Update to “New Benefit Limitations and Authorization Requirements for Obstetric Ultrasounds”

Information posted May 7, 2010

Effective for dates of service on or after July 1, 2010, benefit criteria for obstetric ultrasounds will change. As stated in the article titled “New Benefit Limitations and Authorization Requirements for Obstetric Ultrasounds,” which was posted on this website on April 9, 2010, Medicaid fee-for-service and Primary Care Case Management (PCCM) clients will be limited to three obstetric ultrasounds per pregnancy. If it is medically necessary to perform more than three obstetrical ultrasounds on a client during one pregnancy, the provider must request prior authorization.

The limitation also applies to clients who are pregnant on July 1, 2010, and any obstetric ultrasounds that were performed on these clients before July 1, 2010, will count toward the limit of three ultrasounds. Claims for dates of service prior to July 1, 2010, will not be impacted by this limitation, but they will be counted when processing claims for dates of service on or after July 1, 2010.

This limitation does not apply to obstetric ultrasound procedures that are rendered in the emergency room, outpatient observation, or inpatient hospital setting.

Authorization Requirements for Obstetric Ultrasounds

TMHP will begin accepting prior authorization requests on July 1, 2010.

A new Obstetric Ultrasound Prior Authorization Request Form has been created, and providers must use the form to request prior authorization for this service.

Requests for additional obstetric ultrasounds may be considered if the requests are submitted with documentation of medical necessity on the new Obstetric Ultrasound Prior Authorization Request Form.

Texas Medicaid follows the American Congress of Obstetricians and Gynecologists (ACOG) indications for sonography.

First trimester ultrasounds may be medically necessary for, but are not limited to, the following reasons:

- To confirm the presence of an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose or evaluate multiple gestation
- To confirm cardiac activity
- As an adjunct to chorionic villus sampling or localization and removal of an intrauterine device
To assess certain fetal anomalies, such as anencephaly, in clients at high risk
To evaluate maternal pelvic or adnexal masses or uterine abnormalities
To screen for fetal aneuploidy
To evaluate a suspected hydatidiform mole
Second and third trimester ultrasounds may be medically necessary for, but are not limited to, the following reasons:

- To estimate fetal age
- To evaluate fetal growth
- To evaluate vaginal bleeding
- To evaluate cervical insufficiency
- To evaluate abdominal pelvic pain
- To determine fetal presentation
- As an adjunct to amniocentesis or other procedure
- To evaluate suspected multiple gestation
- To evaluate a significant discrepancy between uterine size and clinical dates
- To evaluate a pelvic mass
- To evaluate a suspected hydatidiform mole
- As an adjunct to cervical cerclage placement
- To evaluate a suspected ectopic pregnancy
- To evaluate suspected fetal death
- To evaluate suspected uterine abnormality
- To evaluate fetal well-being
- To evaluate suspected amniotic fluid abnormalities
- To evaluate suspected placental abruption
- As an adjunct to external cephalic version
- To evaluate premature rupture of membranes or premature labor
- To evaluate abnormal biochemical markers
- As a follow-up evaluation of a fetal anomaly
- As a follow-up evaluation of placental location for suspected placenta previa
- To evaluate clients with a history of previous congenital anomaly
- To evaluate fetal condition in late registrants for prenatal care
- To assess findings that may increase the risk of aneuploidy
- To screen for fetal anomalies
Providers can submit requests for prior authorization or retroactive authorization by telephone, mail, or an approved electronic method.

<table>
<thead>
<tr>
<th><strong>Telephone</strong></th>
<th>Inpatient/Outpatient Prior Authorization line: 1-888-302-6167</th>
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<tbody>
<tr>
<td>Fax</td>
<td>512-302-5039</td>
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<tr>
<td>Mail</td>
<td>Submit requests by mail to:</td>
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<td>Texas Medicaid &amp; Healthcare Partnership</td>
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<td>Inpatient/Outpatient Prior Authorization</td>
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<td>12357-B Riata Trace Parkway Ste.150</td>
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<td></td>
<td>Austin, TX 78727</td>
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<td><strong>TMHP website</strong></td>
<td>Online: <a href="http://www.tmhp.com">www.tmhp.com</a></td>
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When requesting retroactive authorization, providers must submit the request no later than 14 calendar days beginning the day after the study is completed.

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client’s medical record by the provider ordering the test. The form must include all of the following information related to medical necessity of the test:

- The procedure code requested (CPT code) and quantity requested
- The trimester(s) during which the requested ultrasounds will be performed
- The date range during which the procedure(s) will be performed
- Client’s estimated date of confinement (EDC) at the time the request is submitted
- Diagnosis

Additional documentation to support medical necessity may include any of the following:

- Treatment history
- Treatment plan
- Medications
- Previous imaging results

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, and dated by the ordering provider who is requesting prior authorization for obstetric ultrasounds regardless of how the request is made. A physician, nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife (CNM), or physician assistant (PA) may sign the Obstetric Ultrasound Prior Authorization Request Form.

The provider’s signature must be current, unaltered, original, and handwritten. A computerized or stamped signature or date will not be accepted.

Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and provide the group or supervising provider’s provider identifier.
Claims Filing and Reimbursement for Obstetric Ultrasounds

The following obstetric ultrasound procedure codes will require prior authorization when they are billed as an interpretation, technical, or total component and performed in the office or outpatient setting:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>76801</td>
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<tr>
<td>76812</td>
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<tr>
<td>76817</td>
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Obstetric ultrasound procedures that are not listed above are not subject to the three-per-pregnancy limitation.

**Note:** Add-on procedure codes (76802, 76810, 76812, and 76814) do not count toward the three-per-pregnancy limitation when they are billed with the primary procedure code for obstetric ultrasounds.

To be considered for payment, claims that are submitted on the professional claim form for obstetric ultrasounds provided in the emergency department or during a hospital observation stay must be submitted with modifier U6.

Obstetric ultrasounds provided in the emergency department must be submitted with the appropriate corresponding emergency services revenue code to be considered for payment.

Reimbursement for obstetric ultrasounds may be considered on appeal if they are submitted with documentation that indicates any of the following:

- The ultrasound was performed for a different pregnancy.
- The provider was unable to obtain the previous ultrasound records from a different provider.
- The provider was new to treating the client and was not aware the client had already had three obstetric ultrasounds.

Only one appeal will be considered per client for the same provider. Providers must obtain prior authorization for any additional obstetric ultrasounds performed after the appealed service.

The initial three claims paid for obstetric ultrasounds do not require prior authorization. Any obstetric ultrasound claims that are submitted with or without prior authorization for the initial three will count toward the three-per-pregnancy limit.

Reminder: If an attending physician submits a claim for radiology interpretations that are performed in any place of service or ultrasound interpretations that are performed in the inpatient hospital setting, the claim will be denied if the attending physician’s specialty is any of the following:

- Family Practice
- Gynecology (Doctor of Osteopathy [D.O.])
- OB/GYN (Doctor of Osteopathy [D.O.])