

Maryland Medicaid Program OB/GYN Services

Obstetrical Care

Most pregnant members enrolled in Medicaid must enroll in HealthChoice, Medicaid's managed care program. HealthChoice beneficiaries who do not select a managed care organization (MCO) are auto-assigned to an MCO. For additional information about HealthChoice, go to <https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx>.

Pregnant members often access care on a fee-for-service basis prior to enrollment in the MCO. This occurs because some members apply for Medicaid during pregnancy or are only eligible for Medicaid because they are pregnant. Certain members are not eligible for MCO enrollment. For example, members with temporary Hospital Presumptive Eligibility coverage and members with dual coverage (Medicare and Medicaid) will not be enrolled in MCOs.

Providers must check EVS at each visit prior to rendering services to determine if the beneficiary is enrolled in an MCO. Providers who are contracted with MCOs should refer to the MCO's provider contract, provider manual, preauthorization procedures and billing instructions. Go to the **HealthChoice Provider Brochure** for MCO contact information at https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice_Provider_Brochure_August%202023.pdf

Self-Referral Provisions and Continuity of Care

- If a pregnant member has initiated prenatal care with an out-of-network provider prior to MCO enrollment, they may continue to see that provider during their pregnancy. The provider must be willing to bill the MCO. See [Factsheet #1](#).
- When accessing self-referral services, beneficiaries must use in-network pharmacy and laboratory services.
- The MCO is required to reimburse an out-of-network provider at the Medicaid fee for service rate.
- Continuity of Care provisions also require MCOs to allow newly enrolled members to continue to see an out of network provider when the member has already initiated prenatal care.
- Medically necessary services related to prenatal care such as lab tests, prenatal vitamins and prescription drugs, sonograms, and non-stress tests are covered.
- Prenatal care providers must use the appropriate evaluation and management code (E&M) in conjunction with the appropriate ICD-10 pregnancy code for each prenatal visit.

- **Medicaid does not reimburse physicians for “global” maternity care services. Providers must bill deliveries separately from prenatal care.**

CPT Code	Description
99201	Office visit, new patient, minimal
99202	Office visit, new patient, moderate
99203	Office visit, new patient, extended
99204	Office visit, new patient, comprehensive
99205	Office visit, new patient, complicated
99211	Office visit, established patient, minimal
99212	Office visit, established patient, moderate
99213	Office visit, established patient, extended
99214	Office visit, established patient, comprehensive
99215	Office visit, established patient, complicated

Maryland Prenatal Risk Assessment Process

The Program will reimburse prenatal care providers an additional fee for completion of the **Maryland Prenatal Risk Assessment (MPRA)**. See page 5 for sample MPRA. Use HCPCS code H1000. (The program does not use code 99420.) Only one risk assessment per pregnancy will be reimbursed. To complete the MPRA process, providers must:

- 1) Fill out the MPRA form (DHMH 4850) at the first prenatal visit;
 - 2) Fax the form to the local health department (addresses and fax numbers are on the form); and
 - 3) Develop a plan of care based on the member’s risk factors.
- The MPRA identifies members at risk for low birth weight, pre-term delivery and other health care conditions that may put the member and/or infant at risk.
 - The local health departments use the MPRAs to identify members who may benefit from local programs, or who may need assistance navigating the health care system.
 - LHDs are required to forward the MPRAs to the MCO.
 - The MCOs use the MPRAs to identify members that are pregnant and link them to care coordination and case management services.

To retrieve the Maryland Prenatal Risk Assessment, go to <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>

Enriched Maternity Services

The Program will reimburse prenatal care providers an additional fee when “enriched” maternity services are provided. Use HCPCS code H1003. (The Program does not use codes 99411 and 99412.) Only one unit of service per prenatal and postpartum visit will be reimbursed. An “Enriched Maternity Service” must include all the following:

- 1) Individual prenatal health education;
- 2) Documentation of topic areas covered (see page 7 for sample *Enriched Maternity Services*);
- 3) Health counseling; and
- 4) Referral to community support services.

The completed EMS form must be completed and kept in the patient's record. The form can be found here: <https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx>

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

The Program will reimburse for SBIRT intervention codes W7000, W7010, W7020, W7021, and W7022 in conjunction with an office visit. When billing with H1003, the provision of this service must be in addition to the alcohol and substance use counseling component of the “Enriched Maternity Service.”

The Program will reimburse separately for smoking and tobacco use cessation counseling codes 99406 and 99407. However, when billing with H1003, the provision of this service must be in addition to the smoking and tobacco use/cessation counseling component of the “Enriched Maternity Service.”

For more information about SBIRT (Screening, Brief Intervention, and Referral to Treatment), go to: <https://health.maryland.gov/bha/Pages/SBIRT.aspx>

Intrapartum & Postpartum Care

- Providers must bill deliveries separately from prenatal care. The Program does not use procedure codes 59400, 59425, 59426, 59510, and 59610.
- If other procedures are performed on the same date of service, list the code for delivery on the first line of **Block 24** of the *CMS-1500* form. List the modifier in column **24D** for the second or subsequent procedure.
- For vaginal deliveries performed in a “home” or “birthing center”, use codes 59410 and 59614, with the appropriate place of service code “12 or 25” indicated in **Block 24B** of the *CMS-1500* form. Use the unlisted maternity care and delivery code 59899 for supplies used for a vaginal delivery.
- Use code 59430 for postpartum care services only. Postpartum care includes all visits in the hospital and office after the delivery. Postpartum care is not payable as a separate procedure unless it is provided by a physician or group other than the one providing the delivery service.

Refer to the Program’s **Professional Services Provider Manual** and **CMS-1500 Billing Instructions** on the Program’s website:

<https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>

Maternal and Child Health Programs

Medicaid has created several new or enhanced maternal and child health (MCH) initiatives that were implemented in January 2022. Programs and services include:

- Doula services
- Home visiting services
- MOM (Maternal Opioid Misuse) case management services

Additional information about these programs and services can be found at the following link:

<https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Pages/Home.aspx>

Expanded Medicaid coverage for postpartum members

Effective April 1, 2022, Medicaid expanded coverage for pregnant beneficiaries. Medicaid-eligible pregnant members will be able to access full Medicaid benefits for the duration of their pregnancy and

the 12-month postpartum period.

Gynecology

Use the appropriate Preventive Medicine codes for routine annual gynecologic exams:

99383 - 99387 for new patients

99393 - 99397 for established patients

Use the appropriate E&M codes for problem-oriented visits:

99201 - 99205 for a new patient

99211 - 99215 for an established patient

Providers may only bill the Program for laboratory procedures which they perform or are performed under their direct supervision. Physicians' service providers cannot be paid for clinical laboratory services without both a **Clinical Laboratory Improvement Amendment (CLIA)** certification and approval by the Maryland Laboratory Administration, if located in Maryland. Laboratory procedures that the physician refers to an outside laboratory or practitioner for performance must be billed by that laboratory or practitioner.

Interpretation of laboratory results or the taking of specimens other than blood is considered part of the office visit and may not be billed as a separate procedure. Specimen collection for Pap smears is not billable by a physician. For specific information regarding pathology and laboratory services, refer to the **Medical Laboratories Provider Fee Schedule** at <https://mmcp.health.maryland.gov/pages/Provider-Information.aspx>. For additional information, contact Physicians Services at 410-767-1462.

Hysterectomy

Medicaid will pay for a hysterectomy only under the following conditions:

- The physician who secured authorization to perform the hysterectomy has informed the member and their representative, if any, both orally and in writing, that the hysterectomy will render the member permanently incapable of reproducing; AND
- The member or their representative, if any, has signed a written acknowledgment of receipt of that information (patients over the age of 55 do not have to sign); OR
- The physician who performs the hysterectomy certifies, in writing, that either the member was already sterile at the time of the hysterectomy and states the cause of the sterility; OR
- The hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician must include a description of the nature of the emergency.

The Program will not pay for a hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications that alone do not indicate a hysterectomy.

Regulations require physicians who perform hysterectomies (not secondary providers, e.g., assisting surgeons or anesthesiologists) to complete the “**Document for Hysterectomy**” form (DHMH 2990), which is available at: <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>. The completed DHMH 2990 must be kept in the patient’s medical record.

For a list of procedure codes, refer to the FFS Program’s **Professional Services Provider Manual** at <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>.

Hospital Admissions

Preauthorization by Telligen, the Program’s Utilization Control Agent (UCA) is required for all elective hospital admissions for recipients covered under Medicaid’s fee-for-service program. It is the hospital’s responsibility to obtain preauthorization by using Qualitrac to submit level of care requests. For more information regarding Qualitrac, go to <https://telligenmd.qualitrac.com/> or call at 888-276-7075.

For questions regarding Medicaid’s reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-3605.