provider. For additional information refer to the *Durable Medical Equipment (DME): Bill for DME* section in the appropriate Part 2 manual.

Preventing Preterm Births: Hydroxyprogesterone Caproate

Hydroxyprogesterone caproate injections are administered to prolong pregnancy for pregnant patients with documented histories of spontaneous preterm births (less than 37 weeks gestation) and a current singleton pregnancy. The prior and current pregnancies must be singletons; prior or current multiple gestation pregnancy is a contraindication. Hydroxyprogesterone caproate injections may be billed using specific HCPCS codes.

Makena or Not Otherwise Specified

Reimbursement for HCPCS code J1726 (injection, hydroxyprogesterone caproate [Makena], 10 mg) and J1729 (injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg) is limited to one 250 mg injection every seven days between 16 and 36 weeks of gestation. Claims for HCPCS code J1726 or J1729 must include an ICD-10-CM diagnosis code from the range of O09.211 – O09.219 (supervision of pregnancy with history of pre-term labor). Modifiers SA and UD are allowed. Modifier UD is used by Section 340B providers to denote drugs purchased under this program.

For instructions on how to provide Makena brand hydroxyprogesterone caproate by a specialty pharmacy, call the Makena Care Connection at 1-800-847-3418 or visit the Makena Care Connection page of the Makena website at *http://www.makena.com/pages/hcp/care-connection/*.

Compounded

HCPCS codes J1726 and J1729 are not used for the billing of compounded hydroxyprogesterone caproate. If warranted, the compounded form must be billed using HCPCS code J3490 (unclassified drugs) and the claim must be submitted with all appropriate documentation including an invoice, National Drug Code (NDC) and an ICD-10-CM diagnosis code O09.211 – O09.219 (supervision of pregnancy with history of pre-term labor).

Ultrasound During Pregnancy

Ultrasound performed for routine screening during pregnancy is considered an integral part of patient care during pregnancy and its reimbursement is included in the obstetrical fee. Ultrasound during pregnancy is reimbursable only when used for the diagnosis or treatment of specific medical conditions.

Reimbursable Ultrasound Codes

The following are reimbursable ultrasound codes:

CPT-4 Code	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	each additional gestation
76805	Ultrasound, pregnant uterus**,** real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system[s] suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus

76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76820	Doppler velocimetry, fetal; umbilical artery
76821	middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	follow-up or repeat study

Diagnosis, Frequency and Documentation Guidelines

Ultrasound services are reimbursable as follows:

- Diagnosis on the claim must be appropriate for the code as defined on the chart.
- Frequency must meet the restrictions as defined in the chart.
- Some claims must have documentation in the *Remarks* field (Box 80)*/Additional Claim Information* field (Box 19) of the claim to justify medical necessity, as outlined on the following pages.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76801, 76805, 76811	**O00.00** – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O21.9 and O23.00 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.419 and O99.511 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity, unless documentation states that another pregnancy had occurred.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	**O00.00** – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O21.9 and O23.00 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.419 and O99.511 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity, unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76813	**Z36 Encounter for antenatal screening of mother**	One per day Requires documentation with the claim that states: The physician performing or supervising the ultrasound is credentialed by either the Nuchal Translucency Quality Review Program or the Fetal Medicine Foundation.
76814	**Z36 Encounter for antenatal screening of mother**	Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)*//Additional Claim Information* field (Box 19). Requires documentation with the claim that states: The physician performing or supervising the ultrasound is credentialed by either the Nuchal Translucency Quality Review Program or the Fetal Medicine Foundation.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76815	**O00.00** – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O21.9 and O23.00 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.419 and O99.511 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	**O00.00** – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O21.9 and O23.00 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.419 and O99.511 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Once in 180 days (when billed without modifier 59), same provider. Additional claims may be reimbursed if documentation justifies medical necessity. For multiple gestations, bill, procedure code 76816 in conjunction with modifier 59 (any modifier position 1 – 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76817	**O00.00** – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O21.9 and O23.00 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.419 and O99.511 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76820	O36.5110 – O36.5999 Maternal care for known or suspected poor fetal growth O41.00X0 – O41.03X9 Oligohydramnios O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).
76821	O36.0110 – O36.0999 Maternal care for rhesus isoimmunization O36.1110 – O36.1999 Care for other isoimmunization O36.20X0 – O36.23X9 Maternal care for hydrops fetalis O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome O98.511 – O98.519 Other viral diseases complicating pregnancy	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).
76825, 76827	**O24.011 – O24.02,** **O24.111 – O24.12,** **O24.311 – O24.32,** **O24.410 – O24.429,** **O24.811 – O24.82,** **O24.911 – O24.919** Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days, same provider. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76826, 76828	O24.011 – O24.02, O24.111 – O24.12, O24.311 – O24.32, O24.410 – O24.429, O24.811 – O24.82, O24.911 – O24.919 Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)*//Additional Claim Information* field (Box 19).

Nuchal Translucency Ultrasounds

CPT-4 codes 76813 and 76814 (ultrasounds) include fetal viability assessment, crown-rump length determination and nuchal translucency measurement. Providers are not to bill another obstetric ultrasound for the purpose of dating. An additional ultrasound may only be performed if another medical indication exists.

Providers should refer to the *Genetic Counseling and Screening* section of the appropriate Part 2 manual for more information about the California Prenatal Screening Program.

Non-Obstetrical Sonography

CPT-4 codes 76830, 76856 and 76857 (non-obstetrical sonography procedures) are not reimbursable for obstetrical examinations billed in conjunction with ICD-10-CM diagnosis codes O00.00 – O9A.53, Z33.1, Z33.2, Z34.00 – Z34.93, Z36, Z64.0 or Z64.1.

Duplex Scan of Arterial/Venous Flow

CPT-4 codes 93975 (duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study) and 93976 (...limited study) are not reimbursable if billed in conjunction with an ICD-10-CM pregnancy-related diagnosis (A34, O00.00 – O9A.53, Z33.1 – Z36, or Z64.0 – Z64.1). These procedures have not been proven effective nor are they the current medical community practice for investigating perinatal complications.

Obstetrical MRI

CPT-4 codes 74712 (magnetic resonance imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation) and 74713 (…each additional gestation) are reimbursable. An approved *Treatment Authorization Request* (TAR) is required for reimbursement. See the *Radiology: Diagnostic* section of the appropriate Part 2 manual for more information.

Codes 74712 and 74713 must be split-billed with modifiers 26 and TC. When billing only for the professional component, use modifier 26. When billing only for the technical component, use modifier TC.

Cordocentesis

CPT-4 code 59012 (cordocentesis, intrauterine, any method) is reimbursed only for the surgical portion (modifier AG) of the procedure. Cordocentesis, also known as Percutaneous Umbilical Blood Sampling (PUBS), involves the ultrasonographic guidance of a needle into the umbilical cord for diagnosis or therapy.

Reimbursement

Code 59012 is not separately reimbursable when billed in conjunction with CPT-4 code 36460 (transfusion, intrauterine, fetal) by the same provider, for the same recipient and date of service.

Assistant Surgeon and Anesthesiology

Cordocentesis is not reimbursable for assistant surgeon and anesthesiology services.

Fetal Fibronectin Testing

CPT-4 code 82731 (fetal fibronectin, cervicovaginal secretions, semi-quantitative) is reimbursable when billed in conjunction with ICD-10-CM diagnosis codes O60.02 – O60.03 (premature labor after 22 weeks, but before 37 completed weeks of gestation without delivery). Fetal fibronectin assay tests identify a subgroup of pregnant patients who may require aggressive treatment with tocolytics, antibiotics, corticosteroids, and other treatment measures to prevent pre-term delivery or to minimize complications of the delivery. These tests are only recommended once every two weeks between the 24th and 35th weeks of gestation.

Obstetric Panel Frequency Restriction

CPT-4 codes 80055 (obstetric panel) and 80081 (obstetric panel [includes HIV testing]) are restricted to once in nine months for the same provider. Providers may only be reimbursed for either code 80055 or 80081 in a nine month period. The provider may be reimbursed for a second or subsequent obstetric panel within the nine-month period if there is documentation to justify medical necessity or documentation of a different pregnancy.

Gender is Not Barrier to Pregnancy Services

All persons, regardless of gender identity, may request eligibility for pregnancy services when applying for Medi-Cal or other health insurance affordability programs.

A doctor must submit a *Treatment Authorization Request* (TAR) explaining that the services requested are medically necessary. The TAR overrides gender limitations on procedure codes and allows a person with a gender other than female, who is reporting a pregnancy, to receive pregnancy services.

Fetal Stress, Non-Stress Testing

Reimbursement for CPT-4 codes 59020 (fetal contraction stress test) and 59025 (fetal non-stress test) is limited to high-risk pregnancies.

Billing

CPT-4 Code 59025 is reimbursable when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

O09.211 – O09.30	O43.191 – O43.210	O98.411 – O98.419
O09.32	O43.810 – O60.03	O98.511 – O98.519
O09.33	O67.0 – O68	O98.611 – O98.619
O09.511 – O09.90	O77.0 – O77.9	O98.711 – O98.719
O09.92 – O16.9	O88.011 – O88.019	O98.811 – O98.819
O21.0 – O21.9	O88.211 – O88.219	O99.011 – O99.119
O23.00 – O26.62	O88.311 – O88.319	O99.280 – O99.333
O26.821 – O26.849	O90.5 – O90.81	O99.340 – O99.353
O26.872 – O26.899	O98.0 – O98.019	O99.411 – O99.419
O28.0 – O31.8X0	O98.111 – O98.119	O99.511 – O99.830
O32.0XX0 – O41.1499	O98.211 – O98.219	O99.840 – O99.843
O42.00 – O43.119	O98.311 – O98.319	O9A.111 – O9A.53

Codes 59020 and 59025 may be split-billed with modifier 26 (professional component) or TC (technical component). When billing for both the professional and technical service components, a modifier is neither required nor allowed. These codes may not be billed with modifier 51 (multiple procedures).

CPT-4 Code 59020

Reimbursement for code 59020 will be reduced by the amount paid for code 59025 if both codes are billed by the same provider, for the same recipient and date of service.

CPT-4 Code 59025

Claims for code 59025 will be denied if code 59020 has been reimbursed to the same provider, for the same recipient and date of service.

The frequency in billing may be more than 10 times in nine months when code 59025 is billed in conjunction with one of the following ICD-10-CM diagnosis codes:

ICD-10-CM Code	Description
O09.212 – O09.293	Pregnancy with other poor reproductive history
O09.892 – O09.893	Supervision of other high risk pregnancy
O24.011 – O24.919	Diabetes mellitus in pregnancy
O36.5120 – O36.5939	Maternal care for known or suspected poor fetal growth
O36.8920 – O36.8999	Maternal care for other specified fetal problems
O42.112 – O42.113	Preterm premature rupture of membranes

Supplies

Supplies used during fetal stress or non-stress testing are not separately reimbursable because they are considered an integral part of the reimbursement rate for the procedures. Claims billed with modifier UA or UB for fetal stress or non-stress testing will be denied.