Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Maryland Medicaid Program
Reproductive Health Services

This series of factsheets replaces the HealthChoice Self-Referral Manual and the OB/GYN/Family Planning Provider Services Manual.

Most Maryland Medicaid beneficiaries are enrolled in managed care organizations (MCOs) through the HealthChoice program. However, it is common for beneficiaries to have fee-for-service (FFS) Medicaid before MCO enrollment and for short periods of time after breaks in Medicaid eligibility. Some services, referred to as "carve outs," are not covered by MCOs but are covered by FFS Medicaid and reimbursed by the state.

For beneficiaries in MCOs, it is important to understand that beneficiaries can self-refer to out-of-network providers for certain services. This overview and the accompanying factsheets are provided to assist providers in understanding self-referral and reproductive health coverage for both the FFS and MCO systems. Reproductive health topics covered include:

- **Self-Referral Provisions for HealthChoice Members**
- **Family Planning Services**
- **Medicaid Family Planning Program**
- **Long-Acting Reversible Contraceptives (LARCs)**
- **Permanent Sterilizations**
- **Obstetrics and Gynecology**

The Medicaid program covers a wide variety of services including but not limited to:

- General
  - Medically necessary services rendered within the limitations of the CPT, Medicaid, Medicare, and NCCI guidelines, provided by providers who are participating with the Program
- Evaluation and Management (E&M)
  - E&M codes related to providing check-ups and care for individuals with acute or chronic health care conditions
- Anesthesia
  - Services rendered by an anesthesiologist other than for cosmetic surgery
- Surgery

- Medically necessary surgical procedures
- Abortions, sterilizations, and hysterectomies under the limitations detailed in the **Reproductive Health Services Factsheets** and the **Professional Services Provider Manual** available on the Program's website: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

- Drugs and injectables
  - Drugs dispensed by the provider acquired from a wholesaler or specialty pharmacy
  - Injectable drugs administered by the provider
  - Drugs and injectable services within the limitations of COMAR 10.09.03
  - Medicine codes, including administration codes for the Vaccines for Children Program
- Other Services
  - Unlisted services and injectable drugs when accompanied by a medical report, surgery notes, a wholesaler invoice, and/or any other documentation as requested

For specific information, go to the **Professional Services Provider Manual** and **Fee Schedule** at https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

Lab Tests

Providers and clinics should only bill, as a part of the office visit, for labs and cytopathology services that are provided in their facility. If lab and/or cytopathology results are performed by an outside lab, the provider or clinic may not bill Medicaid for the test(s); the lab should bill Medicaid directly.

Fee-for-Service Billing

Providers rendering services under Medicaid's Fee-for-Service program must bill using the CMS-1500 and submit claims within 12 months of the rendered service date. If a claim is received by the Program within the 12-month limit but is rejected due to erroneous or missing data, providers can resubmit the claim within 60 days of rejection OR within 12 months of the date the service was rendered. If the Program rejects a claim because of late receipt, the recipient may not be billed for that claim. Under no circumstances may a Medicaid recipient be billed for a Medicaid covered service. If a provider submits a claim and receives neither payment nor rejection within 90 days, the claim may be resubmitted.

Claims can be submitted in any quantity at any time within the filing statute of limitations, which is 12 months from the date of service. The following guidance is in addition to the initial claim submission:

- 12 months from the date of service of the IMA-81 (Notice of retro eligibility)
- 120 days from the date of the Medicare Explanation of Benefits (EOB)
- 60 days from the date of Third-Party Liability EOB
- 60 days from the date of the Maryland Medicaid Remittance Advice (RA)

The Program **will not** accept computer-generated reports as proof of timely filing. The **only** documentation that will be accepted is a remittance advice, Medicare or third party EOB, IMA-81, and/or a returned date stamped claim from the Program.

Paper claim submissions may take up to 30 days from date of receipt to process. Invoices are processed weekly. Payments are issued weekly and sent to the provider's pay-to address.

Claims should be mailed to the following address:

Claims Processing
Maryland Department of Health
P.O. Box 1935
Baltimore, MD 21203

Electronic claim submissions are processed faster. Claims submitted electronically must be done in the ANSI ASC X12N 837P format, version 5010A. A signed *Submitter Identification Form and Trading Partner Agreement* must be submitted, as well as testing before transmitting such claims.

For questions and information about testing electronic claims submission, please send inquiries to: mdh.ediops@maryland.gov

eClaims allows for direct billing through the e-Medicaid website. This service enables certain provider types that bill using the CMS-1500 to submit their single claims electronically. Claims that require attachments cannot be submitted through this new feature. Claims will be processed the same week they are keyed and payment will follow the next week.

To become an eClaim user, the administrator from the provider's office must register usersby going to the eMedicaid website: https://encrypt.emdhealthchoice.org/emedicaid

For questions regarding this new feature, how to register, or to determine if your provider type can submit eClaims, please email your questions to: mdh.emedicaidmd@maryland.gov

Go to **CMS-1500 Billing Instructions** at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx for additional information regarding billing.

Payment in Full and Maximum Payment

The fee schedule for professional services lists the *Current Procedural Terminology (CPT)* codes and the maximum fee paid for each procedure. A provider using CPT coding selects the procedureor service that most accurately identifies the service performed. Providers are paid either the lesser of their usual and customary charge or the maximum allowable fee. All payments made by the Program to providers shall be considered payment in full for services rendered. Providers are prohibited from collecting additional payment from Program recipients or recipients' families for either covered or denied services; such action constitutes an overpayment and is in violation of both Federal and State regulations. Refer to the **Professional Services Provider Manual and Fee Schedule** at:
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Under no circumstances may a Medicaid provider bill a Medicaid beneficiary or MCO member for a Medicaid covered service. See *Provider Transmittal #81* on the Program's website:
https://health.maryland.gov/mmcp/Documents/PT%2039-15%20FINAL.pdf

Other Third-Party Insurance

In general, the Program is always the payer of last resort. If a recipient is covered by other federal or third-party insurance (i.e., Medicare or commercial insurance), the provider must seek payment from that source first before billing FFS Medicaid. For more information, see the **Professional Services Provider Manual** at: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Medicare Crossover Claims

Some Medicaid beneficiaries also have Medicare. *If a beneficiary has Medicare, they will not be enrolled in an MCO*. The Program is the payer of last resort and follows Medicare guidelines. Physician services that are not medically necessary are not covered under the Program. When a provider bills Medicare B for services rendered to a Medicaid recipient, and the provider accepts assignment on the claim, the payments are made automatically. In the uncommon event that a provider is not paid within four weeks of receipt of the Medicare payment, the provider should submit a hardcopy CMS-1500 form to the Program.

Providers should only submit claims to Medicare for services rendered to patients who are dually eligible for both Medicare and Medicaid. The Program must receive Medicare/Medicaid Crossover claims within 120 days of the Medicare payment date. This is the date on Medicare's "Explanation of Benefits" form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing. In general, the Program will only pay up to the maximum of its allowed amount. For additional information regarding Medicare Crossover claims, go to **CMS-1500 Billing Instructions** 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 pre-authorization 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.

Websites and Resources

CMS-1500 Billing Instructions
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Code of Maryland Regulations (COMAR)
http://www.dsd.state.md.us/COMAR/subtitle_chapters/10_Chapters.aspx

EPSDT/Maryland Healthy Kids Program
https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx

EVS User Guide
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Formulary Information
www.epocrates.com

HealthChoice MCO Program
https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx

HealthChoice Provider Brochure
https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice_Provider_Brochure_August%202023.pdf

ICD 10
https://mmcp.health.maryland.gov/Pages/ICD-10-Conversion.aspx
For general questions about ICD-10, send an email to dhmh.icd10@maryland.gov.

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

Professional Services Provider Manual and Fee Schedule
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Program Transmittals
https://mmcp.health.maryland.gov/MCOupdates/Pages/Home.aspx

SBIRT (Screening, Brief Intervention, and Referral to Treatment)
http://www.marylandsbirt.org/

Reproductive Health Services
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Frequently Requested Phone Numbers

Maryland Medicaid:

- Beneficiary Services/Pharmacy Access: 410-767-5800
- Eligibility Services: 855-642-8572
- HealthChoice Member Helpline: 1-800-284-4510
- HealthChoice Provider Helpline: 1-800-766-8692
- Helpline for Pregnant Members: 1-800-456-8900
- Maryland Pharmacy Program: 1-800-492-5231, option 3
- Mental Health and Substance Use: 1-800-888-1965
- Office of Health Care Quality: 410-402-8000
- Provider Enrollment/Services (covered services, coding, etc.): 410-767-5340
- Provider Relations (billing, claims, other issues):
  410-767-5503 Baltimore Area
  800-445-1159 Outside Baltimore Area

HealthChoice Managed Care Organization (MCOs) Contacts for Providers:

- Aetna Better Health: 866-827-2710
- CareFirst CHPMD: 410-779-9369
- Jai Medical Systems: 888-524-1999
- Kaiser Permanente: 301-816-2424
- Maryland Physicians Care: 800-953-8854
- MedStar Family Choice: 800-905-1722
- Priority Partners: 410-424-4500
- UnitedHealthcare: 800-487-7391
- Wellpoint Maryland: 833-707-0868

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Maryland Medicaid Program
Self-Referral Provisions for HealthChoice Members

A self-referral service is a health care service for which, under specified circumstances, Managed Care Organizations (MCOs) are required to pay an out-of-network provider without a referral or authorization by the primary care provider (PCP). MCOs are required to pay for self-referral services at the Medicaid fee-for-service (FFS) rate. Beneficiaries must use in-network pharmacy and laboratory services when accessing self-referral services.

Beneficiaries who are enrolled in MCOs can self-refer for the following services:

- Family planning services;
- Pregnancy-related services initiated prior to MCO enrollment;
- Prenatal, intrapartum, and postpartum services performed at a free-standing birth center located in Maryland or a contiguous state;
- Newborn's initial medical exam in the hospital;
- Child in State supervised care - initial medical exam by EPSDT certified provider; (Providers must bill with Modifier 32.)
- School-based health center services;
- Emergency services as described in COMAR 10.67.05;
- HIV/AIDS annual diagnostic and evaluation service visit;
- Renal dialysis services provided in a Medicare certified facility; and
- COVID-19 laboratory tests.

Self-Referral for Family Planning

- All Medicaid beneficiaries are covered for family planning services and are free to choose the Medicaid family planning provider of their choice; see Family Planning Services.
- HealthChoice members may go to an out-of-network provider for family planning services without a referral from their primary care provider (PCP), with the exception of permanent sterilization procedures; see Coverage for Permanent Sterilization Procedures.
- The scope of services covered under this self-referral provision is limited to those services required for contraceptive management. Routine and problem-oriented GYN and urology services require prior approval from the MCO.

Billing MCOs

- Submit claims for self-referral services to the beneficiary's MCO within six (6) months of the date of service.
- For self-referred family planning related services, the appropriate ICD-10 diagnosis code (Z30 series) must be indicated on the claim form for the MCO to recognize that the

preventive medicine or E&M code is related to a family planning service.

- Go to the **HealthChoice Provider Brochure** for MCO contact information at: https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice_Provider_Brochure_August%202023.pdf

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

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Maryland Medicaid Program
Family Planning Services

All beneficiaries enrolled in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) have family planning benefits. Family planning covers appropriate office visits and contraceptive methods and services.

- Federal law allows Medicaid beneficiaries to receive family planning services from any qualified provider of their choice. See *Self-Referral Provisions for HealthChoice Members*.

- Some individuals are enrolled in a limited benefit program under Medicaid's Family Planning Program. See *Maryland Medicaid Family Planning Program.*

- Individuals enrolled in MCOs are allowed to self-refer to an out-of-network provider for family planning services without a referral from their PCP, except for permanent sterilization procedures. See S*elf-Referral Provisions for HealthChoice Members and Coverage for Permanent Sterilization Procedures.*

Services

- The scope of services covered under this self-referral provision is limited to those services required for contraceptive management. See *Maryland Medicaid Family Planning Program*.

- Both Medicaid FFS and MCOs cover all FDA-approved contraceptive methods, products and devices, including long-acting reversible contraceptives (LARCs) such as intrauterine devices and contraceptive implants. See L*ong-Acting Reversible Contraceptives (LARCS)***.**

- Contraceptive products that are available at the pharmacy with a prescription include diaphragms, cervical caps, contraceptive rings, and patches.

- Beneficiaries can obtain 12 latex condoms per dispensing without a prescription.

- Emergency Contraception (EC) is a second chance to help prevent an unplanned pregnancy following unprotected sex, contraceptive failure, or sexual assault. EC is available at pharmacies without a prescription regardless of age. Medicaid FFS limits dispensing of EC to 1 pack per 30 days. See *Maryland Medicaid Family Planning Program*.

- For additional MCO information, go to the HealthChoice Provider Brochure: https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice_Provider_Bro chure_August%202023.pdf

- For additional information on Medicaid's FFS Pharmacy Program, go to: https://mmcp.health.maryland.gov/pap/pages/paphome.aspx

Billing

MCOs have their own provider manuals and billing instructions for Medicaid covered services. Contact the MCO for specific coverage questions & billing instructions.

- Codes for Contraceptive Products
  - 57170 - Diaphragm or cervical cap fitting with instructions
  - A4266 - Diaphragm
  - A4261 - Cervical Cap
  - J7303 - Contraceptive vaginal ring
  - J7304 - Contraceptive hormone patch
  - 99070 - Other contraceptive product not listed

- Providers should only use A-codes and J-codes for contraceptives supplied during an office visit.

- Report the NDC/quantity when billing drugs, products, and devices identified by A-codes and J-codes. See *Long-Acting Reversible Contraceptives* for A-codes and J-codes for LARCs.

- Providers must bill no more than their acquisition cost. To facilitate claims processing, FFS Medicaid sets a fee for each code. However, if the provider can document that their acquisition cost was greater than the set fee, attach a copy of the invoice to the claim form for verification, and the acquisition cost will be paid.

For additional information about FFS Medicaid billing, go to the Professional Services Provider Manual and Fee Schedule: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

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

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Maryland Medicaid Family Planning Program

Medicaid Family Planning Program (FPP)

Maryland Medicaid Family Planning Program is a limited benefits program for low-income individuals. Benefits are limited to services related to contraceptive management.

- There are no premiums, copays or deductibles for services.
- There are no pharmacy copays for contraceptives.
- All FDA-approved contraceptive methods, products and devices, including long-acting reversible contraceptives (LARCs) such as IUDs (Intrauterine Devices) are covered. See *Long-Acting Reversible Contraceptives (LARCs)*.
- Permanent sterilizations may be covered. See *Coverage for Permanent Sterilization Procedures* for more details on the requirements for the procedures.

Services Not Covered by the Medicaid Family Planning Program

Examples of services that are specifically excluded are abortion; pregnancy-related care; diagnostic and treatment services for infertility; treatment for gynecological or urologic conditions, cancer treatment; treatment for Hepatitis; and treatment for HIV-AIDS related conditions.

Pregnant members and other individuals who may need the full range of Medicaid services may visit the Maryland Health Connection at www.marylandhealthconnection.gov or their local health department to apply for full coverage.

Services Covered by the Medicaid Family Planning Program

The Medicaid Family Planning Program recognizes office visit codes and preventive visit codes as family planning services when billed with a contraceptive management diagnosis code. Use the appropriate E&M code for new and established patients for family planning visits, based on the complexity of services provided during the visit or the appropriate preventive code. The provider must use the appropriate ICD-10 code from the "Z30" (encounter for contraceptive management) series.

The services below are covered when performed as part of a family planning/contraceptive management visit:

- Physical Exam and advice about birth control methods;
- Screening tests, such as pap smears, labs and/or screening for sexually transmitted infections;
- FDA-approved contraception and contraceptive devices, including emergency contraception;

- Long-Acting Reversible Contraceptives, such as IUDs and contraceptive implants (see *Long-Acting Reversible Contraceptives (LARCs*);
- Screening and treatment for urinary tract infections (UTIs) and vaginitis;
- Screening for hepatitis and HIV;
- Permanent sterilization for individuals ages 21 and older (see Coverage for Permanent Sterilization Procedures); and
- Human Papilloma Virus (HPV) vaccine.

HPV Vaccine Codes

90649-SE (VFC stock)	HPV vaccine, quadrivalent, administration fee
90650-SE (VFC stock)	HPV vaccine, bivalent, administration fee
90649	HPV vaccine, quadrivalent
90650	HPV vaccine, bivalent

For individuals under age 19, providers must obtain vaccines through the Vaccines for Children Program. The SE modifier is used for the administration of VFC vaccines. Administration fees will only be paid when administering VFC vaccines. For beneficiaries ages 19 and over, providers may bill the acquisition cost of the vaccine; the charge for administration is part of the E&M code.

Oral Contraceptives - A maximum twelve-month supply may be dispensed per prescription. Prescribers must complete a FDA *Med-Watch Form* and forward to the Maryland Pharmacy Program for review before the Program will reimburse at the "brand" rate for prescriptions dispensed as "brand medically necessary." For additional information or to obtain the form, go to https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx and click on the link to Maryland Medicaid Pharmacy Program.

Prescriptions - Maryland law allows pharmacists to accept verbal prescriptions, except for Schedule II controlled substances, from prescribing providers via phone for Medicaid recipients. Providers must use tamper-resistant prescription pads for written prescriptions. See *General Provider Transmittal #63* on the Program's website: https://health.maryland.gov/mmcp/docs/PT%205-08.pdf

Emergency Contraception (EC) is a second chance to help prevent an unplanned pregnancy following unprotected sex, contraceptive failure, or sexual assault. EC is available at pharmacies without a prescription regardless of age. Medicaid FFS limits dispensing of EC to 1 pack per 30 days.

Condoms - Beneficiaries can obtain 12 latex condoms per dispensing without a prescription.

Contraceptive products that are available at the pharmacy with a prescription include diaphragms, cervical caps, contraceptive rings, and patches.

Codes for Contraceptive Products

57170	Diaphragm or cervical cap fitting with instructions
A4266	Diaphragm
A4261	Cervical Cap

J7303	Contraceptive vaginal ring
J7304	Contraceptive hormone patch
99070	Other contraceptive products not listed

See *Long-Acting Reversible Contraceptives (LARCs)* **for codes for LARCs.**

Providers should only use A-codes and J-codes for contraceptives supplied during an office visit. Report the NDC/quantity when billing drugs, products, and devices identified by A-codes and J-codes. Providers must bill no more than their acquisition cost. To facilitate claims processing a fee is set for each code. However, if the provider can document that their acquisition cost was greater than the set fee, attach a copy of the invoice to the claim form for verification and the acquisition cost will be paid.

Lab Tests

Providers and clinics may only bill for laboratory procedures performed as a part of the office visit in their facility. If lab and/or cytopathology results are performed by an outside lab, the lab must bill Medicaid directly.

For additional information, go to the Professional Services Provider Manual and Fee Schedule on the Program's website: https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Other drugs covered by the FP Program include drugs to treat sexually transmitted infections, urinary tract infections and vaginitis in the following drug classes:

- Anti-fungals;
- Anti-virals (for HSV);
- Cephalosporins;
- Macrolides;
- Miscellaneous beta-Lactams;
- Penicillins;
- Sulfonamides;
- Tetracyclines;
- Metronidazole; and
- Other miscellaneous antibiotics, not otherwise noted above.

For additional information on Medicaid's FFS Pharmacy Program, go to https://health.maryland.gov/mmcp/pap/pages/paphome.aspx or call at -1-800-492-5231, option #3.

For Medicaid Family Planning Program eligibility questions, go to https://mmcp.health.maryland.gov/familyplanning/pages/Home.aspx or call at 1-855-692-4993.

For additional information related to covered services Medicaid Family Planning Program, call 1-800-456-8900.

For claim inquiries, call Medicaid Provider Relations at 410-767-5503.

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

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Maryland Medicaid Program
Long-Acting Reversible Contraceptives (LARCs)

Intrauterine devices and contraceptive implants, also called long-acting reversible contraceptives (LARC), are the most effective reversible contraceptive methods. LARCs are recommended by the American College of Obstetrics and Gynecology (ACOG).

- LARCs include both intrauterine devices and contraceptive implants.
- Medicaid fee-for-service (FFS) will reimburse for all LARCs, including those placed immediately postpartum.
- Medicaid does not require preauthorization for LARCs.

Intrauterine Device (IUD)

Covered devices (HCPCS Codes):

J7296 Kyleena IUD, levonorgestrel-releasing, 19.5mg/5 yrs
J7297 Liletta IUD, levonorgestrel-releasing, 52 mg/6 yrs
J7298 Mirena IUD, levonorgestrel-releasing, 52 mg/5 yrs
J7300 Paragard IUD Kit, Copper, 10 yrs
J7301 Skyla IUD, levonorgestrel-releasing, 13.5 mg/3 yrs.

Covered procedures (CPT Codes):

58300 Insertion of Intrauterine Device (Failed Attempt - Modifier -53)
58301 Removal of Intrauterine Device

Diagnosis codes (ICD-10):

Z30.014 Encounter for initial prescription of intrauterine contraceptive device
Z30.430 Encounter for insertion of intrauterine contraceptive device
Z30.431 Encounter for routine checking of IUD
Z30.432 Encounter for removal of intrauterine contraceptive device
Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device
Z97.5 Presence of IUD

Contraceptive Implants (etonogestrel single-rod)

Covered device (HCPCS Code):

J7307 Nexplanon (Etonogestrel) implant system, include implant & supplies 68mg/3 yrs

Covered procedures (CPT Codes):

11981 Insertion, non-biodegradable drug delivery implant (Failed Attempt - Modifier -53)
11982 Removal, non-biodegradable drug delivery implant
11983 Removal with insertion, non-biodegradable drug delivery implant

Diagnosis codes (ICD-10):

Z30.017 Encounter for initial prescription of implantable subdermal contraceptive (This code is reported for the initial prescription, counseling, advice, and insertion of the implant)

Z30.46 Encounter for surveillance of implantable subdermal contraceptive (This code is reported for checking, reinsertion, or removal of the implant)

Z97.5 Presence of Implant

Billing and Coding:

LARCs can only be billed with an insertion code on the same date of service. The choice of LARC and the insertion and/or removal of these devices are reported using the appropriate CPT/HCPCS codes.

- Providers should only use the J-code (listed above) for LARCs supplied during an office visit.
- Report the corresponding NDC and quantity when billing drugs, products, and devices identified by the J-codes.
- The CPT codes do not include the cost of supplies. Report any supplies separately using the proper HCPCS code.
- Use the appropriate ICD-10 diagnosis code listed above.

Providers must bill no more than their acquisition cost for the LARC. To facilitate claims processing, a reimbursement rate is set for each code. However, if the provider can document that their acquisition cost was greater, attach a copy of the invoice to the claim form for verification purposes and the acquisition cost will be paid by Medicaid.

For additional information, go to the current Professional Services Provider Manual on the Program's website: https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx. For questions regarding Medicaid's reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-3605.

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Maryland Medicaid Program
Coverage for Permanent Sterilization Procedures

Medicaid Fee-For-Service (FFS) and managed care organizations (MCOs) are required to cover permanent sterilization procedures, including tubal ligation or tubal occlusion, if ALL of the following conditions are met:

1. The individual is at least 21 years of age at the time consent is obtained;
2. The individual is not mentally incompetent;
3. The individual is not institutionalized;
4. The individual has voluntarily given informed consent as described in Part I of the **Sterilization Consent** form (HHS 687, HHS 687-1) available at https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx and
5. At least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. An individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date on the consent form).

The Sterilization Consent form (HHS 687, HHS 687-1) must be completed and kept in the patient's record. Sterilization procedures must be billed on a separate CMS-1500 claim form. If the procedure was performed on the same date of service as another procedure, a modifier-51 is required in Block #24D for the second or subsequent procedure.

Permanent sterilization is not a self-referral service. MCO members must use in-network providers and the provider needs preauthorization from the MCO. Beneficiaries who are not enrolled in an MCO do not need preauthorization for the procedures.

Female Sterilization Codes

58565	Surgical Hysteroscopy w/bilateral fallopian tube cannulation to induce occlusion
58340	HSG - injection uterus/tubes x-ray, 3-month post procedure
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by device (band/clip/falope ring, vaginal or suprapubic approach
58670	Surgical laparoscopy with fulguration of oviducts (with or without transaction)
58671	Surgical laparoscopy with occlusion of oviducts by device (band/clip/falope ring)

Male Sterilization Codes

55250	Vasectomy, excision unilateral-bilateral
55450	Ligation of vas deferens

For questions regarding Medicaid FFS reproductive health services, contact the Division of Community Liaison and Care Coordination at 410-767-3605 or call 1-800-456-8900.

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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 *Self-Referral Provisions for HealthChoice Members*.
- 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 form 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.