B. and prevention of sexually transmitted disease. It is directed at early intervention and prevention of teen pregnancy. Family planning services may be provided to any eligible recipient of childbearing age (including minors who may be considered sexually active).

C. Insertion of Long-Acting Reversible Contraceptives (LARC) immediately following delivery is a covered benefit for eligible recipients. LARC insertion is a covered benefit post discharge as medically necessary.

D. Family Planning Services are not covered for those recipients, regardless of eligibility, whose age or physical condition precludes reproduction.

F. A pelvic exam or pap smear is not required for self-administered birth control.

603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, labor and delivery, and postpartum care provided by a physician, physician assistant, APRN, and/or a nurse midwife. Maternity care services can be provided in the home, office, hospital, or ~~obstetric~~freestanding birthing center settings. All maternity care providers are allowed to provide services within all settings that are allowed per their scope of practice and licensure.

Provider shall follow current national guidelines, recommendations, and standards of care for maternity care services, including but not limited to, USPSTF, ACOG, Society of Maternal-Fetal Medicine, and the American College of Nurse Midwives.

Per NRS 449.0155 "~~Obstetric~~Freestanding Birthing Center" means a facility that is not part of a hospital and provides services for normal, uncomplicated births. ~~This is also Nevada's legal term for a birth center or freestanding birth center.~~ Nevada Administrative Code (NAC) regulations for ~~Obstetric Centers~~ Freestanding b~~B~~irthing c~~C~~enters are located in NAC 449.6113 – 449.61178. Please also refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-01, Freestanding Birthing Centers.

For women who are eligible for pregnancy-related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the entire month in which the 60th day falls. She is eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21 years old, and eligible for pregnancy only, are not entitled to EPSDT services.

It is the responsibility of the treating provider to employ a care coordination mechanism to facilitate the identification and treatment of high-risk pregnancies. "High-Risk" is defined as a probability of an adverse outcome to the woman and/or her baby greater than the average occurrence in the general population. Home and ~~obstetric~~ freestanding birthing center births and corresponding pregnancy services are appropriate for recipients with low-risk pregnancies,

intended vaginal delivery, and no reasonably foreseeable expectation of complication. Recipients that are eligible for ~~Obstetric~~ freestanding birthing c~~C~~enter services is outlined in NAC 449.61134. If assessments suggest the likelihood of complications that could make the delivery high-risk, then services will be reimbursed when provided by a provider in the hospital setting.

For those females enrolled in a managed care program, the Managed Care Organization (MCO) physicians are responsible for making referrals for early intervention and case management activities on behalf of those women. Communication and coordination between the MCO physicians, service physicians, and MCO staff is critical to promoting optimal birth outcomes.

603.4A STAGES OF MATERNITY CARE

1. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery totaling approximately 13 routine visits. Any other visits or services within this time period for non-routine maternity care should be coded separately. Non-emergency antepartum care is not a covered benefit for non-U.S. citizens/aliens who have not lawfully been admitted for permanent residence in the United States or permanently residing in the United States under the color of the law. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for allowable services to non-U.S. citizens.

2. Labor and delivery services include home delivery, admission to the hospital, or ~~obstetric~~ freestanding birthing center, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without an episiotomy/operative delivery (vacuum or forceps)), or cesarean delivery in hospital setting. Medical problems complicating labor and delivery management may require additional resources and should be billed utilizing the CPT codes in the Medicine and Evaluation and Management Services sections in addition to codes for maternity care.

    a. In accordance with standard regulations, vaginal deliveries with a hospital stay of three days or less and cesarean-section deliveries with a hospital stay of four days or less do not require prior authorization. Reference MSM Chapter 200, Hospital Services for inpatient coverage and limitations.

    b. Non-Medically Elective Deliveries

        1. Reimbursement for Avoidable Cesarean Section

        To make certain that cesarean sections are being performed only in cases of medical necessity, Nevada Medicaid will reimburse providers for

performing cesarean sections only in instances that are medically necessary and not for the convenience of the provider or patient. Elective cesarean sections must be prior authorized and will be reimbursed at the vaginal delivery rate.

2. Early Induction of Labor (EIOL)

Research shows that early elective induction (<39 weeks gestation) has no medical benefit and may be associated with risks to both the mother and infant. Based upon these recommendations, Nevada Medicaid will require prior authorization for hospital admissions for EIOL prior to 39 weeks to determine medical necessity.

Nevada Medicaid encourages providers to review the "Early Elective Deliveries Toolkit" compiled by the March of Dimes, the California Maternity Quality Care Collaborative, and the California Department of Public Health, Maternal, Child and Adolescent Health Division at http://www.cmqcc.org/resources-tool-kits/toolkits/early-elective-deliveries-toolkit. The aim of the toolkit is to offer guidance and support to providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

3. Progesterone therapy to prevent preterm birth.

Preterm birth is determined when a baby is born prior to 37 weeks of pregnancy. Women who have a history of preterm birth are at greater risk of future preterm births. Progesterone therapy is a hormone therapy designed to prevent the onset of preterm birth.

Nevada Medicaid covers services related to the prevention of preterm birth. Progesterone therapies are initiated between 16 and 20 weeks of pregnancy, with weekly injections until 37 weeks.

Please see PT 20, 24, 74, and 77 Billing Guides for specific coverage and limitations.

c. Provider responsibilities for the initial newborn examination and subsequent care until discharge includes the following:

1. The initial physical examination done in the home, ~~obstetric~~ freestanding birthing center, or hospital delivery room is a rapid screening for life threatening anomalies that may require immediate billable attention.

2. Complete physical examination is done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized. This examination is billable.

3. Brief examinations should be performed daily until discharge. On day of discharge, provider may bill either the brief examination or discharge day code, not both.

4. Routine circumcision of a newborn male is a Medicaid benefit for males up to one year of age. For males older than one year of age, a prior authorization is required to support medical necessity.

5. If a newborn is discharged from a hospital or ~~obstetric~~ freestanding birthing center less than 24 hours after delivery, Medicaid will reimburse newborn follow-up visits in the provider's office or recipient's home up to four days post-delivery. This is also allowable for all home births.

6. All newborns must receive a hearing screen in accordance with NRS 442.540 and corresponding NAC 442.850. This testing and interpretation are included in the facility per diem rate. Hearing screening is not required if parent or legal guardian objects in writing. If a baby is born in the home setting, the nurse midwife may not have the necessary equipment to conduct the hearing screen. Therefore, a referral can be made to a hearing specialist.

7. All newborns must receive a newborn screening blood analysis in accordance with NRS 442.008 and corresponding NAC 442.020 – 442.050. This testing is included in the facility per diem rate. Newborn screening is not required if parent or legal guardian objects in writing.

3. Postpartum care includes hospital, office visits, and home visits following vaginal or cesarean section delivery. Women, who are eligible for Medicaid on the last day of their pregnancy, remain eligible for all pregnancy related and postpartum medical assistance including family planning education and services for 60 days immediately following the last day of pregnancy, including the entire month in which the 60th day falls. Pregnancy related only eligible women are not covered for any Medicaid benefits not directly related to their pregnancy.

4. Reimbursement: If a provider provides all or part of the antepartum and/or postpartum care but does not perform delivery due to termination of the pregnancy or referral to another provider, then reimbursement is based upon the antepartum and postpartum care CPT codes. A global payment will be paid to the delivering provider, when the pregnant woman

has been seen seven or more times by the delivering provider. If the provider has seen the pregnant woman less than seven times with or without delivery, the provider will be paid according to the Fee-for-Service (FFS) visit schedule using the appropriate CPT codes. For MCO exceptions to the global payment please refer to MSM Chapter 3600, Managed Care Organization. Please refer to MSM Chapter 700, Rates and Supplemental Reimbursement for more information.

603.4B FETAL NON-STRESS TESTING

1. Fetal Non-Stress testing (NST) is a means of fetal surveillance for most conditions that place the fetus at high risk for placental insufficiency. Providers shall follow current national guidelines, recommendations, and standards of care for the indications, techniques, and timing of the appropriate antepartum fetal surveillance methods and management guidelines.

2. Home uterine activity monitoring service may be ordered for a recipient who has a current diagnosis of pre-term labor and a history of pre-term labor/delivery with previous pregnancies. Reference MSM Chapter 1300, Durable Medical Equipment (DME) for coverage and limitation guidelines.

603.4C MATERNAL/FETAL ULTRASOUND STUDIES

Obstetrical ultrasound of a pregnant uterus is a covered benefit of Nevada Medicaid when it is determined to be medically necessary for the woman and/or the fetus.

Per CPT guidelines, an obstetrical ultrasound includes determination of the number of gestational sacs and fetuses, gestational sac/fetal structure, qualitative assessment of amniotic fluid volume/gestational sac shape, and examination of the maternal uterus and adnexa. The patient's record must clearly identify all high-risk factors and ultrasound findings.

1. Coverage and Limitations

A first trimester ultrasound may be covered to confirm viability of the pregnancy, to rule out multiple births and better define the Estimated Date of Confinement (EDC).

One second trimester or third trimester ultrasound per pregnancy with detailed anatomic examination is considered medically necessary to evaluate the fetus for fetal anatomic abnormalities. Refer to most current ACOG guidance for a list of qualified indications.

An initial screening ultrasound due to late entry prenatal care is a covered benefit. The use of a second ultrasound in the third trimester for screening purposes is not covered. Subsequent ultrasounds, including biophysical profiles should clearly identify the findings

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