
Pregnancy: Postpartum and Newborn Referral Services

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

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

Billing Newborn Infant Services with Mother's ID

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

Other Health Coverage

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

Tobacco Cessation

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

Early Discharge

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

Early Discharge Follow-Up Visit

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

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

Physician's Office or Clinic Site

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

Recipient's Home

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

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

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

HHA providers may not bill for a case evaluation and initial treatment plan (HCPCS code G0162 and revenue code 0583) and/or a skilled nursing visit (HCPCS code G0154 and revenue code 0551) in addition to an early discharge follow-up visit on the same date of service.

Pregnancy-Related Services

Pregnancy-related services are services required to assure the health of the pregnant woman and the fetus, or that have become necessary as a result of the woman 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 60-day period following termination of pregnancy ends.

Policy regarding preventive counseling for pregnant and postpartum recipients who are at risk for perinatal depression may be found in the *Psychological Services* section of appropriate Part 2 manual.

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

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

Pregnancy Care Billing

When billing any medically necessary service during the postpartum period, providers should include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

Pregnancy Care Office Visit: Postpartum

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

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

Some women who are Medi-Cal-eligible and receive Medi-Cal services on their last day of pregnancy continue to be eligible for postpartum and pregnancy-related services for 60 days, regardless of whether other eligibility conditions (such as Share of Cost) are met.

Since eligibility for Medi-Cal is established monthly, the postpartum care eligibility period begins on the first day of the month following the month in which pregnancy ends, and ceases on the last day of the month in which the 60th day occurs. (This policy is established in *California Code of Regulations*, Title 22, Section 50260.)

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

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

Services may be billed globally or fee for service.

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

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

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

Breast Feeding: Services Covered by Medi-Cal

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

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

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

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

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

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum woman for specialty or other medically necessary care, providers should advise the specialist or other medical provider that the referral is for a medically necessary service and remind the specialist to include a pregnancy diagnosis code on the claim form for reimbursement. Claims should be billed with either CPT Evaluation and Management (E&M) consultation codes 99241 thru 99245 or the most appropriate billing code for the service provided. These visits must not be billed with either procedure code Z1034 (antepartum office visit) or E&M procedure codes <<99202>> thru 99215 (new or established outpatient visits) <<or 99417>> or the claim may be denied.

Newborn Referral Form

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

Procedure

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

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

«Newborn Referral Form Distribution»

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

Ordering Forms

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

<<Legend>>

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

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