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| 247.000 Obstetrical Services | 7-1-25 |

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible beneficiaries. These services include prenatal services, delivery, and postpartum care. Please refer to Sections 292.670 through 292.675 of this manual for special billing instructions for pregnancy-related services.

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| 292.670 Obstetrical Care | 7-1-25 |

Medicaid reimburses obstetrical care on a fee-for-service basis.

Providers should bill for prenatal, delivery, and postpartum services separately. Effective   
July 1, 2025, and thereafter, global obstetrical billing is not payable.

Providers may bill Medicaid for the delivery and postpartum care with the applicable procedure codes from the following table:

[View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.](https://humanservices.arkansas.gov/wp-content/uploads/PHYSICN_ProcCodes.xlsx)

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. [View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.](https://humanservices.arkansas.gov/wp-content/uploads/AFMC.doc)Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

Providers must ensure that the services are billed within the 365-day filing deadline.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes. If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are dependent on the referring physician for pregnancy related diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code consists of four components: Complete Blood Count, VDRL, Rubella, and blood typing and RH. If the ASO titer is performed, the test must be billed separately using the individual code.

If a blood specimen is sent to an outside laboratory, only one collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

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| 292.674 External Fetal Monitoring | 7-1-25 |

Procedure code must be used exclusively for external fetal monitoring when performed in a physician’s office or clinic with National Place of Service code **“11”.** Physicians may bill for one unit per day of external fetal monitoring. Physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits.

[View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.](https://humanservices.arkansas.gov/wp-content/uploads/PHYSICN_ProcCodes.xlsx)

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| 292.675 Risk Management for Pregnancy | 7-1-25 |

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in Section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

[View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.](https://humanservices.arkansas.gov/wp-content/uploads/PHYSICN_ProcCodes.xlsx)

For early discharge home visits, use one of the applicable CPT procedure codes.