Maternity Issues

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2023 IHCP Works Annual Seminar

Agenda

- Member Eligibility
- Notification of Pregnancy (NOP)
- Billing for Pregnancy-Related Services
- Prenatal Care
- High-Risk Pregnancy Care
- Prenatal Ultrasounds
- Delivery and Postpartum Care
- Institutional and Professional Billing Guidelines for Delivery Services
- Indiana Pregnancy Promise Program
- Alternative Birthing Initiatives

Member Eligibility

- Healthy Indiana Plan (HIP) Maternity
  - This is a benefit program that provides full State Plan coverage, free of cost-sharing obligations to pregnant applicants with a family income at or below 138% of the federal poverty level (FPL) and who meet all other HIP eligibility criteria.
  - Members receive Indiana State Plan level benefits, including Medicaid Rehabilitation Option (MRO), nonemergency transportation (NEMT), dental, vision and chiropractic care.
  - The postpartum coverage period lasts at least 12 months from pregnancy termination date. HIP members retain coverage through the HIP program, under their existing managed care entity (MCE), during pregnancy and at redetermination as long as they continue to meet eligibility requirements.

Member Eligibility, cont.

- Hoosier Healthwise
  - Pregnant applicants with income above 138% of the FPL and eligible for IHCP services will be enrolled in Hoosier Healthwise, with Package A – Standard Plan coverage, which provides the same benefits as HIP Maternity.
- Presumptive Eligibility for Pregnant Women (PEPW)
  - The Presumptive Eligibility for Pregnant Women benefit plan (for the Pregnant Women aid category) is limited to ambulatory prenatal care services only, including the following:
    - Doctor visits for prenatal care
    - Prescriptions related to pregnancy
    - Prenatal lab work
    - Transportation for prenatal or emergency-related care
    - More information can be found in the Presumptive Eligibility Module

Presumptive Eligibility for Pregnant Women, cont.

- PEPW does not cover the following:
  - Hospice
  - Long-term care
  - Inpatient care
  - Labor and delivery services
  - Abortion services
  - Sterilization and hysterectomy services
  - Postpartum services
  - Services unrelated to pregnancy or birth outcome

Member Eligibility Determinations

- After the Division of Family Resources (DFR) makes a determination on the full application, the member will be assigned to the appropriate program based on income and other eligibility criteria:
  - Pregnant applicants ***at or below 138%*** of the FPL and eligible for the HIP program will be enrolled in the HIP Maternity benefit plan with a HIP MCE.
  - Pregnant applicants ***above 138%*** of the FPL and eligible for IHCP services will be enrolled in Package A – Standard Plan with a Hoosier Healthwise MCE.

Notification of Pregnancy (NOP)

- FSSA uses the NOP form to improve the identification of health-risk factors of expectant parents.
- Providers may receive $60 for one NOP per managed care member, per pregnancy. NOP reimbursement requirements are as follows:
  - The NOP must be submitted via the IHCP Portal no more than five calendar days from the date of the office visit on which the NOP is based.
  - The member's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based.
  - The member must be enrolled with a MCE, including pregnant members enrolled in an MCE through HIP, Hoosier Care Connect or Hoosier Healthwise, as well as presumptively eligible pregnant members enrolled with an MCE.
  - Further information on submitting and searching for an NOP in the Provider Healthcare Portal can be found in the Obstetrical and Gynecological Services Module.

NOP Submission Guidelines

The provider that submits the NOP* through the Provider Healthcare Portal must be enrolled with the IHCP with a billing or group classification (***not rendering***), under one of the specialties listed.

*NOP cannot be a duplicate of a previously submitted NOP.

- 010 – Acute Care Hospital
- 080 – Federally Qualified Health Center (FQHC)
- 081 – Rural Health Clinic (RHC)
- 082 – Medical Clinic
- 083 – Family Planning Clinic
- 084 – Nurse Practitioner Clinic
- 090 – Pediatric Nurse Practitioner
- 091 – Obstetric Nurse Practitioner
- 092 – Family Nurse Practitioner
- 093 – Clinical Nurse Specialist
- 095 – Certified Nurse Midwife
- 130 – County Health Department
- 316 – Family Practitioner
- 318 – General Practitioner
- 323 – Neonatologist
- 328 – Obstetrician/Gynecologist
- 344 – General Internist
- 345 – General Pediatrician

Billing for Submitted NOPs

- The date of service (DOS) on the NOP claim should be the date the provider completed the risk assessment.
- For DOS on or after Jan. 1, 2023, providers should use procedure code G9997 with the modifier TH.
  - For NOP claims from hospitals, G9997 TH must be billed with revenue code 940.
- NOP claims must be submitted to the appropriate managed care entity with which the member is enrolled.
- NOPs are not reimbursable under the fee-for-service delivery system.

Billing for Pregnancy-Related Services

- Providers must indicate pregnancy and enter the date of last menstrual period (LMP) on all professional claims for pregnancy-related services.
  - ***CMS-1500* claim form** – Enter the LMP date in field 14. Enter the pregnancy indicator P in field 24H for each service detail.
  - **IHCP Provider Healthcare Portal professional claim (FFS billing only)** – During Step 1 of the claim submission process, in the Claim Information section, select Pregnancy as the Date Type and enter the LMP date in the Date of Current field.
  - **837P electronic transaction** – Indicate pregnancy by submitting Y in PAT09 in the 2000 loop. Submit LMP information in the DTP segment in the 2300 loop with a qualifier of 484.

Prenatal Care

The IHCP reimburses up to **14 visits** for prenatal care during a normal pregnancy, as follows:

Use the appropriate modifier to identify prenatal visits in each trimester **(U1, U2, or U3).**

High-Risk Pregnancy Care

- A ***high-risk pregnancy*** is a pregnancy that threatens the health or life of the birthing individual or their fetus.
- The IHCP reimburses high-risk pregnancy care only when provided by a physician, a physician assistant, or an advanced practice registered nurse (APRN).
  - There is additional reimbursement for services rendered when a high-risk pregnancy diagnosis code is submitted on the claim.
- Members identified as high-risk may receive additional prenatal care visits beyond the maximum of 14 allowed for a normal pregnancy.

Prenatal Ultrasounds

- Claims for prenatal ultrasounds performed when indicated for medical necessity must include:
  - As the **primary diagnosis** – a pregnancy diagnosis code from the Z34 series or O09 series
    - Z34 = normal pregnancy, O09 = high-risk pregnancy
  - As the **secondary diagnosis** – an appropriate antenatal screening diagnosis code that supports the medical necessity of an ultrasound
- The first-trimester fetal nuchal translucency ultrasound does not require prior authorization.
  - This procedure is non-covered when performed alone for the detection of chromosomal defects.
  - A list of indications for medical necessity of an ultrasound can be found in the Obstetrical and Gynecological Services Module.

Delivery and Postpartum Care

- The IHCP provides reimbursement for obstetrical delivery and postpartum care when all coverage and billing requirements are met.
- The delivery service includes the following:
  - Admission to the hospital
  - Admission history and physical examination
  - Management of uncomplicated labor
  - Delivery, including:
    - Vaginal delivery (with or without episiotomy, with or without forceps)
    - Cesarean delivery

Professional Billing Guidelines for Obstetrical Delivery

Professional claims (*CMS-1500* or electronic equivalent) must include one of the following **modifiers**:

UA

Nonmedically necessary delivery prior to 39 weeks of gestation.

UB

Medically necessary delivery prior to 39 weeks of gestation.

UC

Delivery at 39 weeks of gestation or later.

Institutional Billing Guidelines for Obstetrical Delivery

Institutional claims (*UB-04* claim form or electronic equivalent) for obstetrical delivery services related to C-sections or inductions require one of the following **condition codes** (in addition to the appropriate revenue codes and ICD procedure codes:

81

C-sections or inductions performed at less than 39 weeks' gestation for medical necessity.

82

C-sections or inductions performed at less than 39 weeks' gestation electively.

83

C-sections or inductions performed at 39 weeks' gestation or greater.

Indiana Pregnancy Promise Program

Launched statewide in July 2021, the Pregnancy Promise Program is a free, voluntary program that aims to identify pregnant Medicaid members with opioid use disorder (OUD) as early as possible in their pregnancy.

To be eligible for the Pregnancy Promise Program, an individual must be pregnant or within 90 days of the end of their pregnancy, have current or past opioid use, and must be eligible for Medicaid health coverage.

Indiana Pregnancy Program Stats

YEAR 1 : JULY 1, 2021, TO JUNE 30, 2022

275 Pregnancy Promise Program enrollments

97% Program retention rate

82% Of infants born at healthy birth weight

75% Of infants with hospital stay of five days or fewer

93% Of participants achieved sustained recovery during enrollment

100% Survival rate (overdose or otherwise)

[Indiana Pregnancy Promise Program Annual Report 2022]

OUTREACH AND ENROLLMENT, YEAR 1

20 Hospital and community events with My Healthy Baby initiative (IDOH, DCS, FSSA collaboration)

68 Of Indiana's 92 counties with enrollment

158 Community partner organizations engaged

394 Website referrals

1,776 Prospective enrollees identified and contacted

64% Of participants enrolled during the prenatal period

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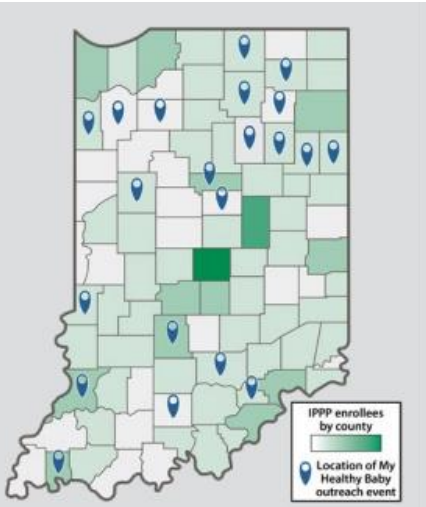

SERVICE UTILIZATION, YEAR 1

78% Of participants received OUD treatment services

85% Of participants who enrolled during pregnancy received prenatal care

72% Received medication for opioid use disorder

24 Infants enrolled in Pregnancy Promise childcare benefit

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION FSSA

Alternative Birthing Initiatives: OMPP Doula Project

GOAL

The goal of the OMPP Doula Project is to expand current doula services and allow doulas to enroll with and be reimbursed by Indiana Medicaid without physician oversight.

ACTION STEPS

OMPP has an engaged stakeholder coalition, the OMPP Doula Stakeholder Group (ODSG), with over 100 stakeholders across Indiana.

The stakeholders convene during the monthly workgroup meetings to discuss doula verification, Medicaid reimbursement, and program sustainability/implementation.

Resources Available

- What resources are available to providers?
  - Regional Field Consultants
  - Provider Reference Materials
  - Provider Education

Additional Resources

OMPPProviderRelations@fssa.IN.gov

- For individual provider concerns requiring assistance from the state, such as:
  - **Claim denials**
  - **Procedure explanations**
  - **Eligibility issues**

IHCPListens@fssa.IN.gov

- Feedback on IHCP presentations
- Ideas for future presentations or workshops
- Questions to be answered in future publications

Telehealth.OMPP@fssa.IN.gov

- For questions regarding Telehealth
  - **Billing**
  - **Policy**
  - **Reimbursement**

Questions?