Nurse Midwife

Nurse midwives (NMs) are advanced practice registered nurses (RNs) who have advanced education and midwifery training and certification. Nurse midwives provide care during pregnancy, childbirth and postpartum period (office, home, hospital, or freestanding birthing center settings), sexual and reproductive health; gynecologic health, family planning including preconception care. Nurse midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life.

Covered Services

Medicaid provides reimbursement to nurse midwives for services as described above. Maternity care services are only available with a Nurse Midwife for low-risk pregnancies. Some lab services are also a covered Medicaid benefit.

Smoking/Tobacco Cessation Counseling

Current Procedural Terminology (CPT) codes 99406 (Smoking and tobacco use cessation counseling visit, intermediate, 3-10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes) may be used to bill smoking cessation counseling for all Nevada Medicaid recipients. Procedure codes 99406 and 99407 are no longer restricted to counseling for pregnant women only. The limitation for both codes is a maximum of 24 encounters per year. These limitations can be exceeded if determined medically necessary by Nevada Medicaid.

Prior Authorization Requirements

Nurse Midwife services do not require prior authorization.

Billing Instructions

Submit all claims electronically using Direct Data Entry (DDE) through the Electronic Verification System (EVS) secure Provider Web Portal or use an approved Trading Partner. Refer to the EVS User Manual and the electronic billing Companion Guides for billing instructions.

Third Party Liability

Providers must bill all third party insurance carriers before billing Medicaid. Medicaid reimburses for Medicare coinsurance and deductible up to the Medicaid allowable amount.

Anesthesia Services

For instructions on billing anesthesia services, go to https://www.medicaid.nv.gov and select “Billing Information” from the “Providers” menu, then click “Anesthesia” under the “Billing Instructions by Service Type” heading.

Evaluation and Management Procedure Codes

Covered Evaluation and Management procedure codes include, but are not limited to, the following:

Procedure Code	Procedure Code Description
99202 - 99205	New patient, office or other outpatient visit
99211 - 99215	Established patient, office or other outpatient visit
99217	Hospital observation care on day of discharge
99218 - 99220	Initial hospital observation care per day
99221 - 99223	Initial hospital inpatient care per day
99231 - 99233	Follow-up hospital inpatient care per day

Nurse Midwife

Procedure Code	Procedure Code Description
99234 - 99236	Hospital observation or inpatient care admitted and discharged on same day
99238 - 99239	Hospital discharge day management
99241 - 99244	Office consultation
99281 - 99285	Emergency department visit
99341 - 99345	New patient, home visit
99347 - 99350	Established patient, home visit
99354, 99355	Prolonged services in outpatient setting
99356, 99357	Prolonged service in the inpatient or observation setting
99381, 99384 - 99387	Initial new patient, preventive medicine evaluation
99391, 99394 - 99397	Established patient, preventive medicine evaluation
99401	Preventive medicine counseling [approximately 15 minutes]
99415 - 99417	Prolonged office or other outpatient service by clinical staff
99460 - 99465	Newborn care services

Fetal Ultrasound Procedure Codes

The following table offers a guideline for fetal ultrasound CPT codes:

Code	Description	Gestation	Approved Indications
76801, 76802	Fetal/maternal eval	<14 weeks	• Once per pregnancy
76805, 76810	Fetal and maternal eval after first trimester	>14 weeks	• Payable one time only, per practice • To screen for congenital malformation • To exclude multiple pregnancy • To verify dates and growth • To identify placental position • Non-payable if 76811 has been utilized, unless a significant 2nd diagnosis
76811, 76812	Fetal and maternal eval w/detailed fetal anatomic exam	14-26 weeks	• Payable one time only, per practice • To screen for congenital malformation • To exclude multiple pregnancy • To verify dates and growth • To identify placental position
76813, 76814	Fetal nuchal translucency measurement	< 14 weeks	One time only with calculation of risk based on: • Maternal age • Human chorionic gonadotropin • Pregnancy-associated plasma protein A
76815	Limited (fetal heartbeat, placental location, fetal		• To answer specific questions required • Investigation • In an emergency to verify cardiac activity

Code	Description	Gestation	Approved Indications
	position and/or qualitative amniotic fluid volume, one or more fetuses)		• To verify fetal presentation during labor • Generally not appropriate if a prior complete exam is not on record
76816	Follow up to eval fetal size, amniotic fluid volume or re-eval of organ system	26+ weeks	• Follow up fetal size, assess for growth • Re-evaluation of organ system • Verify placental position ○ Records must clearly state what the previous growth was. F/U ultrasound to evaluate growth is not payable if the growth was noted to be within normal limits on the initial ultrasound, unless there is a medical reason to suspect aberrant growth (e.g. chronic hypertension, diabetes, maternal obesity, multifetal gestation, prior macrosomic fetus
76817	Transvaginal	Dependent on diagnosis	• To confirm pregnancy • To r/o ectopic or molar pregnancies • To confirm cardiac pulsation • To measure crown rump length • To identify number of gestational sacs • To evaluate vaginal bleeding • To monitor cervix in cases of incompetent cervix, or maternal history of premature delivery < 35 weeks
76818, 76819	Fetal biophysical profile with non-stress testing	Third trimester	• High risk for significant fetal academia • Suspected fetal compromise • Increased risk of stillbirth • Significant deterioration in clinical status • Severe oligohydramnios
76820	Doppler Velocimetry fetal umbilical artery		• Allowed only in cases with documented as asymmetrical IUGR • Oligohydramnios • Discordant twins
76821	Doppler velocimetry fetal; middle cerebral artery		• To determine fetus at risk for anemia (e.g. red blood cell iso-immunization, parvovirus infection) • Poor fetal growth affecting management of mother
76825	Echocardiography Fetal		Once per pregnancy for: • A potential defect noted in the original ultrasound (76805 or 76811) • A high risk of a potential heart defect (congenital history parent or sibling, abnormal screen) • Extra cardiac abnormality • Increased risk of chromosomal abnormality • Fetal cardiac arrhythmia • Non-immune hydrops • Question of cardiac anomaly on prior sonogram • IUGR

Code	Description	Gestation	Approved Indications
			• Teratogenic exposure (alcohol, amphetamines, anticonvulsants lithium) • Maternal disorders (diabetes, collagen vascular disease, PKU, rubella, inherited familial syndromes)
76826	Follow up study; fetal echocardiography		Once per pregnancy if: • 76825 is abnormal earlier in the pregnancy and the F/U up scan will alter or affect the treatment plan
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display complete		Once per pregnancy: • Where a potential defect was noted in the original ultrasound (76805 or 76811) • When there is high risk of a potential heart defect (congenital history, abnormal screen) • **Requires Prior Authorization**
76828	Follow-up or repeat study of Doppler echocardiography, fetal		Once per pregnancy if: • 76827 was abnormal earlier in the pregnancy and the follow up study will alter the treatment plan • **Requires Prior Authorization**
76830, 76831	Transvaginal Saline infusion sonohysterography, including color flow Doppler		• Once per pregnancy
76856, 76857	Ultrasound, pelvic real time with image documentation		• Once per pregnancy
93325	Color flow mapping		• If echocardiography is questionable or ambiguous • If diagnosis depends on hemodynamic evaluation of intracardiac circulation which can only be obtained by Doppler • When the diagnosis rests on measuring the fetal cardiac output • To more precisely define a complicated diagnosis • Add-on code and must be used in conjunction with 76825, 76826, 76827 or 76828

Antepartum, Labor/Delivery, and Postpartum Management Procedure Codes

Covered antepartum, labor/delivery and postpartum management procedure codes include the following:

Procedure Code	Procedure Code Description
59020, 59025	Fetal tests
59050, 59051	Fetal monitoring during labor (Home births only)
59200	Insert cervical dilator

59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery including postpartum care
59412	External cephalic version
59414	Delivery of placenta
59425 - 59426	Antepartum care only
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care (Allowed when assisting physician on cesarean delivery. Bill with modifier 80 or 81)
59514	Cesarean only delivery (Allowed when assisting physician on cesarean delivery. Bill with modifier 80 or 81)
59515	Postpartum care only
59610 - 59614	Vaginal delivery after previous cesarean delivery
59618 - 59622	Cesarean delivery following attempted vaginal delivery after previous cesarean delivery (Allowed when assisting physician on cesarean delivery. Bill with modifier 80 or 81)

Medications dispensed during labor/delivery to birthing person or newborn can be billed with the appropriate Healthcare Common Procedure Coding System (HCPCS) code and National Drug Code for home births only.

Lactation services conducted by a non-qualified health care professional, such as an International Board Certified Lactation Consultant (IBCLC), can be billed under a PT 74 Nurse Midwife and may include procedure codes 96156 through 96171. Procedure code S9443 is not a covered code. For further information on how to bill for lactation services, please see the American Academy of Pediatrics, Supporting Breastfeeding and Lactation: The Primary Care Pediatrician's Guide to Coding, 2022.

Family Planning Procedure Codes

Covered family planning procedure codes include, but are not limited to, the following:

Procedure Code	Procedure Code Description
11981 - 11983	Insertion/removal of non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions
58300, 58301	Insertion/removal of IUD

All dispensed birth control by the provider is billed using the appropriate HCPCS code and National Drug Code.

A pelvic exam or pap smear is not required for self-administered birth control.

Health Behavior Assessments and Screenings

Covered procedure codes involving assessment, screening, intervention of behavior, depression, alcohol and/or drug use, include, but are not limited to, the following:

Procedure Code	Procedure Code Description
96127	Assessment of emotional or behavioral problems
96156, 96158, 96159	Health behavior assessment/re-assessment/intervention
96160, 96161	Administration and interpretation of patient-focused/caregiver-focused health risk assessment
96164 - 96171	Health behavior intervention
99406, 99407	Smoking and tobacco use counseling
99408 - 99409	Alcohol and/or substance abuse screening and intervention
G0442, G0443	Alcohol misuse screening
G0444	Depression screening
G0445	Behavioral counseling to prevent sexually transmitted infections
H0049	Alcohol and/or drug screening

Laboratory Procedure Codes

Covered laboratory procedure codes include, but are not limited to, the following:

Procedure Code	Procedure Code Description
80305 - 80307	Presumptive drug class screening
81000 - 81003	Urinalysis
81025	Urine pregnancy test
82948, 82950	Blood glucose test
83036	Hemoglobin A1C Level
84703	Gonadotropin, chorionic (hCG), qualitative
85013 - 85018	Red blood cell/blood count tests
86318	Immunoassay infectious agent
87081	Screening for pathogenic organisms
87210	Smear wet mount saline/ink
87480, 87510, 87660	Detection test for candida, gardnerella vaginalis, trichomonas vaginalis, direct probe
87661	Infectious agent detection, trichomonas vaginalis
87797	Detection test by nucleic acid for organism, direct probe
87804	Infectious agent detection, influenza
87806	Infectious agent detection, HIV-1 antigen with HIV-1 and HIV-2 antibodies
87880	Infectious agent detection, Streptococcus

Covered COVID-19 Point of Care "Rapid Tests" can be found in the COVID-19 General Billing Guide located at https://www.medicaid.nv.gov/providers/BillingInfo.aspx. Enter modifier QW when billing for laboratory Certified Laboratory Improvement Amendments (CLIA) waived tests that are granted waived status under CLIA from the Centers for Medicare & Medicaid Services (CMS).

Behavioral Health Integration

Behavioral Health Integration Services to Nevada Medicaid recipients are provided utilizing the Collaborative Care Model (CoCM). The CoCM is when a primary care provider identifies a recipient's behavioral health needs and integrates care management support for the recipient and regular psychiatric inter-specialty consultation with the primary care team. An episode of care can range from three to 12 months in duration. The episode ends when targeted treatment goals are met, there is a referral for direct psychiatric care, or there is a break in episode (no behavioral health integration services for six consecutive months).

The complete policy requirements for these services are located in MSM chapter 600, Attachment A, Policy #6-14.

Covered procedure codes include the following:

Procedure Code	Procedure Code Description
99492	Initial Psychiatric Collaborative Care Management, first 70 minutes in the first calendar month
99493	Subsequent Psychiatric Collaborative Care Management, first 60 minutes in a subsequent month
99494 (Add-on Code)	Initial or Subsequent Psychiatric Collaborative Care Management, each additional 30 minutes in a calendar month
G2214	Initial or Subsequent Psychiatric Collaborative Care Management, first 30 minutes in a month

Use G2214 when the services provided do not meet the time requirement for 99492 or 99493.

Additional Procedure Codes

Additional covered procedure codes include, but are not limited to, the following:

Procedure Code	Procedure Code Description
10060	Simple or single drainage of skin abscess
11200, 11201	Removal of skin tags
36415, 36416	Insertion of needle/puncture of skin for collection of blood sample
40806	Incision of tissue joining lip and gum
41010	Incision of tissue connecting tongue and floor of mouth
56405, 56420	Incision and drainage of female genital abscess, gland abscess
56605	Biopsy of external female genitals
58100	Biopsy of lining of uterus
90460 - 90474	Immunization administration
92558	Newborn hearing screen (Allowed only for home births with proper equipment)
92950	Cardiopulmonary Resuscitation (CPR)
94640	Inhalation treatment for airway obstruction of sputum production
94760	Measurement of oxygen saturation in blood using ear or finger device
96360, 96361	Hydration

96365, 96366	Intravenous infusions
96372, 96374	Therapeutic, prophylactic or diagnostic injection
97022	Application of whirlpool therapy
98960 - 98962	Education and training for patient self-management, individual, group
99050	Medical services after hours
99070	Provision of supply and material by physician
A4550	Surgical trays
G0101	Cervical or vaginal cancer screening, pelvic and clinical breast examination
Q0091	Screening pap smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory

Vaccines are billed with vaccine CPT code, vaccine National Drug Code, and vaccine administration code. Instructions on how to bill COVID-19 vaccines can be found in the COVID-19 General Billing Guide located at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

Immune Globulins (IG) are billed with IG CPT code, National Drug Code, and IG administration code 96365, 96366 or 96372.

Telehealth Services

Providers must follow guidelines set forth in Medicaid Services Manual (MSM) Chapter 3400, Telehealth Services. Telehealth may be used by a licensed professional operating within the scope of their practice under state law.

Use the appropriate procedure code for the service provided in addition to the appropriate Place of Service (POS) code and modifier.

Please review the Telehealth Billing Instructions for additional information, including a list of POS codes and modifiers.

Note:

The procedure code lists in this billing guide are not definitive of all covered services allowed by a PT 74 Nurse Midwife. To verify whether a code is covered and the fee that will be paid, please consult the “Search Fee Schedule” on the Provider Web Portal at https://www.medicaid.nv.gov. A full list of codes and rates can also be found at https://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.