

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

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## **Pregnancy: Early Care and Diagnostic Services**

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.

### **Pregnancy Care: Billing**

All care for a woman during pregnancy and the postpartum period must be billed with a pregnancy diagnosis, or the claim may be denied.

### **Presumptive Eligibility Program**

The Presumptive Eligibility (PE) 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* 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 women 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 recipients: 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.

Welfare departments are responsible for informing all mothers who 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 recipients from conception through 60 days after the month of delivery. 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 recipients 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 recipients without cost sharing. These services are required during the prenatal period through the postpartum period (the end of the month in which the 60-day period following termination of the pregnancy ends).

**Pregnancy Care  
Office Visit:  
Antepartum Initial**

HCPCS code Z1032 (initial pregnancy-related 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-4 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 (per antepartum 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-9-CM pregnancy associated diagnosis (V22.0 – V23.9, 640.00 – 676.93). 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, code Z1034 should be used.

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

**Pregnancy Care  
Office Visits:  
Antepartum Follow-Up**

Code Z1034 is used for 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-4 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.

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

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**Pregnancy Care**

Code Z1038 is used for a postpartum visit. While an office visit 7 to 14

**Office Visit:  
Postpartum**

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 office 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*.

**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-9-CM pregnancy diagnosis, may be reimbursed if billed in conjunction with another diagnosis code other than V70.0, V70.5 – V70.9, V72.0, V72.11 – V72.19, V72.6 or V72.9. A pregnancy diagnosis code must be present on the claim form for reimbursement when a recipient's eligibility is restricted to pregnancy-only Medi-Cal. 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 recipients with gestational diabetes. Medical justification of this condition must be present on the claim, using ICD-9-CM diagnosis codes 648.80 – 648.84 or documentation attached to the claim that indicates the recipient is a gestational diabetic. Reimbursement is limited to one glucometer every five years, per recipient, for any provider. For additional information refer to the *Durable Medical Equipment (DME): Bill for DME* section in the appropriate Part 2 manual.

**Preventing Preterm Births:  
Hydroxyprogesterone  
Caproate**

Hydroxyprogesterone caproate injections are administered to prolong pregnancy for women with documented histories of spontaneous preterm births (less than 37 weeks gestation) and a current singleton pregnancy. The prior and current pregnancies must be singletons; prior or current multiple gestation pregnancy is a contraindication.

Claims for hydroxyprogesterone caproate must include the following:

- HCPCS code J1725 (injection, hydroxyprogesterone caproate, 1 mg)
- Modifier UD, which is used by Section 340B providers to denote drugs purchased under this program
- ICD-9-CM diagnosis code V23.41 (pregnancy with history of preterm labor)

Hydroxyprogesterone caproate is billed using HCPCS code J1725 with a quantity of 250 units. Reimbursement is limited to one 250 mg injection every seven days between 16 and 36 weeks of gestation.

HCPCS code J1725 is not used for the billing of compounded hydroxyprogesterone caproate. If warranted, the compounded form must be billed using HCPCS code J3490 (unclassified drugs) and the claim must be submitted with all appropriate documentation including an invoice, National Drug Code (NDC) and ICD-9-CM diagnosis code V23.41 (pregnancy with history of preterm labor).

For instructions on how to provide Makena brand hydroxyprogesterone caproate by a specialty pharmacy, call the Makena Care Connection at 1-800-847-3418 or visit the Makena Care Connection page of the Makena website at <http://www.makena.com/pages/hcp/care-connection/>.

**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:

<u>CPT-4 Code</u>	<u>Description</u>
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	each additional gestation

<u>CPT-4 Code</u>	<u>Description</u>
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	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	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	each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses
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
76821	middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	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.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76801, 76805, 76811	630 – 633.91 Ectopic and molar pregnancy 634.00 – 634.92 Spontaneous abortion 637.00 – 637.92 Unspecified abortion 640.00 – 658.93 Complications mainly related to pregnancy 659.53 Elderly primigravida 659.63 Elderly multigravida 659.73 Abnormality in fetal heart rate or rhythm V28.0 – V28.2 Guide for amniocentesis V28.89 Other specified antenatal screening	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	630 – 633.91 Ectopic and molar pregnancy 634.00 – 634.92 Spontaneous abortion 637.00 – 637.92 Unspecified abortion 640.00 – 658.93 Complications mainly related to pregnancy 659.53 Elderly primigravida 659.63 Elderly multigravida 659.73 Abnormality in fetal heart rate or rhythm V28.0 – V28.2 Guide for amniocentesis V28.89 Other specified antenatal screening	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 <i>Remarks</i> field (Box 80)/ <b><u>Additional Claim Information</u></b> field (Box 19).

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76813	V28.89 Other specified antenatal screening	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	V28.89 Other specified antenatal screening	Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/ <b><u>Additional Claim Information</u></b> 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	630 – 633.91 Ectopic and molar pregnancy 634.00 – 634.92 Spontaneous abortion 637.00 – 637.92 Unspecified abortion 640.00 – 658.93 Complications mainly related to pregnancy 659.53 Elderly primigravida 659.63 Elderly multigravida 659.73 Abnormality in fetal heart rate or rhythm V28.0 – V28.2 Guide for amniocentesis V28.89 Other specified antenatal screening	Once in 180 days, same provider.  Additional claims may be reimbursed if documentation justifies medical necessity.



CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	630 – 633.91 Ectopic and molar pregnancy 634.00 – 634.92 Spontaneous abortion 637.00 – 637.92 Unspecified abortion 640.00 – 658.93 Complications mainly related to pregnancy 659.53 Elderly primigravida 659.63 Elderly multigravida 659.73 Abnormality in fetal heart rate or rhythm V28.0 – V28.2 Guide for amniocentesis V28.89 Other specified antenatal screening	Once in 180 days (when billed without modifier 59), same provider.  Additional claims may be reimbursed if documentation justifies medical necessity. Multiple gestation does not justify second and subsequent claims; use modifier 59.  Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/ <i>Reserved for Local Use</i> field (Box 19).
76817	630 – 633.91 Ectopic and molar pregnancy 634.00 – 634.92 Spontaneous abortion 637.00 – 637.92 Unspecified abortion 640.00 – 658.93 Complications mainly related to pregnancy 659.53 Elderly primigravida 659.63 Elderly multigravida 659.73 Abnormality in fetal heart rate or rhythm V28.0 – V28.2 Guide for amniocentesis V28.89 Other specified antenatal screening	Once in 180 days, same provider.  Additional claims may be reimbursed with documentation justifying medical necessity.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76820	656.50 – 656.53 Poor fetal growth  658.03 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 <i>Remarks</i> field (Box 80)/ <b><u>Additional Claim Information</u></b> field (Box 19).
76821	656.10 – 656.23 Isoimmunization  647.63 Anemia due to Parvovirus B19 infection	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 <i>Remarks</i> field (Box 80)/ <b><u>Additional Claim Information</u></b> field (Box 19).
76825, 76827,	648.00 – 648.03 Diabetes Mellitus  648.50 – 648.53 Congenital cardiovascular disorders  648.80 – 648.83 Abnormal glucose tolerance  655.00 – 655.93 Known or suspected fetal abnormality affecting management of mother  659.73 Abnormality in 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 <i>Remarks</i> field (Box 80)/ <b><u>Additional Claim Information</u></b> field (Box 19).



CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76826, 76828	648.00 – 648.03 Diabetes Mellitus  648.50 – 648.53 Congenital cardiovascular disorders  648.80 – 648.83 Abnormal glucose tolerance  655.00 – 655.93 Known or suspected fetal abnormality affecting management of mother  659.73 Abnormality in 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 <i>Remarks</i> field (Box 80)/ <b><u>Additional Claim Information</u></b> field (Box 19).

Nuchal Translucency  
Ultrasounds

CPT-4 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-4 codes 76830, 76856 and 76857 (non-obstetrical sonography procedures) are not reimbursable for obstetrical examinations billed in conjunction with ICD-9-CM diagnosis codes 630 – 633.99, 640.00 – 663.93, V22.0 – V23.7, V23.81 – V23.89, V23.9, V28.0 – V28.6, V28.81 – V28.99 or V61.5 – V61.7.

<b>Duplex Scan of Arterial/Venous Flow</b>	CPT-4 codes 93975 (duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study) and 93976 (...limited study) are not reimbursable if billed in conjunction with a pregnancy-related diagnosis (640 – 676.9, 626.0 or V22 – V23.9). These procedures have not been proven effective nor are they the current medical community practice for investigating perinatal complications.
<b>Cordocentesis</b>	CPT-4 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-4 code 36460 (transfusion, intrauterine, fetal) by the same provider, for the same recipient and date of service.
Assistant Surgeon and Anesthesiology	Cordocentesis is not reimbursable for assistant surgeon and anesthesiology services.
<b>Fetal Fibronectin Testing</b>	CPT-4 code 82731 (fetal fibronectin, cervicovaginal secretions, semi-quantitative) is reimbursable when billed in conjunction with ICD-9-CM diagnosis code 644.03 (premature labor after 22 weeks, but before 37 completed weeks of gestation without delivery). Fetal fibronectin assay tests identify a subgroup of pregnant females 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 24 <sup>th</sup> and 35 <sup>th</sup> weeks of gestation.
<b>Obstetric Panel Frequency Restriction</b>	CPT-4 code 80055 (obstetric panel) is restricted to once in nine months for the same provider. 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.

**Fetal Stress,  
Non-Stress Testing**

Reimbursement for CPT-4 codes 59020 (fetal contraction stress test) and 59025 (fetal non-stress test) and HCPCS code Z1030 (non-oxytocin fetal stress test) is limited to high-risk pregnancies.

**Note:** Code Z1030 differs from code 59020 in that stress is produced without the administration of oxytocin. Nipple stimulation is a common method used to produce the stress factor.

Billing

HCPCS Code Z1030 and CPT-4 Code 59025 are reimbursable when billed in conjunction with one of the following ICD-9-CM diagnosis codes: 641.00 – 642.94, 644.00 – 644.21, 645.10 – 645.23, 648.00 – 648.94, 656.00 – 656.93, 658.00 – 658.43, 760.0 – 760.5, 760.70 – 766.22, 768.0 – 768.4, 773.0 – 773.5, V23.41 – V23.5, and V23.81 – V23.89.

Codes 59020, 59025 and Z1030 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-4 Code 59020

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.

CPT-4 Code 59025

Claims for code 59025 will be denied if code 59020 and/or code Z1030 have been reimbursed to the same provider, for the same recipient and date of service.

The frequency in billing may be more than 10 times in nine months when code 59025 is billed in conjunction with one of the following ICD-9-CM diagnosis codes:

<u>ICD-9-CM Code</u>	<u>Description</u>
648.03	Diabetes mellitus; antepartum condition or complication
656.33	Fetal distress; antepartum condition or complication
656.53	Poor fetal growth; antepartum condition or complication
658.23	Delayed delivery after spontaneous or unspecified rupture of membranes; antepartum condition or complication
V23.5	Pregnancy with other poor reproductive history
V23.89	Other high-risk pregnancy

HCPCS Code Z1030

Reimbursement for code Z1030 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.

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.