

Chapter 43 Prenatal Services - REPEALED

Rule No. 560-X-43-.01 General

(1) Prenatal care services are those services that are necessary for the health of the pregnant woman and her fetus during the antepartum period.

(2) Prenatal services, including initial and periodic evaluation of patient's status, are covered for the entire gestational period.

(3) Prenatal services are available through providers who are under contract with the Alabama Medicaid Agency, including Primary Care Clinics, Rural Health Clinics, FQHC's, the Department of Public Health Clinics, physicians, and nurse midwives.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.165, 440.50, 440.90, 440.130, and 440.210. Rule effective August 10, 1988. Effective date of this amendment June 14, 1994. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-43-.02 Eligibility

(1) Persons eligible for prenatal services are those Medicaid eligible persons deemed pregnant by laboratory tests or physical examination, without regard to marital status.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 435.1 and 435.110. Rule effective August 10, 1988. Effective date of this amendment June 14, 1994. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-43-.03 Consent for Services

(1) The Code of Alabama, 1975, Title 22, Chapter 8, governs the rights of minors to consent to any legally authorized medical service.

(2) Illiterate recipients may give consent for prenatal services by making their mark (i.e., "X") on the appropriate line. This type of consent for services must be witnessed by an adult with his/her signature after the phrase "witnessed by."

(3) A patient's acceptance of any prenatal service or information is strictly voluntary on the part of the patient. The provider must not administer any form of duress or coercion to gain such acceptance.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 431.51. Rule effective August 10, 1988. This amendment effective June 14, 1994. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-43-.04 Covered Services

(1) Antepartum Care:

(a) Antepartum care includes all usual prenatal services such as the initial office visit, at which time pregnancy is diagnosed, and subsequent visits that include histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling and risk assessments. Antepartum care also includes routine lab work (i.e., hematocrit and chemical urinalysis); therefore, claims for routine lab work should not be filed.

(b) The frequency of return visits should be determined by the risk assessment. For an uncomplicated pregnancy the subsequent visits are to follow the recommendations listed in the Standards for Obstetrical/Gynecological Services, published by the American College of Obstetricians and Gynecologists.

(c) If appropriate, patients with high risk pregnancies shall be referred to a qualified physician for evaluation and management of the pregnancy.

(d) Laboratory services as appropriate for quality prenatal care as recommended by the American College of Obstetricians and Gynecologists are covered.

(2) Post partum care:

(a) Post partum care includes visits following delivery for routine post partum care within sixty (60) days past delivery. Additional claims for routine visits during this time are not covered.

1. One (1) post partum office visit [six(6)-week checkup] is authorized for completion of the maternity cycle.

2. Two (2) additional post partum visits are authorized for post partum patients with obstetrical complications; e.g., infection of surgical wound, during the 60-day post partum period. Medical records should clearly document the complication requiring the additional visit.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.30, 440.50, 440.90 and 441.16. Rule effective August 10, 1988. Rule amended November 13, 1991. Effective date of this amendment June 14, 1994. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-43-.05 Billing of Medicaid Recipients

(1) A provider may bill Medicaid recipients for any noncovered procedure or service provided to a recipient who has exhausted her annual benefits.

(2) Billing of recipients for services not paid by Medicaid due to provider correctable errors on claim submissions or untimely filing is not permissible.

(3) Medicaid recipients are exempt from co-pay requirements for prenatal services.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.15, Att. 4.18A. Rule effective June 14, 1994. **Repealed:** Filed May 22, 2018.

Rule No. 560-X-43-06 Prenatal Program Manual

(1) A Prenatal Program Manual detailing the elements of the antepartum visits, instructions for completion of forms, and procedures to follow in the administration of services is provided to the prenatal providers.

(2) Prenatal providers will be required to follow procedures outlined in the manual. Failure to do so may result in the recoupment of paid claims from provider.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., 401, et seq. Rule effective June 14, 1994. **Repealed:** Filed May 22, 2018.