Page updated: May 2023

Obstetrics

Introduction

Purpose

The purpose of this module is to provide an overview of basic Medi-Cal Obstetrics (OB) billing. General billing and claim form documentation requirements will be discussed.

Module Objectives

- Clarify Medi-Cal OB benefits and limitations
- Identify when and how to bill the initial comprehensive office visit
- Define both per-visit and global services
- Review claim form billing completion requirements
- Discuss ultrasound benefits and billing documentation
- Explain OB ancillary services
- Highlight commonly used modifiers for OB services

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Description

This training module outlines the CPT, ICD-10-CM and HCPCS codes used to bill for services for providers who render obstetrical care.

Confirmation of Pregnancy

Evaluation and Management Codes

When a patient is first seen and the pregnancy has not yet been confirmed, an appropriate Evaluation and Management (E&M) code (CPT codes 99201 thru 99215) and 99417 should be billed with ICD-10-CM diagnosis reflecting the actual reason the patient was seen (for example, amenorrhea, ICD-10-CM diagnosis code N91.0 thru N91.2).

Office visits are not reimbursable with a pregnancy-related diagnosis. Claims submitted with an office visit and a pregnancy-related diagnosis will cause the claim to deny.

Verification of Pregnancy

County welfare departments will accept as verification of pregnancy, either self-attestation of pregnancy or a written statement from the physician, physician's assistant, certified nurse midwife, nurse practitioner or designated medical or clinic personnel with access to the patient's medical records. The statement must give the estimated date of confinement and provide sufficient information to substantiate the diagnosis. Pregnant patients applying for Medi-Cal must either self-attest to pregnancy or submit the written statement as part of their application.

Note: Pregnancy verification is not required for patient's applying for the Minor Consent Program.

A signature stamp, photocopy, or carbon copy is acceptable if initialed or counter-signed by the designated medical or clinic personnel providing the verification.

Refer to the *Pregnancy: Early Care and Diagnostic Services* section (preg early) in the appropriate Part 2 provider manual regarding these topics.

Pregnancy Care Office Visit: Antepartum Initial (Z1032)

Initial pregnancy-related office visit HCPCS code (Z1032) is considered to be the first prenatal visit and is billed after the pregnancy has been confirmed. This code is comparable to a high-complexity Evaluation and Management (E&M) code 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, HCPCS code Z1034 (antepartum follow-up office visit) should be billed.

When billing Z1032, one of the following pregnancy-associated diagnosis codes must be used: O09.00 thru O26.93, O29.011 thru O48.1, O98.011 thru O9A.519, Z34.00 thru Z34.93.

The following billing guidelines apply:

- Z1032 may be billed separately in conjunction with per-visit or global care.
- Limit to once in six months per provider, 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) that pregnancy has recurred within a six-month period.
- Indicate date of transfer or date of fetal demise and document in the *Additional Claim Information* field (Box 19) on the CMS-1500 claim form, or in the *Remarks* field (Box 80) on the UB-04 claim form.

Pregnancy Co-management (Z1032)

Consultants who co-manage a pregnancy without complete transfer of care should not bill with HCPCS code Z1032. Instead, E&M consultation codes 99242 thru 99245 should be used.

Only primary obstetrical providers are to bill codes Z1032 and Z1034. All other providers must bill with E&M consultation codes 99242 thru 99245.

Per-Visit Billing

Refer to the *Pregnancy: Per-Visit Billing* section (preg per) in the appropriate Part 2 provider manual regarding this topic.

Per-Visit Policy

A provider who does not render total obstetrical care during the recipient's entire pregnancy or who renders fewer than 13 antepartum visits must bill each visit or procedure separately. The initial pregnancy-related office visit (Z1032) may not be counted as one of the 13 visits. Each visit is subject to the six-month billing limit, and recipient eligibility must be verified for each month of service.

Antepartum Visits

HCPCS code Z1034 is used for billing antepartum visits and is reimbursable only when obstetrical care is billed on a per-visit basis. Reimbursement for antepartum visits is limited to 13 visits in a nine-month period for the total of all primary obstetrical providers. The exception to billing more than 13 antepartum visits in nine months is if the provider documents a second pregnancy within those nine months.

Delivery

Providers billing a vaginal delivery on a per-visit basis must use CPT code **59409** (vaginal delivery only) or **59612** (vaginal delivery only, after previous cesarean delivery). Providers billing a cesarean delivery on a per-visit basis must use CPT code **59514** (cesarean delivery only) or **59620** (cesarean delivery only, following attempted vaginal delivery, after previous cesarean delivery).

Reimbursement for a per-visit delivery includes:

- Hospital admission
- Patient history
- Physical examination
- Management of labor, vaginal or cesarean section delivery
- Hospital discharge
- All applicable postoperative care

Assistant at Surgery

Certified Nurse Midwife (CNMs) may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by a licensed physician or surgeon. Reimbursement is determined by the following:

- For “assistant at surgery” services performed by a CNM during a cesarean section, modifier AS is used to distinguish the CNMs services.
- The licensed physician and surgeon performing the cesarean section must state on the operative report that the CNM performed the function of an “assistant at surgery.”
- Only non-global cesarean section CPT codes 59514 (cesarean delivery only) or 59620 (cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery) are reimbursable when submitted with an appropriate assistant surgeon modifier (80).

Postpartum Visit

HCPCS Code Z1038 is used for billing the postpartum visit and can be reimbursed when billed in conjunction with one of the following per-visit delivery CPT codes: 59409, 59514, 59614, 59612, or 59620.

Code Z1038 may be billed either by the primary maternity care provider or by a provider who saw the patient for only the postpartum visit. Reimbursement is limited to one visit in a six-month period unless the individual has a medical or mental health postpartum complication or risk factor for postpartum complication.

An additional postpartum visit may be billed more than once in six months by documenting the postpartum complication or risk factor for postpartum complication in the *Remarks* field (Box 80)/*Attachment Claim Information* field (Box 19) of the claim for or in the attachment for reimbursement.

Postpartum Care Reminder

As part of the American Rescue Plan Act (ARPA) effective April 1, 2022, an individual eligible for pregnancy and postpartum care services under Medi-Cal or the Medi-Cal Access Program (MCAP) is entitled to a total 12 months of postpartum coverage.

Coverage shall include the full breadth of medically necessary services through the pregnancy and postpartum period, regardless of immigration status or how the pregnancy ends. These include but are not limited to prenatal care, delivery, postpartum care, and family planning services (including contraception).

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum individual for specialty care 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 E&M consultation codes 99242 thru 99245 or the most appropriate billing code for the service provided.
- Visits must not be billed with HCPC code Z1034 or E&M procedure codes 99202 thru 99215 (new or established outpatient visits) or 99417. This may cause the claim to be denied.

Per-Visit Billing Codes

Per-Visit Obstetrical Codes

HCPCS/CPT Code	Definition	Frequency Limit
Z1032	Initial comprehensive pregnancy-related office visit	1 in 6 months
Z1034	Antepartum office visit	13 in 9 months
Z1038	Postpartum office visit	1 in 6 months: **Note:** More than 1 in 6 months if documentation of complication is indicated in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.
59409	Vaginal delivery only	1 in 6 months
59514	Cesarean delivery only	1 in 6 months
59525	Subtotal or total hysterectomy after cesarean delivery	1 in 6 months (subtotal) or once in a lifetime (total)
59612	Vaginal delivery only, after previous cesarean with/without episiotomy, and/or forceps	1 in 6 months
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	1 in 6 months

Notes:

Knowledge Review 1

1. Office visits (E&M) codes are payable with a pregnancy-related diagnosis code.

   True □ False □

2. Pregnancy verification is not required for patient's applying for the Minor Consent Program.

   True □ False □

3. Consultants who co-manage a pregnancy can bill for HCPCS Z1032 without complete transfer of care

   True □ False □

4. More than 13 antepartum visits are allowed in 9 months if there is documentation of a second pregnancy.

   True □ False □

5. Postpartum visits (HCPCS code Z1038) can be billed by the primary maternity care provider or the provider who saw the patient for only the postpartum office visit.

   True □ False □

See the Appendix for the Answer Key.

Pasteurized Donor Human Breast Milk

Effective for dates of service on or after January 1, 2023, Medi-Cal covers medically necessary pasteurized donor human milk (PDHM) when obtained from a licensed and approved facility. There are two human milk banks in California:

San Jose

- Address: Mother's Milk Bank 1887 Monterey Road, Suite 110 San Jose, CA 95112
- Phone: 408 998-4550
- Email: recipient.coordinator@mothersmilk.org
- Website: https://mothersmilk.org/

San Diego

- Address: University of California Health Milk Bank 3636 Gateway Center Ave, Suite 102 San Diego, CA 92102
- Phone: 858 249-MILK (6455)
- Email: ucmilkbank@health.ucsd.edu
- Website: https://health.universityofcalifornia.edu/patient-care/milk-bank

Eligibility Criteria

Medi-Cal providers can arrange for the provision of PDHM for newborns if at least one of the following situations is true:

- A mother is unable to breast feed due to medical conditions;
- The infant cannot tolerate formula or has medical contra-indications to using formulas, including elemental formulas;
- The infant is born at a very low birthweight (less than1500 g) and very premature (less than 32 weeks gestation);
- The infant has a gastrointestinal anomaly, a metabolic/digestive disorder, or is in recovery from an intestinal surgery when digestive needs require additional support;
- The infant is diagnosed with failure to thrive (not appropriately gaining weight/growing);
- The infant has formula intolerance with documented feeding difficulty or weight loss;
- The infant has been diagnosed with hypoglycemia (low blood sugar), congenital heart disease, pre or post organ transplant, or another serious health condition when the use of banked donor human milk is medically necessary and supports the treatment and recovery of the infant; or
- The mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs.

Authorized Providers

Authorized providers who can prescribe PDHM are physicians and advanced practice nurses (Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives and Physician Assistants).

Prescription

3 ounces per unit, 35 ounces per day only good for 30 days.

Age of Infant

Coverage may be up to 12 months of age if it is medically necessary and appropriate.

Billing Codes

HCPCS Code	Description
T2101	Human breast milk processing, storage and distribution only, to be billed per ounce.
K1005	Disposable collection and storage bag for breast milk, any size, any type, each.

Depression Screening

Pregnant or Postpartum Individuals

Providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum. The combined total claims for screening pregnant or postpartum recipients using HCPCS codes **G8431** and/or **G8510** may not exceed two per year per recipient by any provider of prenatal or postpartum care. Providers must include a pregnancy or postpartum diagnosis code on all claims. Claims submitted without a pregnancy or postpartum diagnosis code may be denied.

Depression Screening Billing Codes

Modifier HD is used with G8431 and G8510 when billing for either a positive or negative depression screening for pregnant or postpartum recipients.

Depression Screening Codes

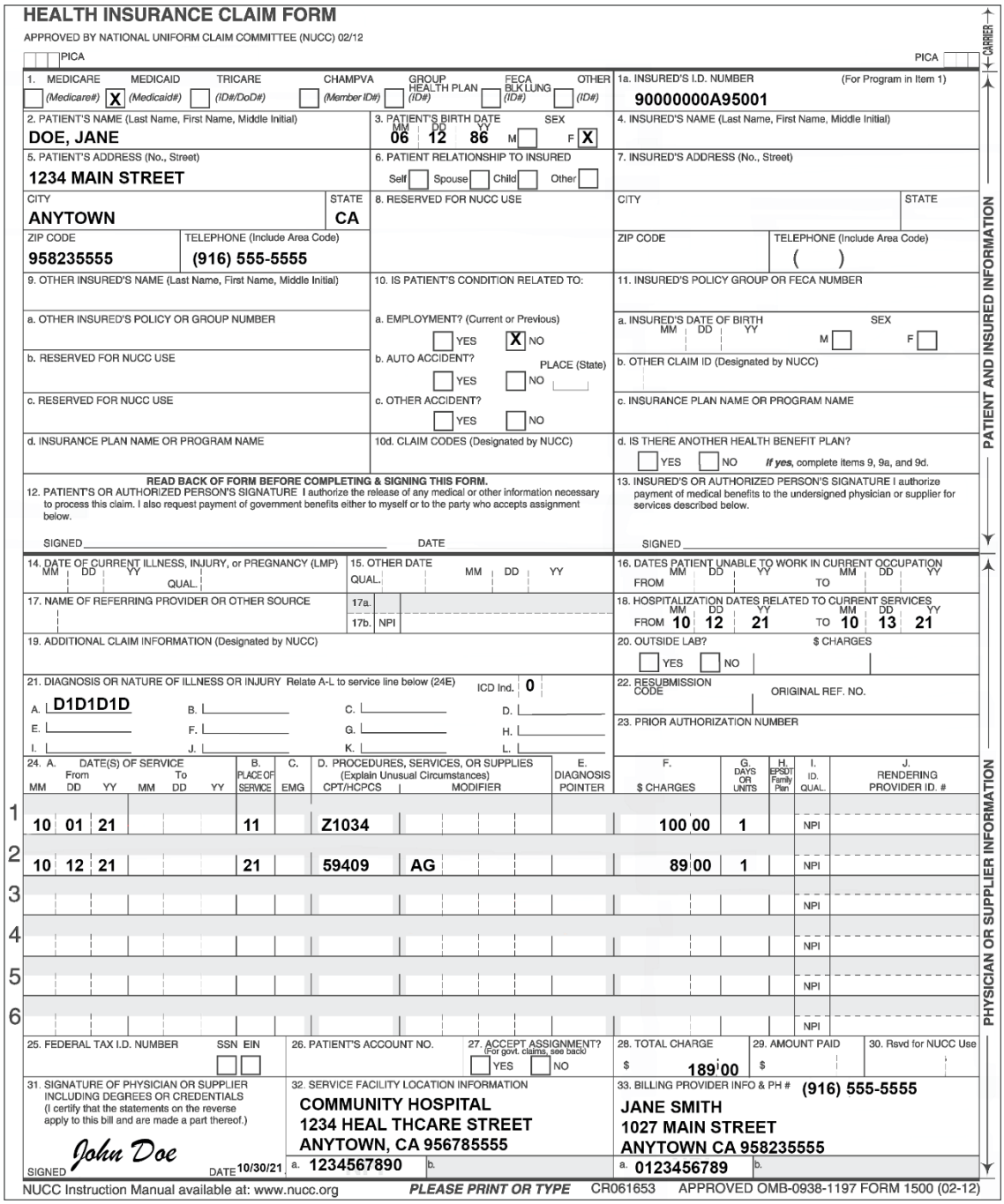
HCPCS Code	Description
G8431	Screening for depression is documented as being positive, and a follow-up plan is documented.
G8510	Screening for depression is documented as negative. A follow-up plan is not required.

For additional claim submission instructions, providers should refer to the "*Pregnancy: Early Care and Diagnostic Services*" and "*Pregnancy: Postpartum and Newborn Referral Services*" sections in the appropriate Part 2 manual.

CMS-1500 Claim Billing Example

Per-Visit Vaginal Delivery and Antepartum Office Visit

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 86 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 10 12 21 TO 10 13 21

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D1D1D1D B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 21		11		Z1034			100 00	1		NPI	
2 10 12 21		21		59409	AG		89 00	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 189 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED John Doe DATE 10/30/21

32. SERVICE FACILITY LOCATION INFORMATION

COMMUNITY HOSPITAL
1234 HEAL THCARE STREET
ANYTOWN, CA 956785555

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

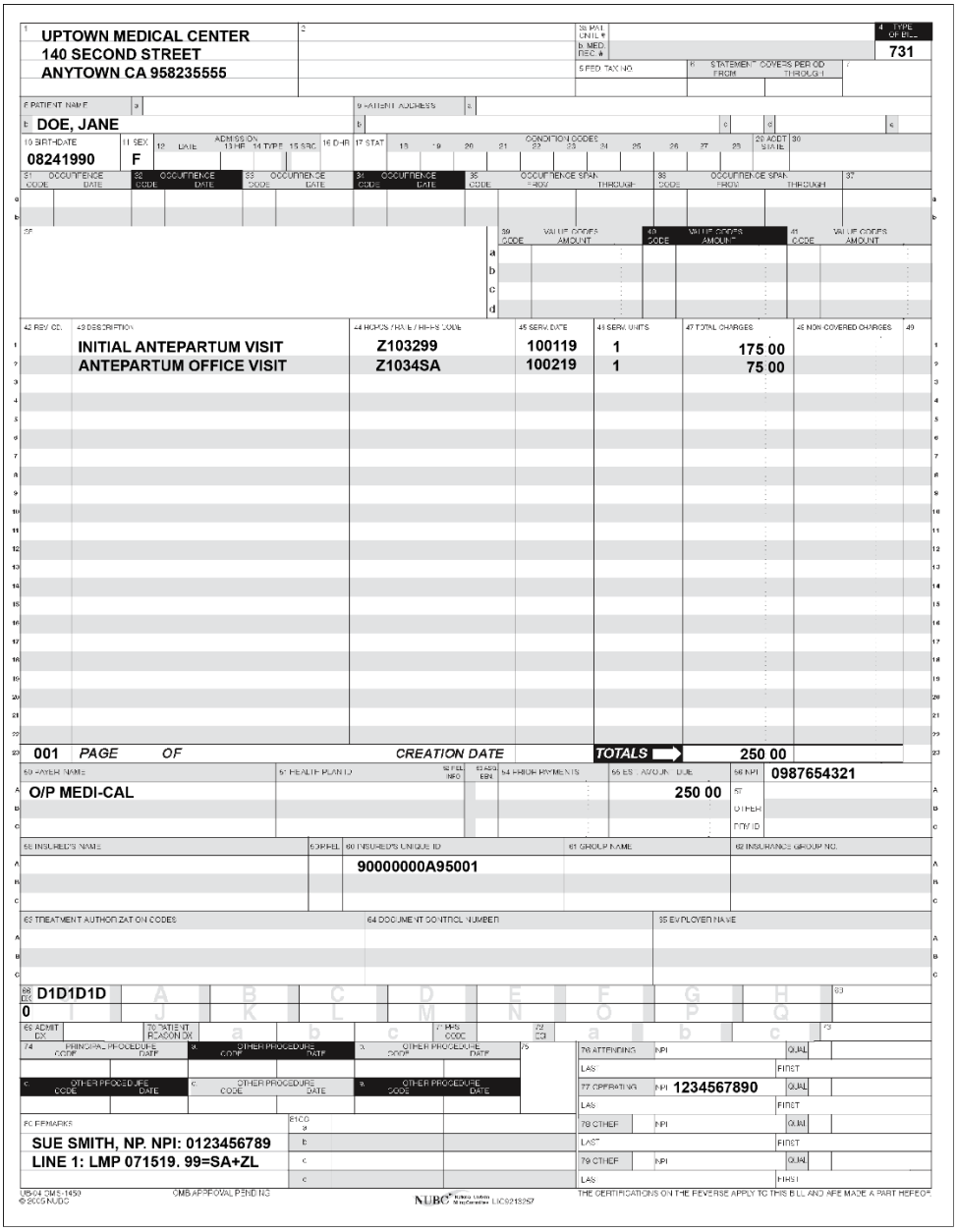
Sample: Per-Visit Billing – *CMS 1500* claim form. Adapt to your billing situation.

UB-04 Claim Billing Example

Per-Visit Initial OB visit and Antepartum Office Visit

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

Per-Visit Billing Initial OB visit and Antepartum Office Visit



Sample: Per-Visit Billing – *UB-04* claim form. Adapt to your billing situation.

Global Billing for Pregnancy

Refer to the *Pregnancy: Global Billing* (preg glo) section in the appropriate Part 2 provider manual regarding this topic.

Policy

The intent of global billing (CPT codes 59400, 59610, and 59618) is to offer a convenient means of billing for providers who render total obstetrical care to an individual throughout their pregnancy. Global obstetrical (OB) billing consists of antepartum care, delivery, and post-partum care. Global billing also includes the following: hospital admission, patient history, physical examination, labor management, postpartum office visit, vaginal or cesarean delivery, vaginal or cesarean section delivery after previous cesarean delivery, hospital discharge and all applicable postoperative care.

Global Billing Requires 13 OB Visits

A provider who bills for global obstetrical care must render at least 13 antepartum OB visits and must document the visits in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment for reimbursement. The initial comprehensive pregnancy-related office visit may not be counted as one of the 13 visits. If fewer than 13 visits are rendered, the provider must bill services on a per-visit basis. Global OB billing is never to be used for recipients who have transferred care and have already received OB care and billing by another Medi-Cal provider.

Non-Reimbursable Global OB Services

Providers choosing the global billing method cannot separately bill per-visit antepartum visit Z1034 or postpartum office code Z1038 with the exception for the Medi-Cal initial antepartum visit code Z1032. Services not separately reimbursable on a global basis include:

- Antepartum visits (Z1034) paid to the same provider, for dates of service within the from-through period of the global billing or within 270 days prior to the global OB delivery date
- Hospital visits
- Postpartum visits (Z1038) for routine postpartum care, paid to the same provider and within the 45-day follow-up period of the global OB delivery date

Global Obstetrical Codes

HCPCS/CPT Code	Definition	Frequency Limit
59400	Global antepartum care, vaginal delivery and postpartum care.	1 in 6 months
59510	Global antepartum care, cesarean delivery and postpartum care.	1 in 6 months
59525	Subtotal or total hysterectomy after cesarean delivery.	1 in 6 months (subtotal) or once in a lifetime (total)
59610	Routine OB care vaginal delivery w/without episiotomy and/or forceps and postpartum care after previous cesarean delivery.	1 in 6 months
59618	Routine OB care cesarean delivery and postpartum care following attempted vaginal delivery after cesarean delivery.	1 in 6 months

Note: Refer to the CPT code book for complete procedure descriptions.

"From-Through" Billing

Global OB claims (CPT codes 59400, 59510, 59525, 59610, and 59618) must be billed in the "from-through" billing format on the CMS-1500 with modifier AG (primary surgeon). The "from" date of service is the first date the recipient was seen for this pregnancy, and the "through" or "to" date of service is the date of delivery.

Verifying Eligibility

To be reimbursed for global claims, providers must verify the recipient's eligibility for services during the month of delivery.

Transfer of Care

Providers who accept a Medi-Cal transfer patient must bill each antepartum visit separately, regardless of the number of times the provider sees the patient prior to delivery.

Providers who accept Medi-Cal transfer patients are not restricted to the number of visits for which they may be reimbursed (up to the Medi-Cal limit of one initial comprehensive and 13 antepartum visits for all primary obstetrical providers within nine months).

Global Billing: Cesarean with Tubal Ligation

CMS-1500 Documentation Requirements

- Date of Last Menstrual Period (LMP) (Box 14)
- Hospitalization dates (Box 16)
- Dates of 13 antepartum visits must be documented in the *Additional Claim Information* field (Box 19)
- Primary and secondary diagnosis codes to support pregnancy and tubal ligation services fields (21A and B)
- Bill in “From-Through” format for cesarean delivery CPT code 59510 field (24A)
- Global delivery CPT code 59510 modifier AG field (24D)
- Intraoperative Tubal Ligation CPT code 58611 modifier 51 field (24D)
- Enter Usual and Customary Charges field (24F)
- Submission of sterilization *Consent Form* (PM 330)

Note: Delivery services performed in an inpatient setting must be billed on a *CMS-1500* claim form. The physician’s billing information is entered in the *Billing Provider Information & PH#* field (Box 33). Physician’s NPI is entered in Box 33a.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) / MEDICAID / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#)	X (Medicaid#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	90000000A95001
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	DOE, JANE
3. PATIENT'S BIRTH DATE MM DD YY / SEX	06 12 86 / M / F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	1234 MAIN STREET
6. PATIENT RELATIONSHIP TO INSURED	Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	ANYTOWN / CA
8. RESERVED FOR NUCC USE	
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	958235555 / (916) 555-5555
ZIP CODE / TELEPHONE (Include Area Code)	( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	M / F
b. RESERVED FOR NUCC USE	
b. AUTO ACCIDENT? PLACE (State)	YES / NO
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	
c. OTHER ACCIDENT?	YES / NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	09 17 21
15. OTHER DATE QUAL. MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	FROM 06 16 21 TO 07 30 21
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
17a. / 17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	ANTEPARTUM VISITS: 10/29/21, 11/26/21, 12/24/21, 01/21/22, 02/18/22, 04/14/22, 04/28/22, 05/12/22, 05/26/22, 06/09/22, 06/16/22, 06/23/22
20. OUTSIDE LAB? / $ CHARGES	YES / NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	0
A. / B.	D1D1D1D / D2D2D2D
C. / D. / E. / F. / G. / H. / I. / J. / K. / L.	
22. RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 21 06 30 22	21		59510	AG		1200 00	1		NPI	
2 06 30 22 06 30 22	21		58611	51		400 00	1		NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $ 1600 00
29. AMOUNT PAID $	30. Rsvd for NUCC Use		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	SIGNED John Doe DATE 07/15/22
32. SERVICE FACILITY LOCATION INFORMATION	COMMUNITY HOSPITAL 1234 HEAL THCARE STREET ANYTOWN, CA 956785555 a. 1234567890 b.
33. BILLING PROVIDER INFO & PH #	(916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample: *CMS-1500* claim form. Adapt to your billing situation.

Ultrasound During Pregnancy

Policy

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

Diagnosis, Frequency and Documentation Guidelines

Ultrasound services are reimbursable as defined below:

- Diagnosis on the claim must be appropriate for the CPT code being billed
- Frequency must meet the restrictions listed
- Some claims must have documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim to justify medical necessity.

Note: See the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for the most current list of codes, frequency limits and documentation.

Reimbursable Ultrasound Codes

Diagnosis, Frequency and Documentation Guidelines

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76801, 76805, 76811	O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9: Spontaneous abortion O09.511 thru O09.513: Elderly primigravida O09.521 thru O09.523: Elderly multigravida O10.011 thru O16.9: Edema, proteinuria and hypertensive disorders O20.0 thru O21.9 and O23.00 thru 029.93: Other maternal disorders O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity O60.00 thru O60.03: Preterm labor without delivery O98.011 thru O98.919: Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse Z33.2: Encounter for elective termination of pregnancy Z36.0 thru Z36.9: 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.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76802, 76810, 76812	O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9: Spontaneous abortion O04.5 thru O04.89: Complications following (induced) termination of pregnancy O09.511 thru O09.513: Elderly primigravida O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity O60.00 thru O60.03: Preterm labor without delivery O98.011 thru O98.919: Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse Z33.2: Encounter for elective termination of pregnancy Z36.0 thru Z36.9: 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. Provider must document the number of fetuses in the *Remarks* field (Box 80/*Additional Claim Information* field (Box 19) of the claim.

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76813	Z36.82 Encounter for antenatal screening for nuchal translucency	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	Z36.82 Encounter for antenatal screening for nuchal translucency	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) of the claim. 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.

Diagnosis, Frequency and Documentation Guidelines (continued)

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

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76816	O00.0 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 thru O03.9 Spontaneous abortion O04.5 thru O04.89 Complications following (induced) termination of pregnancy O09.511 thru O09.513 Elderly primigravida O09.521 thru O09.523 Elderly multigravida O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders O20.0 thruO21.9 and O23.00 thru O29.93 Other maternal disorders O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity O60.00 thru O60.03 Preterm labor without delivery O98.011 thru O98.919 Maternal infectious and parasitic diseases O99.011 thru O99.419 and O99.511 thru O99.89 Other maternal disease classifiable elsewhere O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36.0 thru Z36.9 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 thru 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) of claim.

Diagnosis, Frequency and Documentation Guidelines (continued)

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

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76820	O36.5110 thru O36.5999: Maternal care for known or suspected poor fetal growth O41.00X0 thru O41.03X9: Oligohydramnios O43.021 thru O43.029: Fetus-to-fetus placental transfusion syndrome	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies 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 thru O36.0999: Maternal care for rhesus isoimmunization O36.1110 thru O36.1999: Care for other isoimmunization O36.20X0 thru O36.23X9: Maternal care for hydrops fetalis O43.021 thru O43.029: Fetus-to-fetus placental transfusion syndrome O98.511 thru 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 thru O24.02, O24.111 thru O24.12, O24.311 thru O24.32, O24.410 thru O24.429, O24.811 thru O24.82, O24.911 thru O24.919: Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 thru O35.9XX9: Maternal care for known or suspected fetal abnormality and damage O36.8310 thru O36.8399: Maternal care for abnormalities of the fetal heart rate or rhythm	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).

Diagnosis, Frequency and Documentation Guidelines (continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/Documentation Requirements
76826, 76828	O24.011 thru O24.02, O24.111 thru O24.12, O24.311 thru O24.32, O24.410 thru O24.429, O24.811 thru O24.82, O24.911 thru O24.919: Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 thru O35.9XX9: Maternal care for known or suspected fetal abnormality and damage O36.8310 thru O36.8399: Maternal care for abnormalities of the fetal heart rate or rhythm	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies 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).

Ultrasound Common Billing Denial

Remittance Advice Details (RAD) code 9109: This service is not payable for the diagnosis billed.

Billing Tip: Verify the diagnosis code is valid for the procedure being billed.

Note: See the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary* (remit) section of the Part 1 provider manual. Select the link at the bottom of the page *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*.

Per-Visit Billing Antepartum Office Visit and Ultrasound

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **LINE 1: CNM MARTHA LOWE 1234567890**
LINE 2: SEE ATTACH. FOR ULTRASOUND JUSTIF.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. **0**

A. **D1D1D1D** B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10	**01**	**20**				**11**		**Z1034**	**SB**		**100 00**	**1**		NPI	
10	**04**	**20**				**11**		**76805**			**200 00**	**1**		NPI	
														NPI	
														NPI	

Sample: *CMS-1500* claim form. Antepartum visit rendered by a Nurse Midwife (SB). Please adapt to your billing situation.

Per-Visit Billing Antepartum Office Visit, Ultrasound and Amniocentesis

1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

4 TYPE OF BILL: 731

8 PATIENT NAME: DOE, JANE
10 BIRTHDATE: 082341980
11 SEX: F

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	ANTEPARTUM FOLLOW-UP	Z1034	100120	1	100 00	
	ULTRASOUND	76805	100320	1	200 00	
	AMNIOCENTESIS	59000	100320	1	60 00	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	360 00	

50 PAYER NAME: O/P MEDI-CAL
55 EST. AMOUNT DUE: 360 00
56 NPI: 0123456789

60 INSURED'S UNIQUE ID: 90000000A95001

66 DX: D1D1D1D
0

76 ATTENDING NPI: 1234567890

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC LIC9213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: *UB-04* claim form. Per-visit billing of antepartum visit, ultrasound, and amniocentesis. Please adapt to your billing situation.

Obstetrical Ancillary Services

Routine Urinalysis

Reimbursement for individual antepartum visits and global OB service includes routine urinalysis. Claims for routine urinalysis with a diagnosis related to pregnancy will be denied.

Claims for urinalysis, when billed with an ICD-10-CM diagnosis code for pregnancy, may be reimbursed if billed in conjunction with another diagnosis code other than Z00.00, Z00.8, Z01.00 thru 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 medical necessity of the urinalysis must also be present on the claim form to allow reimbursement, as outlined above.

Office Visits

Office visits for conditions not related to pregnancy must be billed using the appropriate office visit code (CPT codes 99202 thru 99215 or 99417) and a non-pregnancy-related diagnosis.

Non-Physician Medical Practitioners Supervision Changes

Refer to the *Non-Physician Medical Practitioners* section (non ph) in the appropriate Part 2 provider manual.

To comply with new legislative requirements, the Department of Health Care Services (DHCS) is making the following supervision changes for non-physician medical practitioners (NMPs):

- Supervision requirements are no longer required for Certified Nurse Midwives (CNM) and Licensed Midwives (LM).
- Nurse Practitioners (NPs) are confirmed to practice to the full extent of their education and training and authorities two newly created types of NPs
- Physician Assistant (PA) are authorized to perform medical services authorized by the Act if certain requirements are met, including that the medical services are rendered pursuant to a practice agreement, and the PA is competent to perform medical services.

Fetal Stress, Non-Stress Testing

Fetal Non-Stress Testing Benefit Guidelines

Reimbursement for CPT codes 59025 (fetal contraction stress test), 59025 (fetal non-stress test) and 76819 (fetal biophysical profile; without non-stress testing) is limited to high-risk pregnancies.

Billing

CPT code 59025 or 76819 is reimbursable when billed in conjunction with the appropriate antepartum high-risk ICD-10-CM diagnosis code within the range of O09.211 thru O9A.513.

Frequency Limit and ICD-10-CM Codes

Reimbursement for CPT code 76819 is limited to once per week. This code may be billed more than five times in nine months, and CPT code 59025 may be billed more than ten times in nine months when billed in conjunction with one of the ICD-10 diagnosis codes in the following table:

ICD-10-CM Diagnosis	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 of pregnancy
O36.5120 – O36.5939	Maternal care known or suspected poor fetal growth
O036.8920 – O36.8999	Maternal care for other specified fetal problems
O42.112, O42.113	Preterm premature rupture of membranes

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

CPT codes 59020, 59025 and 76819 may be split billed with modifier 26 or TC. When billing for both the professional and technical components, a modifier is not required nor allowed. These codes may not be billed with modifier 51 (multiple procedures).

Pregnancy Share of Cost (SOC)

Refer to the *Pregnancy: Share of Cost* section (preg share) in the appropriate Part 2 provider manual.

Global Billing

Providers who bill on a global basis for obstetrical services must plan to make arrangements with the patient to collect or obligate the SOC for the month of delivery only.

- However, arrangements must also be made to collect or obligate the SOC for the initial antepartum office visit (HCPCS code Z1032) and for non-global OB services (for example, sonogram or amniocentesis).
- When the intent to bill globally is prevented because the patient moves or leaves care, providers must bill on a fee-for-services basis and collect SOC for each month of service.

Per-Visit Billing

Providers who bill on a fee-for-service basis for obstetrical care, must collect the SOC for each month in which services were rendered.

SOC Common Billing Denial

Remittance Advice Details (RAD) code 0314: Recipient is not eligible for the month of service billed.

Billing Tip: Verify the recipient has a Share of Cost (SOC) and is eligible for the month of service.

Early Care and Diagnostic Services

Fetal Fibronectin Testing

Fetal fibronectin assay tests identify a subgroup of pregnant women who may require aggressive treatment with tocolytics, antibiotics, corticosteroids and other treatment measures to prevent pre-term delivery or to minimize complications during delivery. These tests are only recommended once every two weeks between the 24th and 35th weeks of gestation.

Fetal fibronectin testing is reimbursable when billed with the following:

- CPT code 82731 (fetal fibronectin, cervicovaginal secretions, semi-quantitative)
- ICD-10-CM diagnosis codes O60.02 and O60.03 (premature labor after 22 weeks, but before 37 completed weeks of gestation without delivery)

Preventing Preterm Births

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. Both HCPCS codes J1726 10 mg and J1729 250 mg injections are limited to one injection every seven days between 16 and 36 weeks of gestation.

Claims must include ICD-10 diagnosis code from the range of O09.211 thru 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.

Refer to the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for more information.

Obstetric Panel Frequency Restriction

CPT codes 80055 (obstetric panel) and 80081 (obstetrical 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 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 differences on procedure codes and allows a person with a gender other than female who is reporting a pregnancy to receive pregnancy services.

Notes:

Knowledge Review 2

1. Providers have the option when billing globally to choose either the UB-04 or CMS-1500 claim form to bill for services.

   True □ False □

2. When billing for per-visit services, eligibility should be verified each time services are rendered.

   True □ False □

3. For Depression Screening services, providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum.

   True □ False □

4. Ultrasounds performed for routine screening during pregnancy are considered an integral part of patient care, and its reimbursement is included in the obstetrical fee.

   True □ False □

5. Supplies used during fetal stress or non-stress testing can be billed separately.

   True □ False □

See the Appendix for the Answer Key.

Tobacco Cessation Counseling

Providers must offer one face-to-face smoking/tobacco cessation counseling session and a referral to tobacco cessation quit line to pregnant and postpartum recipients.

Counseling and referral services must be offered without cost sharing. These services are required during the prenatal and postpartum period (the end of the month in which the 60-day period following termination of the pregnancy ends).

Commonly Used Modifiers

Modifier	Description
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
59	Distinct procedural service (use only with CPT-4 code 76816, transabdominal ultrasound)
80	Assistant surgeon
99	Multiple modifiers
AG	Primary physician
AS	Certified nurse midwives may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by licensed physician or surgeon.
FP	Family planning services
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Certified nurse midwife service (when not billing as an independent provider)
TC	Technical component
TH	Obstetrical treatment/services, prenatal or postpartum
U7	Services rendered by Physician Assistant (PA)

Resource Information

References

Provider Manual References

Part 1
Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit) and Select Link: *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*.

Part 2
Modifiers: Approved List (modif app)
Non-Physician Medi-Cal Practitioners (non-ph)
Pregnancy Determination (preg determ)
Pregnancy: Early Care and Diagnostic Services (preg early)
Pregnancy Examples: CMS-1500 (preg ex cms)
Pregnancy Examples: UB-04 (preg ex ub)
Pregnancy: Fetal Monitoring, Labor and Delivery Services (preg fetal)
Pregnancy: Global Billing (preg glo)
Pregnancy: Global Billing Codes (preg glo cd)
Pregnancy: Per-Visit Billing (preg per*)*
Pregnancy: Per-Visit Billing Codes (preg per cd)
Pregnancy: Postpartum and Newborn Referral Services (preg post)
Pregnancy: Share of Cost (preg share)
Remittance Advice Details (RAD) (remit adv)

Knowledge Review 1: Answer Key

Question 1: Office visits (E&M) codes are payable with a pregnancy-related diagnosis code.

Answer 1: False

Question 2: Pregnancy verification is not required for patient's applying for the Minor Consent Program.

Answer 2: True

Question 3: Consultants who co-manage a pregnancy can bill for HCPCS Z1032 without complete transfer of care.

Answer 3: False

Question 4: More than 13 antepartum visits are allowed in 9 months if there is documentation of a second pregnancy.

Answer 4: True

Question 5: Postpartum visits (HCPCS code Z1038) can be billed by the primary maternity care provider or the provider who saw the patient for only the postpartum office visit.

Answer 5: True

Knowledge Review 2: Answer Key

Question 1: Providers have the option when billing globally to choose either the UB-04 or CMS-1500 claim form to bill for services.

Answer 1: False

Question 2: When billing for per-visit services, eligibility should be verified each time services are rendered.

Answer 2: True

Question 3: Depression Screening services, providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum.

Answer 3: True

Question 4: Ultrasounds performed for routine screening during pregnancy are considered an integral part of patient care, and its reimbursement is included in the obstetrical fee.

Answer 4: True

Question 5: Supplies used during fetal stress or non-stress testing can be billed separately.

Answer 5: False