Pregnancy: Early Care and Diagnostic Services

Page updated: September 2024

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

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

‹‹Presumptive Eligibility for Pregnant People Program

The Presumptive Eligibility for Pregnant People (PE4PP) program allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending a decision of their formal Medi-Cal application. See the *Presumptive Eligibility for Pregnant People Program Process* section of this manual for more information.››

Prenatal Care Guidance Program

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

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

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

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

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program (CPSP) is a benefit of the Medi-Cal program. ‹‹The program offers a wide range of services to pregnant Medi-Cal members from the day that pregnancy is medically established and postnatally to the end of the month in which the 365-day period following termination of pregnancy ends.›› For information about this program, refer to the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* sections in this manual.

Tobacco Cessation

Providers must offer one, face-to-face smoking/tobacco cessation counseling session and a referral to a tobacco cessation Quitline to pregnant and postpartum members as recommended in *Treating Tobacco Use and Dependence: 2008 Update*, a U.S. Public Health Service Clinical Practice Guideline. Such counseling and referral services must be provided to pregnant and postpartum members without cost sharing. ‹‹These services are required during the prenatal period through the postpartum period (the end of the month in which the 365-day period following termination of the pregnancy ends).››

Prenatal and Postpartum Care

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

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

‹‹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 in the appropriate Part 2 provider manual.

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

Pregnancy Care: Billing

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

Gender Override

‹‹Instructions for overriding gender differences for procedures are in the *Gender Affirming Care Services* section in the appropriate Part 2 provider manual.››

Pregnancy Care Office Visit: Antepartum Initial

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

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

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

Pregnancy Care Office Visits: Antepartum Follow-Up

Code Z1034 is used to an antepartum follow-up visit. Documentation for primary obstetrical providers must conform to current standards equivalent to those defined by ACOG for antepartum visits. Documentation by consultants, including those involved in co-management of a pregnancy, should be consistent with CPT guidelines for consultation services and document the appropriate history, physical examination and medical decision making. These services must be separately identifiable from the professional and/or technical components of any diagnostic study performed. Code Z1034 may not be used to bill obstetric consultation services by a nurse practitioner or certified nurse midwife for high-risk referrals. High-risk consultation services must be provided by a perinatologist and billed with E&M consultation codes 99242 thru 99245. Only primary obstetrical providers are to bill codes Z1032 and Z1034. All other providers must bill with E&M consultation codes 99242 thru 99245.

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

‹‹Antepartum Care Billing with E&M Codes

Antepartum care is reported per encounter rather than as a bundled global service. The appropriate E&M code is selected based on the place of service and the complexity of the encounter. The TH modifier should be used to indicate maternity care services. **The local Comprehensive Perinatal Services Program (CPSP) codes (Z1032 and Z1034) must still be used by CPSP providers and doulas.** The local codes cannot be billed on the same date by the same provider as the E&M codes with TH modifier.

Antepartum care billing applies as follows:

- Antepartum care should be reported per encounter using the appropriate E&M service code with TH modifier to indicate maternity care services.
- The service covers all E&M care of the member and/or fetus(es) prior to the onset of labor. The member must be registered as female. Female indicates sex at birth and does not reflect gender identity.
- E&M code selection is based on either Time or Medical Decision Making (MDM).
- Each encounter may result in a different E&M level. Variation across visits is expected and appropriate.
- Antepartum and Fetal Invasive Services codes remain available for applicable procedures.››

- ‹‹Medically appropriate ICD-10 diagnoses codes are required for billing:
  - Prenatal visits must include ICD-10 codes indicating gestational age Z3A.00-49 and additional relevant diagnosis codes are recommended.
  - Postpartum visits must include relevant ICD-10 code O86-O92, Z39.0-2 or F53.0-1. which include gestational age and any other conditions being evaluated or treated during the visit.

    Note: Since some of these ICD-10 codes are category header codes, the actual sub-codes must be billed.

Note: For care provided by a nonphysician qualified health care professional (QHP) who may not report E&M services — such as genetic counseling or medical nutrition therapy — refer to the applicable service-specific codes or the *Non-Physician Practitioner (NPP)* section of this manual.

Medical Decision Making (MDM)

When MDM is used to select the appropriate E&M level, the following domains must be assessed for each encounter:

MDM Domain	Description
Problem(s) Addressed	Nature and acuity of the presenting problem(s)
Amount and/or Complexity of Data	Data reviewed, ordered, analyzed or independently interpreted
Risk of Complications	Risk of complications, morbidity or mortality from patient management decisions

Coding Examples – Antepartum Course

The E&M code selected must be based on time and complexity involved. For example, a new patient encounter can be denoted by the most appropriate E&M code (such as 99204 or 99205); modifier TH must be included.

Z-Code	Z-Code Description	Frequency	E&M Code	E&M Description
Z1032	Initial Antepartum Office Visit	1 in 6 months	99204	Office O/P New Mod 45-59 Min
Z1032	Initial Antepartum Office Visit	1 in 6 months	99205	Office O/P New Hi 60-74 Min››

‹‹**Coding Examples – Antepartum Course (continued)**

Z-Code	Z-Code Description	Frequency	E&M Code	E&M Description
Z1034	Antepartum Follow-Up Office Visit	15 in 9 months	99213	Office O/P Est Low 20-29 Min
Z1034	Antepartum Follow-Up Office Visit	15 in 9 months	99214	Office O/P Est Low 20-29 Min
Z1034	Antepartum Follow-Up Office Visit	15 in 9 months	99215	Office O/P Est 40 Min
Z1038	Postpartum Follow-Up Office Visit	15 in 9 months	99213	Office O/P Est Low 20-29 Min
Z1038	Postpartum Follow-Up Office Visit	15 in 9 months	99214	Office O/P Est Low 20-29 Min
Z1038	Postpartum Follow-Up Office Visit	15 in 9 months	99215	Office O/P Est 40 Min

The following illustrates expected code variation across a typical antepartum episode of care consisting of seven services, including a telehealth visit and a nurse-only visit: use 99204 or 99205 for a new/initial OB visit even if the patient is not new to the provider.

Visit Description	Code(s)
Visit 1 — Physician/Midwife, office	99204, TH modifier
Visit 2 — Physician/Midwife, office	99214, TH modifier
Visit 3 — Nurse-only visit	99211, TH modifier
Visit 4 — Physician/Midwife, office	99213, TH modifier
Visit 5 — NP, telehealth	99213, TH Modifier, 95/93
Visit 6 — Nurse-only visit	99211, TH modifier
Visit 7 — Physician/Midwife, office	99214, TH modifier

Note: The specific level is determined by MDM or time at each encounter. Variation across visits is expected. New patients use 99203-5.››

Pregnancy Care Office Visit: Postpartum

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

Pregnancy-Related Services

Pregnancy-related services are services required to assure the health of the pregnant patient and the fetus, or that have become necessary as a result of the patient having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, family planning services and services for other conditions that might complicate the pregnancy. Services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postnatally to the end of the month in which the 365-day period following termination of pregnancy ends.

Referrals for Specialty Care or Medically Necessary Care

While referring any pregnant or postpartum patient for specialty or other medically necessary care, providers should advise the specialist and remind the specialist to include a pregnancy diagnosis code on the claim form to ensure 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 the claim may be denied.

Urinalysis (Routine)

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

Genetic Testing

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

Glucometers for Gestational Diabetics

HCPCS code E0607 (home blood glucose monitor) is a benefit for members with gestational diabetes. Medical justification of this condition must be present on the claim, using ICD-10-CM diagnosis codes O24.011 thru O24.919, O99.891 thru O99.893 or documentation attached to the claim that indicates the member is a gestational diabetic. Reimbursement is limited to one glucometer every five years, per member, for any provider. For additional information refer to the *Durable Medical Equipment (DME): Bill for DME* section in the appropriate Part 2 manual.

Continuous Glucose Monitors During Pregnancy and Postpartum

All continuous glucose monitor (CGM) systems are carved-out as pharmacy-billed items through Medi-Cal Rx. A prior authorization (PA) is required for members who are pregnant or up to 12 months postpartum and have gestational diabetes, Type 1 diabetes or Type 2 diabetes. estimated date of delivery and recent glycosylated hemoglobin (Hemoglobin A1c) results are required for medical justification. Insulin and/or hypoglycemia are not requirements for CGM during pregnancy. Refer to the Medi-Cal Rx Provider Manual for details.

Ultrasound During Pregnancy

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

Reimbursable Ultrasound Codes

The following are reimbursable ultrasound codes:

CPT Code	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (fewer than 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (fewer than 14 weeks 0 days), transabdominal approach; each additional gestation
76805	Ultrasound, pregnant uterus**,** real time with image documentation, fetal and maternal evaluation, after first trimester (greater than or equal to 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus**,** real time with image documentation, fetal and maternal evaluation, after first trimester (greater than or equal to 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses

Reimbursable Ultrasound Codes (Continued)

CPT Code	Description
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system[s] suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76820	Doppler velocimetry, fetal; umbilical artery
76281	Doppler velocimetry, fetal; umbilical artery; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study

Diagnosis, Frequency and Documentation Guidelines

Ultrasound services are reimbursable as follows:

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

Diagnosis, Frequency and Documentation Guidelines

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76801, 76805, 76811	O00.00 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception	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.
76801, 76805, 76811	O03.0 thru O03.9 Spontaneous abortion	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.
76801, 76805, 76811	O09.511 thru O09.513 Elderly primigravida	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.
76801, 76805, 76811	O09.521 thru O09.523 Elderly multigravida	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
76801, 76805, 76811	O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders	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.
76801, 76805, 76811	O20.0 thru O21.9 and O23.00 thru O29.93 Other maternal disorders	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.
76801, 76805, 76811	O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity	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.
76801, 76805, 76811	O60.00 thru O60.03 Preterm labor without delivery	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
76801, 76805, 76811	O98.011 thru O98.919 Maternal infectious and parasitic diseases	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.
76801, 76805, 76811	O99.011 thru O99.419 and O99.511 thru O99.891 Other maternal disease classifiable elsewhere	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.
76801, 76805, 76811	O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse	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.
76801, 76805, 76811	Z33.2 Encounter for elective termination of pregnancy	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
76801, 76805, 76811	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.
76802, 76810, 76812	O00.00 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	O03.0 thru O03.9 Spontaneous abortion	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O04.5 thru O04.89 Complications following (induced) termination of pregnancy	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	O09.511 thru O09.513 Elderly primigravida	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O09.521 thru O09.523 Elderly multigravida	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O20.0 thru O21.9 and O23.00 thru O29.93 Other maternal disorders	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O60.00 thru O60.03 Preterm labor without delivery	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	O98.011 thru O98.919 Maternal infectious and parasitic diseases	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O99.011 thru O99.419 and O99.511 thru O99.891 Other maternal disease classifiable elsewhere	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	Z33.2 Encounter for elective termination of pregnancy	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76802, 76810, 76812	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. 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
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). 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.
76815	O00.00 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O03.0 thru O03.9 Spontaneous abortion	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O04.5 thru O04.89 Complications following (induced) termination of pregnancy	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
76815	O09.511 thru O09.513 Elderly primigravida	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O09.521 thru O09.523 Elderly multigravida	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O20.0 thru O21.9 and O23.00 thru O29.93 Other maternal disorders	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O60.00 thru O60.03 Preterm labor without delivery	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O98.011 thru O98.919 Maternal infectious and parasitic diseases	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
76815	O99.011 thru O99.419 and O99.511 thru O99.891 Other maternal disease classifiable elsewhere	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	Z33.2 Encounter for elective termination of pregnancy	Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76815	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	O00.00 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	O03.0 thru O03.9 Spontaneous abortion	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	O04.5 thru O04.89 Complications following (induced) termination of pregnancy	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	O09.511 thru O09.513 Elderly primigravida	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	O09.521 thru O09.523 Elderly multigravida	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	O20.0 thru O21.9 and O23.00 thru O29.93 Other maternal disorders	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	O60.00 thru O60.03 Preterm labor without delivery	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	O98.011 thru O98.919 Maternal infectious and parasitic diseases	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	O99.011 thru O99.419 and O99.511 thru O99.891 Other maternal disease classifiable elsewhere	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	Z33.2 Encounter for elective termination of pregnancy	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).
76816	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 thru 4). Code 76816-59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76817	O00.00 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O03.0 thru O03.9 Spontaneous abortion	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O04.5 thru O04.89 Complications following (induced) termination of pregnancy	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O09.511 thru O09.513 Elderly primigravida	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O09.521 thru O09.523 Elderly multigravida	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O10.011 thru O16.9 Edema, proteinuria and hypertensive disorders	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O20.0 thru O21.9 and O23.00 thru O29.93 Other maternal disorders	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O30.001 thru O48.1 Maternal care related to fetus and amniotic cavity	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
76817	O60.00 thru O60.03 Preterm labor without delivery	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O98.011 thru O98.919 Maternal infectious and parasitic diseases	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O99.011 thru O99.419 and O99.511 thru O99.891 Other maternal disease classifiable elsewhere	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	Z33.2 Encounter for elective termination of pregnancy	Once in 180 days same provider. Additional claims may be reimbursed if documentation justifies medical necessity.
76817	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	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).
76820	O41.00X0 thru O41.03X9 Oligohydramnios	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).
76820	O43.021 thru O43.029 Fetus-to-fetus placental transfusion syndrome	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76821	O36.0110 thru O36.0999 Maternal care for rhesus isoimmunization	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).
76821	O36.1110 thru O36.1999 Care for other isoimmunization	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).
76821	O36.20X0 thru O36.23X9 Maternal care for hydrops fetalis	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).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76821	O43.021 thru O43.029 Fetus-to-fetus placental transfusion syndrome	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).
76821	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	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
76825, 76827	O35.0XX0 thru O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days, same provider. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).
76825, 76827	O36.8310 thru O36.8339 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).
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	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).
76826, 76828	O35.0XX0 thru O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80*)/Additional Claim Information* field (Box 19).

Diagnosis, Frequency and Documentation Guidelines (Continued)

CPT Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76826, 76828	O36.8310 thru O36.8339 Maternal care for abnormalities of the fetal heart rate or rhythm	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, 76826, 76827	O99.891, 099.892 Other specified diseases and conditions 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).

Nuchal Translucency Ultrasounds

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

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

Non-Obstetrical Sonography

CPT codes 76830, 76856 and 76857 (non-obstetrical sonography procedures) are not reimbursable for obstetrical examinations billed in conjunction with ICD-10-CM diagnosis codes O00.00 thru O9A.53, Z33.1, Z33.2, Z34.00 thru Z34.93, Z36.0 thru Z36.9, Z64.0 or Z64.1.

Duplex Scan of Arterial/Venous Flow

CPT codes 93975 (duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study) and 93976 (duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study) are not reimbursable if billed in conjunction with an ICD-10-CM pregnancy-related diagnosis (A34, O00.00 thru O9A.53, Z33.1 thru Z36.9 or Z64.0 thru Z64.1). These procedures have not been proven effective nor are they the current medical community practice for investigating perinatal complications.

Obstetrical MRI

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

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

Cordocentesis

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

Reimbursement

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

Assistant Surgeon and Anesthesiology

Cordocentesis is not reimbursable for assistant surgeon and anesthesiology services.

Fetal Fibronectin Testing

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

Obstetric Panel Frequency Restriction

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

Gender is Not Barrier to Pregnancy Services

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

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

Fetal Stress, Non-Stress Testing

Reimbursement for CPT codes 59020 (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 an appropriate antepartum high-risk ICD-10-CM diagnosis code within the range of O09.211 thru O9A.513.

Codes 59020, 59025 and 76819 may be split-billed with modifier 26 (professional component) or TC (technical component). When billing for both the professional and technical service components, a modifier is neither required nor allowed. These codes may not be billed with modifier 51 (multiple procedures).

CPT Code 59020 and 59025

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

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

Frequency Limit and ICD-10-CM Codes

Reimbursement for CPT code 76819 is a five per day maximum when billing for pregnancy with multiple gestation. Providers must document the number of fetuses in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19). CPT code 59025 may be billed more than 10 times in nine months, when billed in conjunction with one of the ICD-10-CM diagnosis codes in the following table:

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

Supplies

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

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.