Pregnancy: Postpartum and Newborn Referral Services

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This section contains information about postpartum care, early discharge, breast feeding and newborn referral services.

Note: For assistance in completing claims for pregnancy services, refer to the *Pregnancy Examples* section of this manual. For information about inpatient delivery services, Inpatient providers should refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section in the Part 2 *Inpatient Services* provider manual. This section may also be used by non-DRG-reimbursed Inpatient providers.

Billing Newborn Infant Services with Mother's ID

Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number. For additional information, refer to the *CMS-1500 Completion* section in the appropriate Part 2 manual.

Other Health Coverage

‹‹For a list of preventative pediatric services that may be billed directly to Medi-Cal (unless the member has Other Health Coverage through a Health Maintenance Organization) refer to the "Recipients with OHC Coverage Through an HMO" chart in the *Other Health Coverage (OHC): CPT® and HCPCS Codes* section of the appropriate Part 2 manual.››

Tobacco Cessation

‹‹Refer to the *Pregnancy: Early Care and Diagnostic Services* section of this manual for information about provider requirements regarding pregnant and postpartum members who use tobacco.››

Early Discharge

‹‹Hospitals are prohibited by law (*Welfare and Institutions Code*, Section 14132.42) from discharging Medi-Cal members earlier than the mandated post-delivery lengths of stay (two consecutive days following a vaginal delivery or four consecutive days following a delivery by cesarean section) unless the early discharge is agreed upon by both the treating physician and mother.››

Early Discharge Follow-Up Visit

If prescribed by the treating physician, a post-discharge follow-up visit must be made available to the mother and her newborn within 48 hours after an early discharge. If an early discharge visit is prescribed, the treating physician must determine, in consultation with the mother and after assessment of the transportation needs of the family and environmental and social risks, whether the visit should occur at home, the clinic (facility site) or the treating physician's office.

The early discharge follow-up visit must be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The visit must include, at a minimum, parent education, training in breast or bottle feeding, and any necessary neonatal and maternal physical assessments.

Physician's Office or Clinic Site

If the early discharge follow-up visit is provided in the treating physician's office or at the clinic site, services provided to the mother or newborn are reimbursed with existing Evaluation and Management (E&M) code 99499 with modifier -ZW. A visit may be billed for the mother and a separate visit may be billed for the newborn on the same date of service with code 99499 and modifier -ZW.

‹‹Member's Home

An early discharge follow-up visit provided in a member's home by a physician, a Certified Nurse Midwife or Certified Nurse Practitioner for services provided to the mother or newborn may be reimbursed when billed with code 99348 and modifier -ZW››. An early discharge follow-up visit may be billed for the mother and a separate visit may be billed for the newborn on the same date of service.

One early discharge follow-up visit for the mother and one for the newborn is reimbursable without prior authorization within a nine-month period for procedure codes 99499 and 99348.

An early discharge follow-up visit provided in the home by a Home Health Agency (HHA) to assess the mother must be billed with CPT code 99501 and revenue code 0580. A follow-up visit for prenatal care and assessment for the newborn must be billed with CPT code 99502 and revenue code 0580. These procedure codes include the evaluation and plan of care for the patient and are billed without a modifier. Only one early discharge follow-up visit for services provided to the mother or the newborn is reimbursable without authorization within a six-month period. This service may only be provided by a registered nurse.

HHA providers may not bill for a case evaluation and initial treatment plan (HCPCS code G0162 and revenue code 0583) and/or a skilled nursing visit (HCPCS code G0299 or G0300 and revenue code 0551) in addition to an early discharge follow-up visit on the same date of service.

Pregnancy-Related Services

‹‹Pregnancy-related services are services required to assure the health of the pregnant individual and the fetus, or that have become necessary as a result of the individual having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, family planning services and services for other conditions that might complicate the pregnancy.

Effective April 1, 2022, the American Rescue Plan Act (ARPA) extended the postpartum period from 60 days to 365 days. Medi-Cal members are eligible for pregnancy and postpartum care services throughout their pregnancy and for 365 days after the pregnancy ends. This coverage shall include the full breadth of medically necessary services during the pregnancy and for the 365 days postpartum regardless of immigration status or how the pregnancy ends. The pregnancy or its end must be reported to the County Medi Cal office.

Policy regarding preventive counseling for pregnant and postpartum members who are at risk for perinatal depression may be found in the *Non-Specialty Mental Health Services: Psychiatric and Psychological Services* section of appropriate Part 2 manual.

Policy regarding screening for depression in pregnant or postpartum members may be found in the *Evaluation and Management (E&M)* section of the appropriate Part 2 manual.››

For information about other pregnancy-related services, providers should refer to the *Pregnancy: Early Care and Diagnostic Services* section of the appropriate Part 2 manual.

Pregnancy Care Billing

‹‹There is no special billing process during the pregnancy and postpartum period.››

Pregnancy Care Office Visit: Postpartum

Policy for postpartum pregnancy care office visits is in the *Pregnancy: Early Care and Diagnostic Services* section in the appropriate Part 2 provider manual.

Postpartum Care for Members Who Might Otherwise Be Ineligible: Aid Code 76

‹‹Some women who are Medi-Cal-eligible and receive Medi-Cal services on their last day of pregnancy continue to be eligible for postpartum and pregnancy-related services for 365 days. Assigning aid code 76 to pregnant individuals on a restricted aid code provides the full breadth of medically necessary services, as long as the service is covered under Medi-Cal.

Since eligibility for Medi-Cal is established monthly, the postpartum care eligibility period begins on the first day of the month following the month in which pregnancy ends and ceases on the last day of the month in which the 365th day occurs. (This policy is established in *California Code of Regulations*, Title 22, Section 50260.)››

Services covered under aid code 76 include all antepartum (prenatal) care, care during labor and delivery, and postpartum care of the pregnant woman. Examples of covered services include:

- All care normally provided during pregnancy – examinations, routine urinalyses, evaluations, counseling and treatment
- Initial postpartum care – hospital and scheduled office visits during the puerperium, assessment of uterine involution, and, as appropriate, contraceptive counseling

Services may be billed globally or fee for service.

Note: Refer to the *Pregnancy: Global Billing and Pregnancy: Per Visit Billing* for information on billing.

Comprehensive perinatal services, however, including nutrition, psychosocial, or health education services, must continue to be billed fee for service.

Note: Refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* section of this manual for additional CPSP information.

Breast Feeding: Services Covered by Medi-Cal

Nutritional counseling services related to breast feeding may be rendered by a physician, a registered nurse or a registered dietician working under the supervision of a physician. The services of registered dieticians must be billed by the physician/clinic as a physician visit. Physicians and clinics should bill these services with the CPT Evaluation and Management (E&M) code that most accurately reflects the level of service provided.

Note: ‹‹When a member visits a physician and a registered dietician on the same day, the physician/clinic must bill the code that reflects the combined level of service.›› Physician/clinics should bill E&M code 99211 for a service performed by a registered dietician without a physician present.

Reimbursable nutrition services that support breast feeding include, but are not limited to:

- Persistent discomfort to the woman while breast feeding
- Infant weight gain concerns
- Milk extraction
- Suck dysfunctions of the infant

Reminder: Comprehensive Perinatal Services Program (CPSP) providers should bill with HCPCS codes Z6200 thru Z6208 for nutritional counseling services, codes Z6300 thru Z6308 for psychosocial support services and codes Z6400 thru Z6414 for health education services.

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum woman for specialty or other medically necessary care, providers should advise the specialist or other medical provider that the referral is for a medically necessary service and remind the specialist to include a pregnancy diagnosis code on the claim form for reimbursement. Claims should be billed with either CPT Evaluation and Management (E&M) consultation codes 99242 thru 99245 or the most appropriate billing code for the service provided. These visits must not be billed with either procedure code Z1034 (antepartum office visit) or E&M procedure codes 99202 thru 99215 (new or established outpatient visits) or 99417 or the claim may be denied.

Pasteurized Donor Human Breast Milk

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
  - Mothers' Milk Bank 1887 Monterey Road, Suite 110 San Jose, CA 95112
  - Phone: 408-998-4550
  - Email: recipient.coordinator@mothersmilk.org
- San Diego
  - 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

Criteria

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

- ‹‹A mother is unable to breast feed due to medical conditions
- The infant cannot tolerate or has medical contra-indications to using formulas including elemental formulas
- The infant is born at a very low birthweight (less than 1500 g) and very premature (less than 32 weeks gestation)
- Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery when digestive needs require additional support
- Diagnosed with failure to thrive (not appropriately gaining weight/growing)
- Formula intolerance, with documented feeding difficulty or weight loss
- Infant hypoglycemia (low blood sugar); congenital heart disease, pre or post organ transplant
- Other serious health conditions when the use of banked donor milk is medically necessary and supports the treatment and recovery of the infant››
- 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 who can prescribe PDHM are: physicians, advance 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 is medically necessary and appropriate.

Billing Code

HCPCS code T2101 (human breast milk processing, storage and distribution only) to be billed per 3 ounces per unit, 35 ounces per day, only good for 30 days.

HCPCS code K1005 (disposable collection and storage bag for breast milk, any size, any type, each).

Sample Cases

The following sample cases are scenarios where pasteurized donor human milk (PDHM) can be prescribed.

Sample Case 1

AA is a 30-year-old woman at 26 weeks gestation with severe pregnancy induced hypertension. Delivery was urgent due to severe high blood pressure not responding to medical management and done via Cesarean delivery. Her male infant was a 600 gram, 26 week premature infant who was admitted to the NICU and stabilized. Mother was encouraged and assisted in milk expression soon after delivery but had no milk production during her initial postpartum stay. Per NICU feeding guidelines the infant was initiated and advanced on small feedings via naso-gastric (NG) tube pasteurized donor human milk, and tolerated the feedings well. By postpartum day 7, mother's milk production was adequate to meet the child's nutritional needs and thereafter, he received only her milk until he was discharged on day of life 90.

Sample Case 2

DD is a 35-year-old woman who had had a healthy full-term baby at 39 weeks gestation. After an urgent Cesarean delivery, DD has not been able to produce enough milk to meet her baby boy's nutritional needs. She tried to supplement her own supply with cow's milk formula, but her baby demonstrated an intolerance, including vomiting and large stool output. After attempting four cow's milk formulas, her pediatrician recommended two hypoallergenic formulas. Baby boy continued to demonstrate formula intolerance when fed any nutrition other than mother's own milk. After documented formula intolerance and trialing six formulas, the pediatrician determined PHDM was the best option. DD supplemented with donor milk for one month until her own supply increased, and she was able to exclusively breastfeed.

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Newborn Referral Form

The *Newborn Referral Form* is designed to simplify establishing Medi-Cal eligibility for a newborn of a Medi-Cal-eligible mother. Completing the *Newborn Referral Form* and sending it to the county central location helps ensure continuation of Medi-Cal services for the newborn.

Procedure

The provider or the parent/guardian may complete the *Newborn Referral Form*. However, the provider must obtain written consent from the parent/guardian before completing and submitting the form to the county. The form must include the mother's name, correct date of birth and Social Security Number or Benefits Identification Card (BIC) number. It is also important to confirm the newborn's date of birth.

The *Newborn Referral Form* is a two-page form. It is distributed as follows:

Newborn Referral Form Distribution

Copy	Description
Copy 1:	County copy. Mail or fax to the county central location. If mailing, mail the original form and keep a copy in administrative files. A list of the county central locations and contacts is included on page 2 of the form.
Copy 2:	Hospital copy.
Copy 3:	Parent/guardian copy.

Ordering Forms

Providers can obtain copies of the *Newborn Referral Form* on the Forms page of the Department of Health Care Services (DHCS) website located at *www.dhcs.ca.gov.*

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.