

Chapter 10

Reproductive Health – Obstetrics and Gynecology (OB/GYN)

The following health services are included in this chapter:

1. Family Planning
2. Sterilization
3. Hysterectomy
4. Obstetrics and Gynecology (OB/GYN) Services
5. Doula Services
6. Free-Standing Birth Center Services
7. Certified Nurse Midwife (CNM) Services
8. Certified Neonatal Nurse Practitioner (CNNP) Services
9. Enhanced Prenatal Services for “At-Risk” Pregnancies
10. Covered Services
11. Human Immunodeficiency Virus (HIV) Counseling and Testing for Pregnant Women
12. Abortion Services

Definitions

Ambulatory Uterine Monitoring Device: Medical equipment designed to be used by the layperson to monitor uterine activity.

“At-Risk”: A pregnant woman who requires additional prenatal care services because of factors that increase the probability of a preterm delivery, a low birth weight infant, or a poor birth outcome.

Certified Nurse Midwife (CNM): An individual licensed as a registered nurse (RN) by the Board of Nursing and certified by a national nurse certification organization acceptable to the Board of Nursing to practice as a nurse midwife.

Certified Nurse Midwife (CNM) Practice: The management of women’s primary health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women, including diagnosing and providing non-pharmacologic treatment within a system that provides for consultation, collaborative management, and referral as indicated by the health status of patients.

Certified Nurse Practitioner (CNP): Is certified for advanced registered nurse practice in a specific field or nurse practice.

Certified Nurse Practitioner (CNP) Practice: Within the context of collaborative management, diagnosing, directly managing, and preventing acute and chronic illness and disease, and promoting wellness, including providing non-pharmacologic treatment. The CNP is certified for advanced registered nurse practice in a specific field of nurse practitioner practice.

Collaborative Management: A mutually agreed upon plan between a CNP and one or more physicians or surgeons that designates the scope of collaboration necessary to manage the care of patients. The nurse practitioner and the one or more physicians must have experience in providing care to patients with the same or similar medical problems.

Enhanced Services: Services available to members identified as “at-risk” for a poor pregnancy outcome. These services are reimbursed in addition to routine OB services. Enhanced services include “at-risk” antepartum management, care coordination, Prenatal Health Education I & II, prenatal nutrition education, and postpartum follow-up home visit.

Family Planning Agency: A family planning agency is an entity having a medical director that provides family planning services under the direction of an IMCare-enrolled physician. The medical director must ensure that the counseling and information on family planning are performed by trained personnel and according to accepted community standards.

Family Planning Services: Family planning health services include screening, testing, and counseling for sexually transmitted diseases/infections (STDs/STIs), such as HIV, when provided in conjunction with the voluntary planning of conception and childbearing and related to a member’s condition of fertility.

Family Planning Supply: A prescribed drug or contraceptive device ordered by a physician or other eligible provider with prescribing authority for treatment of a condition related to a family planning service.

Hysterectomy: A medically necessary procedure or operation for the purpose of removing the uterus.

Institutionalized Individual: An individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility (including a mental health or other facility for the care and treatment of mental illness), or confined under a voluntary commitment in a mental health or other facility for the care and treatment of mental illness.

Low Birth Weight: Birth weight less than 2,500 grams (5.5 pounds).

Mentally Incompetent Individual: An individual who is declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization. **Note:** A member who has a legal guardian is considered a mentally incompetent individual.

Prescribing: The act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device in accordance with Minnesota law. Prescribing does not include recommending the use of a drug or therapeutic device that is not required by the Food and Drug Administration (FDA) to meet the labeling requirement for prescription drugs and devices.

Preterm Birth: Birth before the gestational age of 38 weeks.

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

Sterilization: Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Family Planning

1. IMCare covers family planning services and supplies for men and women of childbearing age, including minors.
2. Members must be free of coercion and free to choose the method of family planning they want to use.
3. The provider cannot require that an unmarried minor's parent or guardian consent to family planning services for the minor.
4. Family planning services have no copays.

Confidentiality

Family planning services do not appear on any explanations of benefits (EOBs) sent to the member or member's family.

Providers

1. Physicians
2. CNMs,
3. CNPs,
4. Physician assistants (PAs),
5. Clinical Nurse Specialists (CNSs),
6. Clinics, outpatient hospital departments, pharmacies, and family planning agencies may provide some or all of the available family planning services and family planning supplies (refer to applicable chapters for information and requirements relevant to the various providers).

Dispensing by Protocol – Family Planning Registered Nurse (RN)

An RN in a family planning agency may dispense oral contraceptives prescribed by a licensed practitioner, according to a dispensing protocol established by the agency's medical director or under the direction of a physician. RNs may not dispense oral contraception to a member who is less than 12 years of age. Follow state requirements for dispensing prescription drugs.

Refer to the applicable chapters for information and requirements relevant to the various providers.

Free Choice of Provider

All IMCare members have free choice of family planning providers and may obtain the following services from any qualified provider, including those outside of the IMCare provider network:

1. Family planning, including family planning supplies and sterilization (does not include abortion)
2. Testing and treatment of an STD/STI
3. Testing for Acquired Immune Deficiency Syndrome (AIDS) and other HIV-related conditions; this does not include treatment for HIV/AIDS. IMCare members must seek treatment for HIV/AIDS through the IMCare network.
4. Diagnosis of medical conditions that result in infertility; this does not include treatment for infertility. IMCare members must seek infertility treatment through the IMCare network.

Eligible Members

All IMCare members, of childbearing age, including minors, are eligible to receive family planning services.

Covered Services

The following family planning services are covered (although all providers listed above may not directly provide all of these services):

1. Contraceptive devices (e.g., diaphragm, intra-uterine device [IUD])
2. Family planning supplies (e.g., condoms, thermometers)
3. Contraceptive injections (e.g., Depo-Provera)
4. Prescriptions for the purpose of family planning
5. Emergency contraception (e.g., Plan B)
6. Consultation, examination, and medical treatment
7. Genetic counseling (refer to *Physician Extenders* section in [Chapter 6, Physician and Professional Services](#))
8. Family planning counseling
9. Laboratory examination and tests, including screening for cervical cancer by Pap smear and pregnancy testing as clinically indicated
10. Infertility services, limited to diagnosis and treatment of medical problems causing infertility (e.g., pituitary or ovarian tumor, testicular mass; refer to *Non-Covered Services* section below)
11. Voluntary sterilization (refer to *Sterilization* section)
12. Testing for STDs/STIs
13. Treatment of non-HIV-related STDs/STIs
14. HIV blood screening and counseling (performed before and after HIV blood screening test)

MFPP procedure codes are available on the [Minnesota Family Planning Program \(MFPP\) Procedure Codes](#) list.

Lab Services

Refer to [Chapter 11, Laboratory/Pathology, Radiology and Diagnostic Services](#), when ordering or referring lab tests.

Certified MFPP providers may perform or order lab tests found in the [Minnesota Family Planning Program \(MFPP\) Procedure Codes](#) list that are performed during the PE period under the conditions that the MFPP-certified provider found the recipient presumptively eligible.

Secondary MFPP Services

Applicable secondary MFPP procedure codes are listed on the last page of the Minnesota Family Planning Program (MFPP) Procedure Codes list. Listed secondary services are covered only when they meet one of the following:

1. Provided on the same date of service as the primary family planning services and billed with a primary diagnosis code in the Z30 - Z30.9 range
2. Provided as follow-up to a previous primary family planning visit within the preceding 180 days, if the member is still enrolled as a IMCare member and reported with the most appropriate ICD primary diagnosis code

The member must have full knowledge of and consent freely to all family planning services.

Non-Covered Services

1. Reversal of voluntary sterilization

2. Fertility drugs and all associated services
3. Artificial insemination, including in vitro fertilization
4. Surrogate pregnancy services

Billing

For more information on billing, please see electronic data interchange (EDI) requirements in [Chapter 4, Billing Policy](#).

1. Bill in the 837P claim format electronically.
2. Pharmacies: Bill CVS/Caremark via point of sale for all medications. Supplies and devices can be billed directly to IMCare on the 837P claim format.
3. Indian Health Service (IHS), family planning agencies, and community health clinics dispensing oral contraceptives: Use Healthcare Common Procedure Coding System (HCPCS) code S4993. Bill up to a three-month supply (3 units). For non-hormonal emergency contraceptives, use procedure code J8499 and diagnosis code Z30.012 when billing Minnesota Family Planning Program (MFPP). When billing Medical Assistance (Medicaid) or MinnesotaCare, use J3490.
4. Bill emergency contraceptives using HCPCS code J8499 and the appropriate diagnosis code. If you provide oral contraceptives (OCPs) and emergency contraceptives (ECs) on the same date of service, list OCP (J8499) on one claim line and list EC on an additional claim line.
5. For genetic counseling, refer to the special billing instructions in the *Physician Extenders* section in [Chapter 6, Physician and Professional Services](#).

Sterilization

Informed Consent/Sterilization Consent Form: A [Sterilization Consent Form](#) must be completed for each IMCare member who requests a sterilization procedure. The [Sterilization Consent Form](#) provides an opportunity for providers to obtain *informed* consent by giving the member all of the following:

1. An opportunity to ask questions about the sterilization process
2. An oral explanation about the procedure and any procedural risks in accordance with consent form requirements
3. A copy of the consent form
4. Advice that the decision to be sterilized will not affect future care or benefits and that the sterilization will not be performed for at least 30 days, except in the case of premature delivery

The Code of Federal Regulations (CFR) ([Title 42 CFR 441, subpart F](#)) outlines requirements, including use of the [Sterilization Consent Form](#) for obtaining informed consent, which must be met for IMCare to reimburse providers for performing sterilization procedures. The requirements apply to all IMCare members. **Under no circumstances will these requirements be waived.**

It is the physician's responsibility to obtain informed consent. If the physician does not believe the member can give informed consent, he/she should not perform the sterilization or may request additional information to determine whether the member is capable of giving informed consent (such as a psychiatric evaluation).

Transfer of Consent

If a member moves or changes providers, the consent form may be transferred to the new provider. However, the physician who performs the surgery must complete the physician section and sign within the appropriate time limits.

Sterilization Consent Form: The **Sterilization Consent Form** is contained in U.S. Department of Health and Human Services (HHS) booklets that explain the sterilization procedure.

1. **Information for Women – Your Sterilization Operation**
2. **Information for Men – Your Sterilization Operation**

Hysterectomies: For information about **hysterectomies**, refer to the *Hysterectomy* section; different guidelines apply.

Free Choice of Provider

Sterilization is a family planning service. All IMCare members have free choice of family planning providers and may obtain family planning services from any qualified provider, including those outside of the IMCare provider network.

Eligible Members

The following criteria must be met in order for a sterilization to be covered by IMCare:

1. The individual is at least 21 years of age at the time the consent form is signed
2. The individual is mentally competent
3. The individual is not institutionalized
4. The individual has voluntarily signed the **Sterilization Consent Form** (a consent form signed by a guardian, conservator, or anyone other than the individual to be sterilized will not be accepted)
5. The following **Sterilization Consent Form** signature timelines must be met:
 - a. **Dates**: Dates corresponding to signatures must be filled in by the person whose signature is on the preceding line (patient, interpreter, person obtaining consent, or physician). Consent form dates must not be typed onto the form or filled in by someone other than the signatory. Dates can be changed only to correct a clerical error. If, for example, a person writes 1/8/01 instead of 1/8/02, the error should be struck through, but not obliterated, and the correct date entered. The reason for the change should be evident
 - b. **The individual to be sterilized** must sign and date the consent form. At least 30 days, but not more than 180 days, must pass between the date the individual signed the consent form and the date of surgery.
 - c. **The interpreter**, if one was provided, must sign and date the consent form after the patient signs, but before the day of surgery
 - d. **The person obtaining the consent** must sign and date the consent form after the patient signs, but before the day of surgery. The person obtaining the consent certifies by signing the consent form that he/she explained the requirements for informed consent orally and, to the best of his/her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.
 - e. **The physician** who performs the sterilization procedure must sign and date the consent form shortly before (no more than 15 days prior to surgery) the day of surgery or after the surgery. The physician certifies by signing the consent form that he/she advised the individual to be sterilized that no Federal benefits will be withdrawn if the member chooses not to be sterilized, explained the requirements for informed consent, and, to the best of his/her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

Exceptions to Timelines

1. Emergency abdominal surgery – when an individual is sterilized at the time of emergency abdominal surgery, payment will be made if at least 72 hours have passed since he/she signed the consent form.
 - a. **Note**: An emergency Cesarean section is not considered emergency abdominal surgery.
2. Premature delivery – when an individual is sterilized at the time of premature delivery, payment will be

made if at least 72 hours have passed since she signed the consent form **and** the consent form was signed by the individual at least 30 days before the expected date of delivery.

There may be situations, other than those listed above, in which the provider believes that the member is unable to give informed consent. It is incumbent upon the physician to obtain **informed** consent. If the physician does not believe the member can give informed consent, he/she should not perform the sterilization or may request additional information to determine whether the member is capable of giving informed consent (such as a psychiatric evaluation).

Covered Services

The following sterilization procedures are covered, providing all requirements are met:

1. Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified (NOS)
2. Anesthesia, tubal ligation/transection
3. Hysteroscopy, surgical with bilateral fallopian tube cannulation to induce occlusion (Essure)
4. Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
5. Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, Falope ring)
6. Ligation or transection of fallopian tube(s), abdominal or vaginal approach
7. Occlusion of fallopian tube(s) by device (band, clip, Falope ring), vaginal or suprapubic approach
8. Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen exam

Non-Covered Services

The following services are not covered:

1. Reversal of voluntary sterilizations
2. Sterilization of a mentally incompetent individual
3. Sterilization of an institutionalized individual. Individuals living in the following institutions, whether voluntarily civilly committed or court-ordered are considered institutionalized:
 - a. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
 - b. Regional Treatment Centers that are not Institutions for Mental Disease (RTC, not IMD)
 - c. Regional Treatment Centers that are Institutions for Mental Disease (RTC-IMD)
 - d. IMDs
 - e. Correctional facilities (county or non-county)
 - f. Chemical dependency (CD) rehabilitation programs
 - g. Residential facilities for mentally ill persons
4. Sterilization of anyone under age 21 at the time consent was obtained
5. **IMCare does not cover sterilization procedures without the informed consent of the individual being sterilized. Under no circumstances will IMCare pay for a sterilization in which a person has given consent for another person. This includes court-ordered sterilization of a mentally incompetent or institutionalized individual.**
6. Sterilizations consented to by members:
 - a. In labor or childbirth
 - b. Seeking to obtain or obtaining an abortion
 - c. Under the influence of alcohol or other substances that affect the member's state of awareness
 - d. In a situation in which the provider believes that the member is unable to give informed consent

Required Counseling

The person obtaining the consent for the sterilization must answer the member's questions regarding the procedure, provide a copy of the [Sterilization Consent Form](#), and explain the requirements for informed consent that are listed on the consent form. Additionally, shortly before the sterilization, the physician who will perform the procedure must explain the requirements for informed consent that are listed on the [Sterilization Consent Form](#).

Interpreter Services

The provider must supply a language interpreter to ensure that the information regarding the sterilization is communicated effectively for members who do not understand English. A sign language interpreter must be provided to ensure that information is communicated effectively to hearing impaired. Refer to [Chapter 1, Requirements for Providers](#).

Billing

A copy of the [Sterilization Consent Form](#) must be retained in the member's file.

1. Complete every space on the form except: "Race and Ethnicity of Designation" (optional) and "Interpreter's Statement" (if an interpreter was unnecessary).
2. **Dates corresponding to signatures must be filled in by the person whose signature is on the preceding line (patient, interpreter, person obtaining consent, or physician). Under no circumstances should the consent form dates be typed onto the form or filled in by someone other than the signatory.**
3. Dates can be changed only to correct a clerical error. If, for example, a person writes 1/8/01 instead of 1/8/02, the error should be struck through, but not obliterated, and the correct date entered. The reason for the change should be evident.
4. The "Alternate Final Paragraphs" section (lower right-hand section of the consent form) requires a choice between paragraphs one and paragraph two. If you select paragraph two, provide information about the premature delivery or emergency abdominal surgery.

Retroactive Eligibility

1. [Sterilization Consent Form](#) requirements cannot be met retroactively. When an individual without financial resources or insurance coverage requests sterilization and indicates that he/she is considering application or has applied for Medical Assistance (Medicaid), it is advisable for the provider to obtain informed consent, complete a consent form, and allow for the 30-day waiting period.
2. If the individual becomes retroactively eligible for fee-for-service Medical Assistance (Medicaid) and has paid for the sterilization procedure, the provider must reimburse the individual the full amount paid and bill the Minnesota Department of Human Services (DHS).

Hysterectomy

IMCare does not cover hysterectomy for sterilization purposes.

[42 CFR 441, subp. F](#) outlines requirements, including member acknowledgment of information that must be followed for IMCare to reimburse providers for performing hysterectomy procedures. See the sample Hysterectomy Acknowledgment Statement (HAS) at the end of this section.

Authorization Standards for Hysterectomy

Claims for non-emergency hysterectomies may be subject to retroactive review by IMCare for medical necessity. Prior authorization is not currently required.

A HAS must be completed and retained in the member's file.

Conditions supporting medical necessity for hysterectomy may include, but are not limited to, the following:

1. Malignant disease of the cervix, uterus, ovaries, or fallopian tubes
2. Symptomatic uterine fibroids (leiomyomas) that are either:
 - a. Causing bladder pressure, pain, fullness, functional disturbance;
 - b. Bleeding unresponsive to conservative therapy; or
 - c. Showing rapid and progressive enlargement.
3. Recurrent or persistent uterine bleeding or discharge with failure to respond to conservative management
4. Confirmed diagnosis of endometriosis with documented failure of non-surgical management (e.g., use of hormonal therapy and/or low-dose contraceptives)
5. Endometritis that is unresponsive to conservative management
6. Chronic pelvic inflammatory disease unresponsive to conservative management
7. Adenomatous endometrial hyperplasia with moderate or severe atypia recurring despite conservative management
8. Obstetrical catastrophes, such as uncontrollable postpartum bleeding, uterine rupture, uncontrolled uterine sepsis developing from septic abortion, placenta accretion, etc.
9. Septic abortion not responsive to conservative management
10. Removal of the uterus in non-gynecologic pelvic surgery where necessary to encompass disease originating elsewhere, as in uterine involvement in colon cancer or in abscesses secondary to diverticulitis
11. Symptomatic uterine prolapse or descent resulting in general pelvic relaxation
12. Other conditions determined to be medically necessary

Eligible Providers

1. Ambulatory surgical centers
2. Certified Registered Nurse Anesthetists (CRNAs)
3. Hospitals
4. Indian health facility provider
5. Nurse midwife
6. Nurse practitioner
7. Physician assistant
8. Physicians

Covered Services

All medically necessary hysterectomy procedures/operations for the purpose of removing the uterus are covered.

Non-Covered Services

A hysterectomy is not covered when:

1. Performed solely for the purpose of making a member sterile; or
2. More than one purpose exists for the procedure, and the hysterectomy would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Written Acknowledgment

A written HAS is required in order for the procedure to be covered.

1. IMCare requires the provider to secure authorization to perform a hysterectomy by informing the individual (and her representative, if applicable) that the hysterectomy will make her permanently incapable of reproducing.
2. The individual and her representative, if any, must sign an HAS verifying that the member received this information, both orally and in written form. The HAS must be retained in the member's file.

A sample HAS is included at the end of this section. It is not mandatory for the provider to use this sample acknowledgment statement. Any document that the individual (or her representative) has signed that shows the provider informed the individual that she would be incapable of reproducing due to the hysterectomy is permissible.

Do not use the *Sterilization Consent Form*. IMCare does not cover a hysterectomy as a means for sterilization.

3. The member or guardian may sign the HAS before or after the hysterectomy. However, if the statement is signed after the hysterectomy, it must indicate that before the surgery took place, the member was informed that the hysterectomy would make her sterile.
4. Guardians must sign the HAS for mentally incompetent members.
5. A member residing in an institution, such as an RTC, may sign the HAS for herself unless she has been found incompetent by a court or unless the head of the institution determines that the member is incompetent and requires a representative.
6. The HAS must be faxed as an attachment following the electronic claim attachment instructions found in [Chapter 4, Billing Policy](#), on any claim(s) submitted by the physician, anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), and hospital.

Sample Hysterectomy Acknowledgment Statement

My doctor informed me, both orally and with written materials, that the performance of a hysterectomy would make me sterile (not able to have children).

Signed _____ Date _____

If the member signs the acknowledgment after the hysterectomy, the acknowledgment must show that the member was informed of the consequences of the hysterectomy before the procedure was performed.

Exceptions to Hysterectomy Acknowledgment Statement (HAS)

The written HAS requirement is waived in the following situations:

1. **Life-Threatening Emergency:** When a member needs a hysterectomy because of a life-threatening emergency in which a physician determines that prior acknowledgment is not possible. The physician must provide a written certification (including physician signature and date) that prior acknowledgment was not possible and describe the nature of the emergency.
2. **Member Already Sterile:** A hysterectomy performed on a member who was sterile before the surgery is

not subject to the written acknowledgment requirement.

In both situations the physician who performed the hysterectomy must provide a written certification (including physician signature and date) that prior acknowledgment was not possible and describe the nature of the emergency, or of the member's sterility and the cause of the sterility.

The physician's certification must be faxed as an attachment following the electronic claim attachment instructions found in [Chapter 4, Billing Policy](#).

The patient chart/medical record must indicate sterility prior to surgery. Refer to sample statement below.

Sample Statement – Recipient Already Sterile

(Recipient's name) had a tubal ligation procedure on (date) making her sterile prior to the hysterectomy performed on (date).

Signature of physician: _____ Date: _____

Billing

Use an 837P or 837I claim form.

Obstetrics and Gynecology (OB/GYN) Services

IMCare covers prenatal, enhanced prenatal for at-risk pregnancies, delivery, postpartum, and newborn care services.

Eligible Providers

1. CNMs
2. CNPs
3. CNSs
4. Clinics
5. Doctor of osteopathy (DO)
6. Outpatient hospital
7. Physician
8. PAs
9. Physician extenders

Non-Covered Services

1. Services related to surrogate pregnancies are not covered by IMCare.

Billing Obstetrics (OB) Services

OB care can be billed either globally or by components. The billing method used is the provider's choice, but only one method can be used for each OB case. Follow Current Procedural Terminology (CPT) guidelines for global and component billing.

1. The following services are paid independent of the component and global methods:
 - a. OB laboratory panel, regardless of the billing method used. However, do not bill the CPT OB panel code

unless all components of the laboratory panel are performed. If all components of the panel are not performed, bill the individual laboratory procedure codes using the appropriate CPT code. Refer to [Chapter 11, Laboratory/Pathology, Radiology, and Diagnostic Services](#).

- b. Miscellaneous services (e.g., amniocentesis, ultrasound, fetal non-stress test (NST), fetal fibronectin, oxytocin challenge, estradiol) are billed with the appropriate codes
2. IMCare no longer pays a higher rate for vaginal deliveries for women who previously delivered by Cesarean section (VBAC). Use the appropriate CPT procedure code.
3. To bill for vaginal delivery of multiple gestation births, use modifier 22 with the appropriate CPT procedure code.
4. Bill Cesarean section done in response to an emergency using the ET modifier with the appropriate CPT procedure code.
5. Bill pregnancy and non-pregnancy related services on separate invoices using appropriate ICD-9-CM diagnoses.
6. Bill all services provided to a newborn using the newborn's IMCare ID number and date of birth (DOB). This includes normal newborn care and any inpatient services to the newborn, whether before or after the mother's discharge.
7. Bill for services provided to the mother using the mother's IMCare ID number.
8. Refer to [Chapter 13, Inpatient Hospital Notification and Authorization](#), for billing instructions when a newborn is transferred to another facility for specialty services.

Certified Nurse Midwife (CNM) Services

Enrollment

A CNM may enroll as an independent IMCare provider.

Scope of Service

Payments for services provided by a CNM are limited to those within the CNM's scope of practice, provided directly to the patient, and in accordance with Minnesota law.

1. CNMs must practice within a scope that provides for consultation, collaborative management, and referral as indicated by the health status of patients.
2. A CNM may prescribe and administer drugs and therapeutic devices within the scope of practice of a CNM as defined in Minnesota law. In addition, a CNM who is authorized to prescribe drugs is authorized to dispense drugs subject to the same requirement established for the prescribing of drugs.

Billing

1. Refer to billing sections in this chapter for detailed instructions on billing maternity and delivery care, enhanced services, and standby attendance for newborn care.
2. To receive payment, the CNM's individual National Provider Identifier (NPI) must be entered as the rendering provider on the 837P or 837I claim format. Do not use a modifier when billing CNM services.
3. If a CNM provides services as part of a clinic or physician practice (group clinic or physician office), the 837P claim format should include the clinic or physician group NPI in the "Billing Provider" field. The CNM individual NPI must be entered in the rendering provider field on the electronic claim format.
4. If a CNM provides services as part of a CNM practice, the CNM should submit his/her individual provider number in the "Billing Provider" field of the 837P claim format.

Certified Neonatal Nurse Practitioner (CNNP) Services

Enrollment

Neonatal nurse practitioners (NNPs) are eligible to enroll in IMCare and bill for services provided when the following criteria are met:

1. The NNP is certified as an NNP by the Minnesota Board of Nursing and according to Minnesota law
2. The NNP is in independent practice

Covered Services

Services performed by a CNNP are covered under the following circumstances:

1. The service provided is a physician service
2. The service is within the scope of practice of the CNNP
3. The service is a covered service
4. The service is medically necessary
5. The service, if provided on an inpatient basis, is not included as part of the cost for inpatient services included in the hospital's operating payment rate. If services have been billed historically by a hospital as inpatient services, the costs for these services are included in the calculation of the hospital's payment. Therefore, these services cannot be billed separately by another provider.
6. The service is within the scope of practice of the CNNP as described in [MN Stat. secs. 148.171 – 148.285](#)

Billing

Refer to the *Education and Counseling* section of [Chapter 6, Physician and Professional Services](#), for information on billing procedures.

Evidence-Based Childbirth Program Policy

Via the [Minnesota Information Transfer System \(MN-ITS\)](#), DHS is posting the list of hospitals that have submitted their policy for approval on restricting elective inductions before 39 weeks. IMCare encourages providers that perform delivery services to review this list. Additional information on the Evidence-Based Childbirth program can be found in [Chapter 14, Hospital Services](#).

Doula Services

Overview

Effective with services provided on or after July 1, 2014, IMCare covers doula services provided by certified doulas for fee for service (FFS) recipients. These services include emotional and physical support for pregnant women.

Eligible Providers

Doulas who are registered with the Minnesota Department of Health (MDH) and are certified by one of the following organizations are eligible to provide and bill for services under a supervising professional's NPI:

1. [Association of Labor Assistants and Childbirth Educators \(ALACE\)](#)

2. [BirthWorks](#)
3. [Childbirth International](#)
4. [Childbirth and Postpartum Professional Association \(CAPPA\)](#)
5. [Commonsense Childbirth Inc.](#)
6. [Doula of North America \(DONA\)](#)
7. [International Center for Traditional Childbearing \(ICTC\)](#)
8. [International Childbirth Education Association \(ICEA\)](#)

Supervision

You must provide all doula services under the supervision of an IMCare-enrolled:

1. Physician
2. Nurse practitioner
3. Certified nurse midwife

Eligible members

All pregnant MA and MinnesotaCare recipients are eligible to receive doula services from certified providers.

Covered Services

Covered services are limited to childbirth education and support services, which include emotional and physical support provided at the following times:

1. Before childbirth (antepartum)
2. Labor and delivery
3. Postpartum

IMCare covers up to seven sessions, one of which must be for labor and delivery. The remaining six sessions may be used in the antepartum and postpartum periods as needed. Refer to the Authorization Requirements section below for information on adding additional sessions.

Non-Covered Services

Travel time and mileage are not covered services.

Documentation Requirements

The documentation requirements for doulas are the same as those for all IMCare providers.

Birth Weight Requirement

IMCare now requires that all claims for babies less than 29 days old include a birth weight. Include Value Code 54 (Newborn Birthweight in Grams) on all claims for babies under 29 days at time of admission. This is regardless of whether the baby was born inside or outside the hospital, and of whether the newborn was transferred to or from the hospital. If an ICD-10 diagnosis code indicating birth weight is reported on the claim, the birth weight must correlate to the weight reported with Value Code 54.

Authorization Requirements

To provide additional sessions, the doula must request prior authorization following the guidelines in the [Authorization](#) section of this manual. Include documentation supporting the medical necessity of the additional sessions with the request.

Billing

Refer to the Billing Policy and Provider Requirements sections of this manual for an overview of IMCare billing policies and procedures, which includes the following:

1. Bill using the 837P
2. Enter the NPI for the supervising physician, nurse practitioner, or certified nurse midwife in the rendering field.
3. Bill all non-labor and non-delivery sessions with S9445 and the U4 modifier
4. Bill the labor and delivery session with 99199 and the U4 modifier

Free-Standing Birth Center Services

IMCare covers services provided in a licensed, free-standing birth center if the service is covered when provided in a hospital by a licensed health professional. Free-standing birth centers are licensed health care facilities in which licensed health care professionals perform low-risk deliveries following a low-risk pregnancy. A low-risk pregnancy is a normal, uncomplicated pregnancy. A free-standing birth center is not a hospital or licensed as part of a hospital. All free-standing birth centers must be accredited by the [Commission for the Accreditation of Birth Centers](#) (CABC). The [Minnesota Department of Health](#) (MDH) issues licenses for free-standing birth centers.

IMCare requires notification from hospitals and free-standing birth centers for all OB deliveries.

The notification must include the following:

1. Mother's name, DOB, and Personal Member Identifier (PMI) number
2. Infant's DOB, gender, and name (if available)

Failure to notify IMCare with the above information following an OB delivery may result in denial or delayed claims payment.

Eligible Providers

Refer to [Chapter 1, Requirements for Providers](#), for provider policies. IMCare reimburses the following licensed providers for free-standing birth center services:

1. CNMs (must be licensed by the [Minnesota Board of Nurses](#))
2. Certified traditional midwives (CPMs) (must be licensed by the [Minnesota Board of Medical Practice](#))
3. Physicians

A licensed, free-standing birth center may not render care or services other than the services it is permitted to provide within the scope of the issued license or accreditation.

Covered Services

Covered Professional Services include the following (all care must be documented):

1. Antepartum visits
2. Antepartum routine lab services
3. Ultrasounds
4. Labor and delivery
5. Newborn care services
6. First postpartum visit

Covered facility services include the following:

1. Uncomplicated delivery; a single global payment for routine obstetric care that includes:
 - a. Antepartum care
 - b. Delivery services
 - c. Postpartum care
 - d. Ancillary services and/or items relating to delivery or labor
2. Member transfer to a hospital before delivery

Ultrasounds for Zika Virus

IMCare will cover ultrasounds for the Zika virus if a positive diagnosis is determined from a blood test.

Covered facility services include uncomplicated delivery, a single global payment for routine obstetric care that includes the following:

1. Antepartum (before childbirth) care
2. Delivery services
3. Postpartum care
4. Ancillary services and items relating to delivery or labor
5. Recipient transfer to a hospital before delivery

Non-Covered Services

1. Home births
2. Services provided by an unlicensed traditional midwife
3. Abortion services
4. Travel time
5. Facility charges

Limitations of Services

The following limitations apply to the services performed at a free-standing birth center:

1. Surgical procedures must be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair
2. No general or regional anesthesia may be administered (local anesthesia may be administered at a free-standing birth center if the administration of the anesthetic is performed within the scope of practice of a health care professional)
3. Nursery charges are not separately reimbursed

A normal, uncomplicated pregnancy and delivery will be reimbursed at a global or all-inclusive payment level.

This payment includes pre-delivery office visits, delivery, and first post-delivery visit. There is no reimbursement for travel or facility charge if the visit is a home visit.

Billing Free-Standing Birth Center Services

1. Bill facility charges on the 837I.
2. Bill CNM and CPM charges on the 837P.
3. Use CPT code 59400 for antepartum (before birth) labor and delivery and postpartum care.
4. Refer to [Chapter 4, Billing Policy](#), for detailed billing policy.
5. Refer to [Chapter 11, Laboratory/Pathology, Radiology, and Diagnostic Services](#), for policy information and information regarding the Newborn Metabolic Disorder Screening.

Maternal Health Education

Do not bill for classes that are provided free to non-IMCare members or Medicaid recipients.

Use HCPCS codes S9442 and S9443 to bill for birthing and lactation classes. Bill 1 unit for each class encounter. A class that meets for three weeks has three encounters. For weekend or Saturday classes, use the appropriate code and bill up to four units.

Public Health nursing clinics may bill for maternal health classes or other group education using S9446. Bill 1 unit per member for each class encounter. A class that meets for three weeks has three encounters.

The following providers may provide and bill for prenatal education classes:

1. CNMs
2. CNSs
3. **Enrolled** physicians
4. Nurse practitioners (NPs)
5. PAs

In addition, clinics and outpatient hospitals whose prenatal education program is directed by one of the enrolled providers listed above may bill for RNs or health educators with at least a baccalaureate level degree in health education and/or certification for prenatal education from one of the following organizations:

1. International Childbirth Education Association (ICEA)
2. National Commission for Health Education Credentialing (NCHEC)
3. Lamaze
4. International Board Certified Lactation Consultants (IBCLC)

Enhanced Prenatal Services for “At-Risk” Pregnancies

Prenatal Screening and Enhanced Services for “At-Risk” Pregnancies

Determining “At-Risk” Pregnancies

OB/GYN providers are required to screen all pregnant IMCare members using a standardized prenatal assessment tool (e.g., American Congress of Obstetricians and Gynecologists’ [ACOG] Obstetric Medical History, Minnesota Pregnancy Assessment Form [MPAF]) or an assessment tool that is developed or customized in the provider’s office and is equivalent to one of the standardized tools. This assessment is generally performed at the member’s first prenatal visit.

A copy of the prenatal risk assessment must be mailed or faxed to IMCare at:

IMCare
1219 Southeast 2nd Avenue
Grand Rapids, MN 55744

Fax: **1-218-327-5545**

Enhanced prenatal services continue to be available for women determined to be “at-risk” for poor birth outcomes.

Enhanced Services for “At-Risk” Pregnancies

Based on information gathered from the prenatal assessment and screening process, a provider may determine that a member is “at-risk” for a poor birth outcome. Members determined to be “at-risk” are eligible for enhanced services. The primary care provider is responsible for ordering and referring the member to enhanced services.

Six enhanced services are covered for “at-risk” pregnancies:

1. “At-risk” antepartum management
2. Care coordination
3. Prenatal Health Education I
4. Prenatal Health Education II: Lifestyle and Parenting Support
5. Prenatal nutrition education
6. Postpartum follow-up home visit

Refer to the *Billing Enhanced Services* section for limits and eligible providers.

“At-Risk” Antepartum Management (H1001)

When a pregnant woman is identified as being “at-risk,” the primary care provider is eligible for IMCare payment for the additional time and expertise required, beyond routine prenatal care, to manage the member’s care based on her “at-risk” status. The primary care provider who is responsible for the care of the member during pregnancy determines what additional health services would benefit the member and provides medical care as determined by the woman’s needs.

Care Coordination (H1002)

Care coordination is the development, implementation, and ongoing evaluation of the plan of care for an “at-risk” pregnant woman. The care coordinator provides continuity, makes referrals, monitors the woman’s progress, and advocates for the woman to ensure access to services that support a healthy pregnancy and improve birth outcomes. Care coordination services include the following:

1. Documentation that the pregnant woman is “at-risk” for a poor birth outcome
2. Development of an individual plan of care that addresses the woman’s specific needs and risks related to the pregnancy
3. Ongoing evaluation and, when appropriate, revision of the plan of care
4. Involvement of the pregnant woman and her support network in the assessment and plan of care
5. Coordination of services and referrals to appropriate community resources and health care providers
6. Advocacy for the pregnant woman in working with the various health care providers
7. Monitoring, on an ongoing basis, to determine whether or not the woman is receiving enhanced prenatal services in a timely and economical manner, and that each service is of expected and adequate quality

Documentation Requirements for Care Coordination

1. A written, individualized plan of care that addresses the woman’s specific needs related to the pregnancy, including any revisions of that plan
2. Evidence of all referrals made, and follow-up on those referrals
3. Evidence of the following activities: monitoring, coordinating, and managing nutrition and prenatal education services to ensure that they are provided in the most economical, efficient, and cost-effective manner

Prenatal Health Enhanced Education

Health education for the “at-risk” pregnant woman is a core intervention that is preventive, resource-efficient, and consistent with the member’s individualized plan of care. Educational services are based on the pregnant woman’s risks as identified on the prenatal screening tool, and her needs as determined by the primary care provider and care coordinator, in consultation with the pregnant woman.

Designated “at-risk” pregnant women require innovative and individualized approaches to prenatal care to effectively meet their educational needs. Educational interventions target risk factors, medical conditions, and health behaviors that can be alleviated or improved through education. Educational services begin with the initial assessment visit and continue throughout the perinatal period. Services can be provided on a one-to-one basis, in small group settings, or in classes individualized to the woman’s own needs and interests. Prenatal health education promotes behavior changes in the woman’s daily life that will support a healthy pregnancy and result in an improved perinatal outcome.

Prenatal Health Enhanced Education I (H1003)

Prenatal Health Education I provides general information about pregnancy and prenatal care. It also covers high-risk medical conditions and behaviors that can be alleviated or improved through education. It includes the following:

1. Information about pregnancy and physical changes that occur during pregnancy
 - a. Description and importance of continued prenatal care
 - b. Comfort measures
 - c. Self-care during pregnancy
 - d. Pregnancy danger/warning signs
 - e. Specific medical conditions
 - f. Diagnosis and significance of condition during pregnancy
 - g. Treatments including medications, activity level, options, and rationale
 - h. Appropriate referrals
2. Normal changes due to pregnancy (specific to trimester)
 - a. Maternal anatomy and physiology
 - b. Fetal development
 - c. Emotional/psychosexual issues
3. Information to prepare the pregnant woman for the birth process when she is near the end of the second trimester or early third trimester
 - a. Anatomy and physiology of labor and delivery
 - b. Coping skills
 - c. Medical management
 - d. Hospital procedures
 - e. Danger signs

- f. Communication with health providers
- 4. Information that helps the pregnant woman identify and take steps to prevent preterm labor and delivery
 - a. Symptoms of preterm labor
 - b. Self-detection of preterm labor
 - c. Treatment
 - d. Preventive measures

Prenatal Care Health Enhanced Education II: Lifestyle & Parenting Support (H1003)

Lifestyle and Parenting Support Educational Services supplement the Prenatal Health Education I services and are necessary for pregnant women who require more time and specialized education to bring about change in risk behaviors and lifestyle. Behavior and lifestyle changes resulting from this early and consistent education may have long-term effects on improving the health of the mother, baby, and subsequent pregnancies.

Topics addressed in Prenatal Education II will depend upon the individual needs of the “at-risk” pregnant woman. They may include the following:

1. Education/assistance to stop smoking
 - a. Effects of smoking on mother and fetal development
 - b. Smoking cessation/decrease smoking education
 - c. Referral to support program to quit
2. Education/assistance to stop the use of alcohol or street drugs
 - a. Effects of alcohol/drugs on fetal development
 - b. Abstinence education
 - c. Referral to support program if needed
3. Education on safe use of over-the-counter (OTC)/prescription drugs
 - a. Emphasis on need to consult with primary provider before using any type of medication during pregnancy
4. Environmental/occupational hazards (e.g., lead)
 - a. Identify potential exposure to hazard in woman’s own environment
 - b. Effects on fetal growth and development
 - c. Efforts to minimize exposure
 - d. Referrals for follow-up if needed
5. Stress management
 - a. Identification of potential stressors in the woman’s life: job, unemployment, school
 - b. Self-identification of signs of stress
 - c. Relaxation techniques
 - d. Referral to support services when appropriate
 - e. Coping skills
6. Communication skills and resources
 - a. Family support systems
 - b. Health care providers
7. Building self-esteem
8. Parenting skills to meet the physical, emotional, and intellectual needs of the infant; bonding
9. Identification and affirmation of positive prenatal parenting behaviors
 - a. Infant needs/cares
 - b. Nurturing
 - c. Infant feeding preparation
 - d. Referral to community resources if needed
10. Planning for continuous, comprehensive pediatric care following delivery

Documentation Requirements for Prenatal Health Education I and II

Evidence that education/information was provided, amount of time spent, materials used, notes about the woman's reactions to information, review of information at subsequent visits, dates and person(s) providing the service, referrals, and follow-up.

Prenatal Nutrition Education (H1003)

Prenatal Nutrition Education includes nutritional assessment and education that identifies nutritional risks and problems that the pregnant woman may already have or be in danger of developing. Develop an individualized nutrition care plan for each "at-risk" pregnant woman based on the assessment of her nutritional status and address the prevention and resolution of identified risks and problems. Incorporate the nutrition care plan into the overall individualized plan of care.

Nutrition interventions include individual and/or group nutrition education and provide information that will assist the pregnant woman in making informed nutritional choices and accepting responsibility to change nutritional behaviors to support a healthy pregnancy.

Prenatal Nutrition Education includes the following:

1. An initial assessment of "nutritional risk" based on height, current and pre-pregnancy weight, laboratory data, clinical data, and self-reported dietary information
2. Ongoing assessment of the pregnant woman's nutritional status (at least once every trimester) based on dietary information, adequacy of weight gain, measures to assess uterine/fetal growth, laboratory data, and clinical data
3. Development of an individualized nutrition care plan that addresses the woman's nutritional deficits, prioritizes her nutritional needs, and proposes interventions and time frames with expected outcomes
4. Referral to food assistance programs, if indicated (Women, Infants, and Children [WIC], food support, Mothers and Children Program, etc.)
5. Nutritional interventions and education including the following:
 - a. Nutritional requirements of pregnancy and how nutrition is linked to fetal growth and development
 - b. Recommended Dietary Allowance (RDA) for normal pregnancy
 - c. Appropriate weight gain
 - d. Importance of vitamin and iron supplements and recommendations for taking them
 - e. Infant nutritional needs and feeding practices, including breastfeeding
6. Incorporation of prenatal and postnatal exercise and physical activity

Documentation Requirements for Prenatal Nutrition Education

1. A written assessment of the woman's nutritional status and evidence of ongoing assessment and monitoring of her nutritional status.
2. A written, individualized nutritional care plan indicating proposed interventions, time frames, expected outcomes, and evidence of monitoring and ongoing evaluation of the care plan.
3. Evidence that education/information on nutrition was provided, materials used, amount of time spent, notes about the woman's reactions to the information, review of information at subsequent visits, dates, and person providing the service, referrals, and follow-up.

Postpartum Follow-Up Home Visit (H1004)

The Postpartum Follow-Up Home Visit is in addition to and separate from the mother's six-week postpartum visit to her primary care provider. It is to be done within the first two weeks of the mother's hospital discharge.

This visit gives special support to “at-risk” mothers and infants by following up on identified “at-risk” behaviors or medical conditions and addressing the stress involved in caring for a new baby. It is an opportunity to provide the following:

1. Reinforcement and support for positive behavior changes
2. Family planning counseling
3. Anticipatory guidance for healthy parenting
4. Education about infant care

The home visit assesses any needs of the family that will require additional home visits or referrals to appropriate health and social service providers. Services include the following:

1. Assessment of the woman’s health
 - a. Follow-up on risk behaviors and/or medical conditions
 - b. Reinforcement of positive behavior and lifestyle changes
2. Physical/emotional changes occurring during the postpartum period
 - a. Anticipatory guidance regarding relationship with partner
 - b. Sexuality
 - c. Potential stress with family
 - d. Nutritional needs
 - e. Physical activity and exercise
3. Contraceptive education
4. Parenting skills and support
 - a. Adapting to parenthood
 - b. Parent/child relationship; bonding
 - c. Child care arrangements and support
5. Grief support if unexpected outcome
6. Parenting a sick or preterm infant, if indicated
 - a. Follow-up on risk factors and conditions
7. Assessment of infant’s health
 - a. Infant weight/growth
 - b. Infant development and abilities

Documentation Requirements for Postpartum Follow-Up Visit

1. Written assessment of mother’s and infant’s health and the home environment.
2. Evidence that education/information on nutrition was provided, materials used, amount of time spent, notes about the woman’s reactions to the information, review of information at subsequent visits, dates and person(s) providing the service, referrals, and follow-up.
3. Evidence of all referrals made and follow-up on those referrals.
4. Infant care
 - a. Feeding and infant nutritional needs
 - b. Recognition of illness in the newborn
 - c. Accident/injury prevention
 - d. Immunizations and pediatric care
 - e. Child and Teen Checkups (C&TCs)
5. Identification and referral of community health and social service resources and assessment of need for additional home visits
 - a. Mother
 - b. Infant

Billing Enhanced Services

Enhanced Services	HCPCS Code	Providers Authorized to Provide Service and Bill
“At-Risk” Antepartum Management	H1001	Doctor of medicine (MD), DO, CNM
Care Coordination	H1002	MD, DO, CNM, CNP, CNS, PA, RN
Prenatal Health Education I	H1003	MD, DO, CNM, CNP, CNS, PA, RN, Health Education Professional*
Prenatal Health Education II	H1003	MD, DO, CNM, CNP, CNS, PA, RN, Health Education Professional*
Prenatal Nutrition Education	H1003	MD, DO, CNM, CNP, CNS, PA **, RN** Dietitian, Nutritionist
Postpartum Follow-Up Home Visit	H1004	MD, DO, CNM, CNP, CNS, PA, RN
<p>* Health educators with at least a baccalaureate level degree in health education and/or certification for prenatal education from one of the following organizations: ICEA, Lamaze, NCHEC, or IBCLC.</p> <p>** Providers authorized to perform service with documented specialized nutritional education.</p>		

1. Bill each enhanced service once per member per pregnancy.
2. **Enhanced services will be paid only for “at-risk” pregnant women.** Screen all pregnant IMCare members using a standardized prenatal assessment tool (e.g., ACOG’s Obstetric Medical History, MPAF), or an assessment tool that is developed or customized in the provider’s office and is equivalent to one of the standardized tools to determine “at-risk” status.
3. Maintain a copy of the prenatal risk assessment in the member’s record and send a copy to the IMCare Maternal Child Care Coordinator.
4. The primary provider may contract or refer the enhanced services to other IMCare-enrolled providers. In this case, the enrolled provider performing the service may bill IMCare directly using the 837P claim format with the codes listed in this section.
5. The primary provider may contract or refer enhanced services to providers not enrolled in IMCare (i.e., RN or nutritional counselor). In this case, the primary provider is responsible for billing IMCare for all services provided and paying the provider(s) who performed the services.
6. Physician extender modifiers are not required when billing for enhanced prenatal services.

Covered Services

Breast Pumps

Breast pumps are covered when ordered by a physician, CNM, or NP for any nursing mother experiencing separation from her infant because of work, school, illness, or medically necessary reasons (refer to [Chapter 23, Equipment and Supplies](#)). Prior authorization is not required for manual breast pumps (E0602) or personal electric breast pumps (E0603); they are for purchase only. The purchase of a personal electric breast pump is limited to one pump every 36 months.

IMCare only covers rental of hospital-grade electric breast pumps (E0604). Prior authorization is required for rental beyond three months. Documentation should include the reason why a manual or personal electric breast pump is not clinically-appropriate for the member.

Subcutaneous Terbutaline Pump (SQTP)

Use of the SQTP is a covered service for IMCare members. The following criteria must be met and documented in the medical record:

1. Gestation of 20 weeks or greater but less than 37 weeks
2. Experiencing symptoms suggestive of preterm labor
3. Intact amniotic membranes
4. Cervical dilation less than 4 cm
5. Modified or complete bed rest

Screening Ultrasound in Uncomplicated Pregnancy

IMCare allows a single screening ultrasound (ideally conducted at 16 – 20 weeks' gestation) per pregnancy to evaluate gestational age and anatomy, detect multiple pregnancies, and to evaluate potential abnormalities. Additional diagnostic ultrasounds are covered only as medically necessary. Indications supporting medical necessity for additional ultrasounds include, but are not limited to, the following:

1. Abnormal maternal serum analytes
2. Adjunct to:
 - a. Amniocentesis, chorionic villus biopsy, fetal blood sampling
 - b. Cervical cerclage placement
 - c. External cephalic version
 - d. Localization and removal of an intra-uterine contraceptive device
 - e. Special diagnostic or therapeutic procedures on the fetus
3. Completion of anatomical screen for inadequate visualization of fetal organs
4. Confirm fetal viability or fetal death
5. Diabetes/gestational diabetes
6. Evaluation of:
 - a. A pelvic mass
 - b. Incompetent cervix and/or risk of preterm delivery
7. Fibroid uterus
8. Follow-up of observed fetal anomaly
9. History of previous congenital anomaly
 - a. Hyperemesis
 - b. Hypertension, essential and pregnancy induced
 - c. Identification and follow-up of placenta previa
10. Nonreactive NST
11. Post-term pregnancy
12. Rh sensitization/isoimmunization
13. Serial evaluation of fetal growth in multiple gestation
14. Significant uterine size and dates discrepancy
15. Suspected:
 - a. Abruptio placentae
 - b. Ectopic pregnancy
 - c. Hydatidiform mole
 - d. Oligohydramnios or polyhydramnios
 - e. Uterine abnormality
16. Vaginal bleeding

Ambulatory Uterine Monitoring Device

Equipment and Standards

A Service Authorization is required if the ambulatory uterine device is over \$1000.00. Requests for the ambulatory uterine device will be considered when the following equipment standards are met:

1. The equipment is ambulatory, which means monitoring may occur while the patient is conducting daily activities. A unit that must be plugged into an electrical outlet to function is not ambulatory.
2. The equipment records data specifically labeled with the time on the printout
3. The equipment is designed for use by a layperson
4. The equipment monitors uterine activity for a minimum of two one-hour sessions daily
5. The equipment transmits uterine contraction data on a daily basis
6. The prescribing physician or CNM is notified immediately by a nurse when normal contraction data or contraction data that fall outside of the prescribing physician's or CNM's parameters is transmitted
7. The physician or CNM receives a report and graph describing each week's uterine activity on a weekly basis
8. The belt fits properly for the monitor to work effectively. The device may not accommodate extremely obese patients.

Obtain authorization for the rental of this device from IMCare Utilization Review, if rental cost is greater than \$1000 per month. It is the responsibility of the medical supply provider to submit the *Itasca Medical Care (IMCare) Authorization Request* with sufficient information from the medical supply provider establishing that criteria listed in *Equipment Standards* have been met. There must be sufficient information from the prescribing physician or CNM to establish that criteria listed in *Medical Necessity Standards/Documentation* has been met.

Medical Necessity Standards/Documentation

Authorization requests for this device will be approved only when the following requirements are met:

1. The patient is "at-risk" for preterm labor and delivery based on the MPAF and a combination of the following medical necessity factors exist:
 - a. Occurrence of preterm labor with current pregnancy (describe)
 - b. Preterm labor or delivery with a previous pregnancy
 - c. Multiple gestations
 - d. An anomalous uterus
 - e. Cervical problems including: an incompetent cervix; cervical changes (describe); and placenta previa
2. The patient is, or has recently been, under treatment to prevent preterm labor with a combination of the following methods:
 - a. Bed rest or restricted activity (describe restricted activity)
 - b. Tocolysis drug therapy (describe), including dosage/frequency
 - c. Increased office visits or phone contact for patient counseling and monitoring
 - d. Hospitalization for preterm labor (admission and discharge dates)
 - e. Less expensive appropriate alternative treatment was undertaken but was not successful or was contraindicated (describe)
3. The device is prescribed for a period that begins no earlier than the 24th week and continues no longer than the 34th week
4. In the opinion of the physician or CNM, the patient is capable of complying with a home monitoring program (explain)
5. The information required above is in letter format, individualized to the patient, and includes the following:
 - a. Documentation of each item listed under medical necessity standards
 - b. The duration of pregnancy or estimated due date (EDD)

Billing

1. The medical supplier must bill the home uterine monitoring device.
2. IMCare will not pay for days in which data is not transmitted from the patient to the nurse.
3. IMCare will not pay for “add-on” programs such as blood pressure, pulse, weight gain, or glucose monitoring.

Physician Standby Attendance for Newborn

IMCare will cover a pediatric standby when there is fetal distress. The following are examples of fetal distress that may warrant a pediatric standby:

1. Fetal bradycardia
2. Diabetes in the mother
3. Meconium
4. Premature labor
5. Foul-smelling amniotic fluid
6. Mother taking certain medications

If the pediatrician bills for standby services, the reason(s) for the pediatrician giving unusual services to the infant must be thoroughly documented.

Problems such as prolonged labor, failure to progress, and cephalopelvic disproportions are generally not reasons for billing physician standby services unless fetal distress is also a factor.

Obstetric Services

Obstetric care can be billed either globally or by components. The billing method used is the provider’s choice, but only one method can be used for each obstetric case. Follow CPT guidelines for global and component billing.

The following must be true for services paid independently of the component and global methods:

1. Do not bill the CPT obstetric panel code unless all components of the laboratory panel are performed
2. If all components of the panel are not performed, bill the individual laboratory procedure codes. Refer to the *Laboratory/Pathology, Radiology and Diagnostic Services*
3. Miscellaneous services (e.g., amniocentesis, ultrasound, fetal non-stress test, fetal Fibronectin, oxytocin challenge, estriol) must be billed with the appropriate codes
4. Bill pregnancy and non-pregnancy-related services on separate invoices using appropriate ICD-CM diagnoses
5. Bill vaginal delivery of multiple gestation births using modifier 22 with the appropriate CPT procedure code
6. Bill cesarean section done in response to an emergency using the ET modifier with the appropriate CPT procedure code
7. Bill newborn services using the newborn’s IMCare ID number and date of birth. This includes normal newborn care and any inpatient services to the newborn, whether before or after the mother’s discharge
8. Bill the mother’s services using the mother’s IMCare ID number
9. Refer to *Inpatient Hospital Authorization* for billing instructions when a newborn is transferred to another facility for specialty services
10. IMCare covers male circumcision only when the procedure is medically necessary

Human Immunodeficiency Virus (HIV) Counseling and Testing for Pregnant Women

General Information

IMCare follows the recommendations of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), ACOG, and MDH, which advocate HIV testing for **all** pregnant women.

IMCare recommends that all pregnant members receive screening, education, counseling, and voluntary testing for HIV at the first prenatal visit to ensure timely and therapeutic reproductive decision making. Advances in the treatment of HIV infection and progress in reducing the transmission of HIV infection to newborns makes early intervention crucial. HIV screening, education, counseling, and testing is reimbursed in addition to routine prenatal care. Physician extenders may provide HIV counseling to pregnant women within their scope of practice. Keep a consent form or passive consent notification for HIV testing in the medical record. If the member refuses HIV testing after counseling, document the refusal in the medical record. Counseling, screening, and education for HIV will be reimbursed if provided, whether or not the member consents to have HIV testing. Testing will be reimbursed when consent is given and the testing is complete.

Inform HIV-positive pregnant women of their treatment options and of the related HIV services that are available. For more information, call the HIV/AIDS Unit of DHS (commonly called Program HH) office at **1-651-431-2414** or **1-800-657-3761** (toll free).

Voluntary Testing: A member consents to HIV testing after she receives pretest counseling, is informed of her right to refuse HIV testing, is informed that her refusal will not jeopardize her health benefits, and does not refuse the testing.

Pretest Counseling: Includes the following components:

1. Explanation of what HIV is
2. Risk factors for HIV infection and how the virus is transmitted
3. Treatment available for HIV-positive women during pregnancy and after delivery
4. Risk factors for the newborn
5. Treatment options for the newborn
6. Rights of the pregnant woman to choose testing
7. Who has access to test results and confidentiality
8. HIV risk assessment

Post-test Counseling: Includes the following components:

1. Giving and explaining test results
2. Explaining risk factors for HIV infection and how to reduce the risk of infection
3. If HIV test results are positive, referrals for additional services and information about treatment options
4. Information about how the virus is transmitted and how to reduce the risk of transmission
5. If HIV test results are positive, counseling and/or referrals related to health issues for partner(s) and children that may have been infected
6. Information about the need for repeat follow-up testing whether the results are positive or negative
7. Referral for case management services for HIV-positive women and their newborns
8. Referral to local community support services such as Minnesota AIDS Line **1-612-373-AIDS (2437)**, **1-800-248-AIDS** (toll free); TTY **1-612-373-2465**, statewide TTY **1-888-820-2437** (toll free).

Informed Consent: The member received the following information:

1. That HIV testing is voluntary
2. The entities who have access to HIV test results (such as third party payers or public health agencies)

3. When, and under what circumstances, this information can be released (such as a legal subpoena)

Confidentiality: Documentation indicating that HIV test results are private. Confidential HIV information can be released only to individuals or entities with the written permission of the member. The member must be informed about the law that allows the release of the HIV test results (without permission) under limited circumstances.

Positive Test: A test result that is positive for the HIV antibody.

Negative Test: A test result that is negative for the HIV antibody (additional follow-up testing, especially for members with known recent HIV exposure or with continued risk behaviors, may be needed to determine recent infection).

Follow-Up: Follow-up health services provided to HIV-positive women and their infants should include the following:

1. Review of what it means to be HIV positive (it does not mean that they have AIDS, but it does mean they can infect others)
2. Ongoing lab tests to evaluate immune function
3. Ongoing counseling regarding HIV status and treatment options
4. Emphasis on the need for good health practices
5. Information about current treatment practices to reduce the risk of transmission of HIV and to promote the health of the woman
6. Information that a positive HIV test result can mean that children and partners could be infected with HIV and that those individuals should be referred for medical testing and follow-up
7. Information that a baby born to an HIV-positive mother should receive regular medical care from a physician who is knowledgeable about HIV treatment to ensure appropriate care
8. Information that all babies are born with the mother's antibodies and many months of follow-up are required to determine the newborn's HIV status. If a baby is not infected, the HIV test will be negative by 18 – 24 months.
9. Discussion with women who are breastfeeding or considering breastfeeding of the risk of transmission of HIV through breastfeeding (the CDC recommends that HIV-positive women not breastfeed)
10. Emphasize that HIV is not spread through casual contact

Providers

A physician, CNM, DO, PA, CNP, licensed RN, and other physician extenders may provide HIV counseling to pregnant women within their scope of practice.

Billing

1. IMCare pays for HIV screening, education, counseling, and testing in addition to routine prenatal care.
2. Providers must bill on the 837P claim format and use the appropriate continuation CPT codes for services related to HIV screening, education, testing, and counseling.
3. Physician extenders must use the appropriate modifier.

Abortion Services

Non-Covered Services

IMCare does not cover induced abortions or abortion-related services.

Abortion-Related Services

Abortion-related services are services directly related to performing an induced abortion. Examples of abortion-related services include the following:

1. Hospitalization when the abortion is performed in an inpatient setting
2. The use of a facility when the abortion is performed in an outpatient setting
3. Counseling related to the abortion
4. General or local anesthesia provided in conjunction with the abortion
5. Drugs provided during or directly after the abortion (treatment of infection or other complications as a result of the abortion is a covered service)
6. Uterine ultrasound, performed immediately following abortion
7. Abortion service codes (surgical induced abortion and medical abortion service codes)
8. Supplies (trays, laminaria, etc.)
9. Drugs (anti-anxiety, narcotics, anesthetics, antibiotics, etc.)
10. Cervical block and/or related services.

Covered Non-Abortion-Related Services

IMCare covers the following non-abortion-related services (this list is not all-inclusive):

1. A history and physical exam performed on the same day as the procedure
2. Tests for pregnancy and venereal disease
3. Blood tests
4. Rubella titre
5. Gonadotropin levels (hCG)
6. Hemoglobin (Hgb) and hematocrit (HCT)
7. The GAM (TM)
8. A Pap smear
9. Laboratory examinations for the purpose of detecting fetal abnormalities
10. Family planning services provided as a separate service
11. Uterine ultrasound to confirm pregnancy
12. RhD drugs
13. Drugs used in conjunction with pregnancy, or post-pregnancy state

Billing

1. Non-abortion-related services provided to women enrolled in IMCare must be billed to IMCare. See the *Covered Non-Abortion-Related Services* section.
2. Services performed for pregnancy, but performed prior to, on the day of, or after an induced abortion are billable to IMCare.
3. Other non-induced abortion diagnoses such as a pregnancy with fetal demise, missed abortion, spontaneous abortion, etc., are billed to IMCare.

Legal References

[MN Stat. sec. 144.615](#) – Birth Centers

[MN Stat. Chap. 147D](#) – Traditional Midwives

[MN Stat. secs. 148.171 – 148.285](#) – Nurses

[MN Stat. sec. 256B.0625, subd. 13](#) – Covered Services: Drugs

[MN Stat. sec. 256B.0625, subd. 14](#) – Covered Services: Diagnostic, screening, and preventive services

[MN Stat. sec. 256B.0625, subd. 54](#) – Covered Services: Services provided in birth centers

[MN Rules part 9505.0235](#) – Abortion Services

[MN Rules part 9505.0320](#) – Nurse Midwife Services

[MN Rules part 9505.0355](#) – Preventive Health Services

[42 CFR 440.165](#) – Nurse-midwife service

[42 CFR 441.21](#) – Nurse-midwife services

[42 CFR 441, subp. E](#) – Abortions

[42 CFR 441, subp. F](#) – Sterilizations

[MN Stat. sec. 144.651, subd. 10](#) – Health Care Bill of Rights: Participation in Planning Treatment; Notification of Family Members)

[MN Stat. sec. 148.995, subd. 2](#) – Definitions: Certified Doula

[Laws of Minnesota 2014, chapter 291, article 4, section 23](#) (amended section 148.995, subd. 2)

[MN Stat. sec. 148.996](#) – Registry

[Laws of Minnesota 2014, chapter 291, article 4, section 24](#) (amended section 148.996, subd. 2)

[MN Stat. sec. 256B.0625, subd. 28b](#) – Covered Services: Doula Services