

519.19 WOMEN'S HEALTH SERVICES

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BACKGROUND

A wide range of women's health services are covered for West Virginia Medicaid members when provided by enrolled Physicians, Physician assistants (PAs), or Advanced Practice Registered Nurses (APRNs) acting within the scope of his/her license. Services include, but are not limited to, preventive, pregnancy related, and disease related services. This section lays out the conditions under which these women's health services are provided under Medicaid.

POLICY

519.19.1 Gynecological Services

Payment will be made for one annual gynecological examination to include one routine pap smear, breast examination and physician interpretation, per calendar year for all females. Practitioners should not bill for a gynecological exam in addition to an evaluation and management (E&M) service on the same day.

519.19.2 Maternity Services

Physicians, PAs, or APRNs that meet the [West Virginia State Code Chapter 30, Professions and Occupations](#) requirements to provide maternity services may provide all or a portion of antepartum care, delivery, and/or postpartum care.

519.19.2.1 Prenatal Care

Antepartum care includes the initial and subsequent history, physical examinations, monitoring of weight, blood pressure, fetal growth and development, heart tones, and routine chemical urinalysis. During a normal pregnancy, prenatal visits are monthly up to 28 weeks gestation, biweekly to 36 weeks gestation, and weekly until delivery.

West Virginia Medicaid accepts 99213-TH for each individual pre-natal visit. Adjustments to the frequency of prenatal visits may be made based on documentation of maternal and fetal risk factors. Prenatal visits are limited to 20 visits in six months. Services by a physician specializing in maternal-fetal medicine may be billed using the appropriate E&M code.

West Virginia Medicaid covers obstetrical ultrasounds and fetal non-stress tests when medically necessary and in accordance with the criteria for high risk pregnancies established by the American Congress of Obstetrics and Gynecology (ACOG). Obstetrical ultrasounds on a routine basis or for determining the gender of the fetus are not covered. Documentation of medical necessity must be retained in the member's medical record. Refer to <http://www.acog.org/>.

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519.19.2.2 Delivery

Delivery services include delivery in the home or admission to a hospital or birthing center; an admission history and physical examination; management of labor; vaginal delivery with or without episiotomy and with or without forceps; and postpartum care. Cesarean delivery must be provided in the hospital by an enrolled OB/GYN physician. When a newborn is delivered by someone other than the Physician or APRN (e.g., nurse or paramedic) and the Physician or APRN delivers the placenta, the Physician or APRN is eligible for reimbursement of the delivery.

An independent enrolled Certified Nurse Midwife (CNM) may bill for vaginal deliveries in a hospital when the hospital has approved these services through the credentialing and delineation of privileges process and the CNM has a collaborative agreement with an enrolled Obstetrician/Gynecologist. The CNM's delineation of privileges and collaborative agreement must be on file with BMS Provider Enrollment Unit. In addition, covered services within the CNM's scope of practice may be provided in an office, outpatient, inpatient, free-standing birthing centers, and the member's home setting. CNMs are eligible for reimbursement for newborn assessments, hospital observation care related to pregnancy and postpartum visits. CNMs are approved for billing the appropriate CPT codes in the Emergency Department.

Maternity anesthesia is limited to a maximum of eight time units (two hours) regardless of the different types of anesthesia services provided during labor and delivery. See [Chapter 519 Practitioner Services, Policy 519.2 Anesthesia Services](#) for additional information.

"Attendance at delivery," as defined by CPT coding, is covered when requested by the delivery practitioner and initial stabilization of newborn is required. The delivering practitioner must document the request in the member's medical record and explain the reasons for the request. The statement "high risk delivery" is **not** sufficient to document the necessity of "attendance at delivery." **Note:** Newborn delivery resuscitation with provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output is included in "attendance at delivery" and must not be separately billed.

Care of newborns requiring life support (specifically, positive pressure ventilation and/or chest compressions in the presence of inadequate ventilation and/or cardiac output) following delivery **without** "attendance at delivery," may be billed separately by the practitioner, when the services are provided in the initial hospital, birthing center, home, or neonatal critical care unit.

519.19.2.3 Postpartum Care

Postpartum care, up to 60 days post-vaginal and post-Cesarean deliveries, is covered when provided by the delivering practitioner or a different practitioner.



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519.19.4 PREGNANCY TERMINATION

Effective November 6, 2018 at 7:30p.m., the West Virginia Bureau for Medical Services will only reimburse providers for pregnancy terminations in the following three circumstances, consistent with W.Va. Code §9-2-11:

- (1) If, on the basis of the physician's best clinical judgment, there is a medical emergency that so complicates a pregnancy as to necessitate an immediate abortion to avert the death of the mother or for which a delay will create grave peril of irreversible loss of major bodily function or an equivalent injury to the mother: Provided, That an independent physician concurs with the physician's clinical judgment; or
- (2) If, on the basis of the physician's best clinical judgment, there is clear clinical medical evidence that the fetus has severe congenital defects or terminal disease or is not expected to be delivered; or
- (3) If the individual is a victim of incest or the individual is a victim of rape when the rape is reported to a law-enforcement agency.

When the provisions in [W.Va. Code §9-2-11](#) have been met, certification by the physician is required for payment. All related services, including informed consent and the Physician Certification for Pregnancy Termination Form, must be completed before termination services are provided and must be maintained in the member's medical record and available upon request by BMS or its designee. This form can be accessed through the BMS Fiscal Agent's website at www.wvmmis.com.

The State of West Virginia prohibits pregnancy terminations when the fetus reaches a gestational age of 20 weeks after fertilization in accordance with WV State Code. West Virginia Medicaid will apply this same limitation to requests for pregnancy terminations performed out-of-state.

The drug Mifeprex (mifepristone, RU-486) is utilized and subject to the physician's compliance with all of the federal and manufacturer's requirements. The Physician Certification for Pregnancy Termination Form must be completed and maintained on file at the practice location and available for review upon request by BMS or its designee. A copy of the order form/prescriber's agreement that certifies compliance with all manufacturers prescribing requirements and the guidelines for use of the drug must be signed by the Medicaid member prior to treatment, and a copy must be maintained in the member's medical record.

Medicaid coverage of pregnancy termination utilizing Mifeprex (mifepristone, RU-486) includes:

- A visit for administration of Mifeprex (mifepristone, RU-486) taken by mouth.
- A second visit 24 to 48 hours later for administration of misoprostol taken buccally (in the cheek pouch), at a location appropriate for the member.
- A follow-up visit within two weeks to ensure and document that the pregnancy termination is complete.

Under Federal law, Mifeprex (mifepristone, RU-486) must be provided by or under the supervision of a physician who meets the following qualifications:



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- Ability to assess the duration of pregnancy accurately
- Ability to diagnose ectopic pregnancies

Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and is able to assure member access to medical

519.19.5 HYSTERECTOMY

This section lays out the conditions under which hysterectomies are covered.

There are special federal requirements related to these services. Hysterectomies are covered in accordance with the Federal Social Security Act [42 CFR 441, Subpart F – Sterilizations](#), §441.255 and §441.256 requirements, which require informed consent and medical necessity.

West Virginia Medicaid covers hysterectomies performed for medical reasons regardless of the member's age. Federal regulations ensure that women can make informed and voluntary choices and emphasize that a hysterectomy is not an appropriate or acceptable means of sterilization. A medically necessary hysterectomy is covered when:

- The physician who performs the hysterectomy has informed the member and her representative, if any, orally and in writing, that the hysterectomy will render the member permanently incapable of reproduction; and,
- The physician and member or her representative has signed and dated the hysterectomy acknowledgment form.

The [Hysterectomy Acknowledgment Form](#) must be completed in its entirety and submitted with the claim. If any portion of the consent form is incomplete, inaccurate, or illegible, the claim will be denied. The BMS Fiscal Agent will not return the consent form for correction, changes, or additions.

The BMS Fiscal Agent must accept the form regardless of whether it was signed by the member before or after the procedure. When the member signs the acknowledgement form after the surgery, the member's records must contain language which clearly states she was informed before surgery of the consequences of the surgery (i.e., it would render her sterile) and that the member was competent to sign.

The member must sign a [Hysterectomy Acknowledgment Form](#) except under the following conditions:

- The member was already sterile when the hysterectomy was to be performed;
- The member requires a hysterectomy because of a life-threatening emergency (e.g., the member is in imminent danger of loss of life) for which the physician determines prior acknowledgment is not possible, or
- The member has a hysterectomy during the time of retro-eligibility.



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The physician who performs a hysterectomy under the exceptions noted above must certify in writing on the [Physician Certification for Hysterectomy Form](#) that the exception conditions are met. The Physician Certification Form must be submitted with the claim. If the member was already sterile at the time of the hysterectomy the physician must indicate the cause of the sterility, e.g. member is postmenopausal or has previously undergone a sterilization procedure. If the hysterectomy was performed during a life-threatening emergency in which the physician determined prior acknowledgment was not possible, the nature of the emergency must be documented. An example of a life-threatening emergency that does not require a prior acknowledgment statement is a hysterectomy necessitated by a perforated uterus or uteroplacental apoplexy. If the hysterectomy was performed during a period of retroactive Medicaid eligibility, medical records, and documentation of proof must be attached that proves the member was told prior to the hysterectomy it would make her permanently incapable of bearing children.

West Virginia Medicaid accepts photocopies or faxes of the Hysterectomy Acknowledgement Form or Physician Certification Form as acceptable documentation. A photocopy or fax must be an exact copy of the actual signed form and must contain all the required signatures. The provider must retain the original copy of the Hysterectomy Acknowledgement Form or Physician Certification for Hysterectomy Form. These forms can be accessed through the BMS' Fiscal Agent's webpage located at www.wvmmis.com.

If the appropriate form or required medical documentation are not on file or submitted with the claim, no reimbursement will be provided to the physician.

519.19.6 NON-COVERED SERVICES

West Virginia Medicaid does not cover a hysterectomy that was performed solely to render a member incapable of reproduction; even when there are other indicators for a hysterectomy. Non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

REFERENCES

West Virginia State Plan Sections [3.1\(a\)\(1\)](#), [3.1-A\(20\)](#), reference eligibility for pregnancy-related services. West Virginia State Plan [Section 3.4](#) references special federal requirements for hysterectomies.



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CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Women's Health Services	January 15, 2016
519.19.4	Pregnancy Terminations	December 1, 2016
519.19.4	Pregnancy Termination updated language to reflect W.Va. Code §9-2-11	November 6, 2018 at 7:30pm
519.19.4	Updated language regarding Mifeprex (mifepristone, RU- 486) to <u>match FDA-approved regimen</u>	November 14, 2018
519.19.3	Emergency Contraception was removed	August 30, 2019

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