The following content is in response to questions submitted to the Family & Social Services Administration (FSSA) for the November 19, 2010, Medicaid Coalition meeting at the Indiana State Medical Association. This document has been provided by the FSSA to supplement the *Medicare/Medicaid Coalition Report*.

---

1. **Family Planning ICD-9 Code Update for Package B - OMPP communicated to Representative William Crawford's office that the family planning diagnosis codes (V25 series) have been added to the list of covered Package B diagnosis codes, which will allow providers to utilize a code from the family planning series as a primary diagnosis code for Package B members, instead of being required to use a pregnancy diagnosis code for patients who are no longer pregnant.**

   a. Please confirm in writing that the appropriate tables in the HP processing system have been updated to allow these codes as primary diagnosis codes.

      – **IHCP Response:** The following diagnosis codes were added to diagnosis groups 22-23 Family Planning on 8/4/10. V25-V25.9 All inclusive.

   b. Please confirm in writing that each of the MCEs, and any MCE subcontractors, have been instructed to add these codes to the list of covered Package B diagnosis codes.

      - **OMPP Response:** All MCEs have been instructed to add these codes and have confirmed that their systems are compliant.

2. **General ICD-9 Code Update for Package B Coverage- OMPP communicated to Representative William Crawford's office that the list of covered diagnoses for Package B has been updated to include all pregnancy-related diagnosis codes added to the ICD-9 manual from 2006-2009, which were not previously incorporated into the list.**

   a. Please confirm in writing that the appropriate tables in the HP processing system have been updated to include all pregnancy-related diagnosis codes for the aforementioned years.

      – **IHCP Response:** The following codes were added to diagnosis Group 31 Sobra Pregnant Women on 8/4/10. V22-V24.2, 630-648.94, 652.00-676.94, 649 series, 650 and 651 series.

   b. Please confirm in writing that the MCEs, and any MCE subcontractors, have been provided with a current comprehensive listing of all pregnancy-related diagnosis codes and been instructed to allow these codes for Package B pregnancy-related claims.

      - **OMPP Response:** All MCEs have been instructed to add these codes and have confirmed that their systems are compliant.

   c. In the past, the list of Package B diagnosis codes was included in the IHCP Provider Manual. We have been unable to locate this list in the current manual or on the IHCP website. Please provide a comprehensive listing of the Package B diagnosis codes that providers may use when billing pregnancy-related services for Package B members.

      – **IHCP Response:** in the past the IHCP Provider Manual has not supplied an all inclusive list of pregnancy related diagnosis codes; however, there is an abbreviated listing of family planning primary diagnosis codes in the current provider manual located in Chapter 8 Section 4 and of the Package B ICD-9 diagnosis codes in Chapter 8 Section 2 on the IHCP website. In addition, the IHCP will work to update the provider manual with a comprehensive listing. A work plan and timeline has not yet been put together to accomplish this listing.

3. **Package B Members with Eligibility Segments Extending Well Beyond Delivery or Pregnancy Termination**

a. To whom and how does a provider report a Package B member with coverage extending well beyond the established postpartum period? Some of these members may be entitled to Package A and are not being switched and are therefore, not able to receive coverage for all services to which they may be entitled or the member may no longer qualify for any level of Medicaid but continues to show active eligibility.

   – **IHCP Response:** Federal eligibility rules do not permit automatic end dating of coverage without a review of all other eligibility categories being conducted. Therefore the State must allow a member to remain in their current category until the eligibility process has been completed.

     If the provider knows whether or not the infant has been enrolled in Medicaid that will generally give an indication of the nature of any case processing error that may be happening. If the infant is enrolled, then the DFR Office is either still in the process of determining eligibility for a new category for Mom, or an improper delay is occurring. Either way, the provider may first try to speak with the member to determine what contact she has had with her DFR Office. And, the provider may send his or her concern about the situation to the appropriate Regional Manager for the DFR office of the member's residence. See attachment for DFR regional office email addresses.

b. Please define the postpartum period. It appears that HP and the MCEs may not all be following the same standard with respect to postpartum coverage.
   – **IHCP Response:** The postpartum period is a function of eligibility and therefore is defined in DFR's program policy manual. It is not defined/managed by HP or the MCEs. The DFR policy states:

     A woman is eligible for 60 days of postpartum coverage if she was eligible for Medical Assistance on the day her pregnancy ended.

     The 60 day period begins on the last day of pregnancy and extends through the end of the month in which the last day of the 60 day period ends.

4. TPL Issues/90-Day Rule - OMPP communicated to Representative William Crawford's office that the MCEs will be directed to follow the 90-day rule as it applies to TPL situations.

a. Please provide the effective date for which the MCEs will be required to adhere to the 90-day rule process.
   - **OMPP Response:** The 90-day rule is currently effective, and MCEs will be required to adhere immediately.

b. ISMA is requesting that a Bulletin or Banner page be issued regarding this directive and the effective date to notify providers.
   - **OMPP Response:** BR201043 was distributed on October 26, 2010.

c. Once effective, ISMA would like each MCE to provide written instruction regarding how providers are to submit a claim using the 90-day rule.
   – **MDwise Response:** At the time this update is being provided, MDwise is conducting a gap analysis of this new requirement and determining what procedures need to be developed in order to meet the requirement for its Hoosier Healthwise business. Due to the complex nature of instituting the 90 Day Rule Provision as outlined in the IHCP Provider Manual, Ch 5, Section 3 (i.e. paper claim processing, any system changes such as suspending claims that invoke the 90 Day Insurance Rule, electronic claim note recognition, training staff, etc.). Once this analysis has been completed and a process put into place, MDwise will be updating its provider manual and posting this to its website at http://www.mdwise.org/.
   – **MHS Response:** MHS and the OMPP are discussing the aforementioned items. MHS will follow OMPP direction.
   – **Anthem Response:** Anthem is aware of the 90-day rule and will be providing instruction to providers.

General Coverage Issues/Not HP or MCE Specific

5. Does Medicaid cover children's sports physicals?

- **IHCP Response:** Please provide a CPT code and HP can provide a response as to whether the specific code is covered. Providers may utilize http://provider.indianamedicaid.com/general-provider-services/billing-and-remittance/fee-schedule.aspx to access program coverage for a particular procedure to determine if it is a covered service.
- **MDwise Response:** As with any question regarding covered services, please provide specific Current Procedural Terminology (CPT) codes the provider will use for this service so a specific answer can be given. In general,

MDwise covers a physical as part of the evaluation and management (E&M) office visit codes submitted by the provider. Physician codes reimbursement is based on Resource Based Relative Value Scale (RBRVS) methodology. This methodology contains three components of physician services which are physician work, practice expense, and malpractice expense. An administrative cost including completing paperwork is figured into the components of an E&M code's reimbursement. We recommend using the 2010 American Medical Association CPT Professional reference and Appendix C – Clinical Examples as a resource to providers.

- **MHS Response:** MHS reimburses an annual physical, which may serve as a sports-related physical, if the member has not had an annual physical. Sports physicals, in general, are not covered.
- **Anthem Response:** It will only be covered if it is a well child visit and all criteria have been met.

6. **Does Medicaid cover physician services related to the completion of Family Medical Leave Act (FMLA) paperwork for Medicaid members?**
   - **IHCP Response:** Please provide a CPT code and HP can provide a response as to whether the specific code is covered. Providers may utilize http://provider.indianamedicaid.com/general-provider-services/billing-and-remittance/fee-schedule.aspx to access program coverage for a particular procedure to determine if it is a covered service.
   - **MDwise Response:** As with any question regarding covered services, please provide specific CPT codes the provider will use for this service so a specific answer can be given. In general, MDwise covers a physical as part of the E&M office visit codes submitted by the provider. Physician codes reimbursement is based on Resource Based Relative Value Scale (RBRVS) methodology. This methodology contains three components of physician services which are physician work, practice expense, and malpractice expense. Administrative costs including completing paperwork is figured into the components of an E&M code's reimbursement. We recommend using the 2010 American Medical Association CPT Professional reference and Appendix C – Clinical Examples as a resource to providers.
   - **MHS Response:** HCPCS code 99080, ―completion of special reports, such as insurance forms‖ , typically billed for completion of FMLA, permits, sports physical documentation, or disability cases, is non-covered per IHCP guidelines. Like-codes billed for the same purpose are non-covered. Reimbursement is not available for completing reports or forms separate from medical services.
   - **Anthem Response:** No, this is not covered by IHCP.
7. **Does Medicaid cover physician services related to completion of paperwork for patients to obtain handicap parking permits?**
   - **IHCP Response:** Please provide a CPT code and HP can provide a response as to whether the specific code is covered. Providers may utilize http://provider.indianamedicaid.com/general-provider-services/billing-and-remittance/fee-schedule.aspx to access program coverage for a particular procedure to determine if it is a covered service.
   - **MDwise Response:** As with any question regarding covered services, please provide specific CPT codes the provider will use for this service so a specific answer can be given. In general, MDwise covers a physical as part of the E&M office visit codes submitted by the provider. Physician codes reimbursement is based on Resource Based Relative Value Scale (RBRVS) methodology. This methodology contains three components of physician services which are physician work, practice expense, and malpractice expense. Administrative costs including completing paperwork is figured into the components of an E&M code's reimbursement. We recommend using the 2010 American Medical Association CPT Professional reference and Appendix C – Clinical Examples as a resource to providers.
   - **MHS Response:** HCPCS code 99080, ―completion of special reports, such as insurance forms‖ , typically billed for completion of FMLA, permits, sports physical documentation, or disability cases, is non-covered per IHCP guidelines. Like-codes billed for the same purpose are non-covered. Reimbursement is not available for completing reports or forms separate from medical services.
   - **Anthem Response:** No, this is not covered by IHCP.
8. **Does Medicaid cover physician services related to completing disability paperwork or disability exams which are NOT initiated by the Medicaid Review Team/Division of Disability?**
   - **IHCP Response:** Please provide a CPT code and HP can provide a response as to whether the specific code is covered. Providers may utilize http://provider.indianamedicaid.com/general-provider-services/billing-and-

remittance/fee-schedule.aspx to access program coverage for a particular procedure to determine if it is a covered service.

- **MDwise Response:** As with any questions regarding covered services, please provide specific CPT codes the provider will use for this service so a specific answer can be given. There is no separate IHCP coverage for completion of disability paperwork if the member is eligible for Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP). If the provider billed MDwise for a disability examination, reimbursement for administrative work including paperwork completion is included in the reimbursement the provider receives.

  Members who wish to be considered disabled under the IHCP disability benefit must apply at their local division of family resources (DFR). If the DFR authorizes Medical Review Team services, administrative services may be considered for reimbursement as part of covered MRT services. All services must be submitted to HP from an actively enrolled Medical Review Team (MRT) provider on a CMS-1500 claim form, Web interChange, or appropriate 837P transaction and the member must be valid participants. For more information, providers may consult the IHCP Provider Manual Ch 8, Section 4, pg. 8-361.
- **MHS Response:** HCPCS code 99080, ―completion of special reports, such as insurance forms‖ , typically billed for completion of FMLA, permits, sports physical documentation, or disability cases, is non-covered per IHCP guidelines. Like-codes billed for the same purpose are non-covered. Reimbursement is not available for completing reports or forms separate from medical services.
- **Anthem Response:** No, this is not covered by IHCP.

9. **BR201039 dated September 28, 2010, provided information about ICD-9 updates to the Emergency Department Diagnosis List, High-Risk Pregnancy Diagnosis List, and Hospital Acquired Conditions List; however, no ICD-9 updates were provided for Package B or Package P.**

   a. The updates for other lists are typically in order; however, the Package B list is continually neglected. What, if any, methodology has been put in place to keep this list up-to-date with current coding conventions?

      – **IHCP Response:** The Office of Medicaid Policy and Planning (OMPP) reviews the new, revised and deleted ICD-9 codes on a yearly basis. The OMPP determines which codes should be placed on the specific diagnosis tables as it relates to each Medicaid program. HP works in conjunction with the OMPP to ensure the determination information is entered into IndianaAIM in a timely manner.

   b. Is anyone currently reviewing the 2011 ICD-9 codes to include new pregnancy-related codes on the Package B and Package P lists? When will providers be notified of 2011 codes that have been added to these lists?

      – **IHCP Response:** The Centers for Medicare & Medicaid Services (CMS) compiles the new, revised and deleted ICD-9 procedure codes and publishes those codes several weeks prior to the October 1st effective date. Once the codes have been released, on the CMS website, the OMPP will begin reviewing the codes. The provider will be notified via Banner prior to the October 1st effective date.

   c. Are the MCEs kept up-to-date with the changes to these types of coverage lists and under what time frame are they required to comply.

      – **OMPP Response:** MCEs are aware of and adopt these changes in the time frame given by OMPP. Time frames for required compliance may vary and are dependent on the extent of the changes being made. Many times, changes are made within a 30-60 day timeframe.

10. **At the Medicaid NCCI virtual workshop 10/8/2010, and the IHCP Annual Seminar at the National Correct Coding Initiative workshop. Slide 40 states: "Administrative review must be requested within seven days of notification of claims payment or denial". Seven days is unreasonable and not practical for most providers. If/when a review needs to take place after the Seven days, how should the provider proceed?**

    - **IHCP Response:** This process is designed to follow the Administrative Review policies as outlined in chapter 10 of the IHCP provider manual. If this process changes for NCCI, HP will send out an update.

NCCI Implementation

11. **Does HP or FSSA have any new information regarding the implementation of NCCI that they would like to share?'**

    - **Reminder:** All providers should review BT201036 regarding the NCCI implementation. Providers experiencing problems related to NCCI bundling/edits after the implementation should contact Gloria Kirkham at the ISMA to ensure that issues are identified and resolved in a timely manner for all providers.

a. NCCI implementation will be a recurring item for the Medicaid Coalition Agenda. HP/FSSA is asked to provide an update on the implementation, mass-adjustments, and provide a list of issues that have been identified for each Medicaid Coalition meeting.

- **IHCP Response:** The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national coding and to correct improper coding. The Office of Medicaid Policy and Planning (OMPP) plans to implement claim editing methodologies to accept generally accepted code auditing principle and standards in phases. Refer to BR201027, dated July 6, 2010, for additional details regarding NCCI and implementation. You may review edits and information on the CMS Web site at http://www.cms.gov/NationalCorrectCodInitEd/. Also, watch the Indiana Health Coverage Programs (IHCP) Web site for publications such as banner pages, bulletins, and newsletters for forthcoming updates.

5010 Implementation

12. Please provide an update on the status of the 5010 implementation.

- **IHCP Response:** HP has provided publications regarding the 5010 implementation as listed below and will continue to provide additional updates regarding the implementation as more information is available. Questions should be directed to INXIXTradingPartner@hp.com or call the EDI Solutions Service Desk at 1-877-877-5182 or locally at (317) 488-5160.

  Watch for additional information on the testing process, revised IHCP Companion Guides, and the schedule for transaction testing on this mandated initiative in bulletins, banner pages, and newsletters at www.indianamedicaid.com.

  - HIPAA 5010 Updates for providers and software vendors - October IHCP Newsletter http://provider.indianamedicaid.com/ihcp/Publications/newsletters.asp
  - The information to reference is HIPAA 5010 FAQ http://provider.indianamedicaid.com/general-provider- services/health-insurance-portability-and-accountability-act-(hipaa)/faqs---hipaa.aspx#HIPAA%205010%20and%20NPCDP%20D.0
  - HIPAA 5010 and NCPDP D.0 What's New for EDI Vendors http://provider.indianamedicaid.com/general- provider-services/electronic-data-interchange-(edi)-solutions/what's-new-for-edi-vendors.aspx
  - HIPAA 5010 Updates for providers and software vendors - October IHCP Newsletter http://provider.indianamedicaid.com/ihcp/Publications/newsletters.asp

13. Medicare has created a Provider Action Checklist for a Smooth Transition document which identifies actions providers need to take to ensure they are ready for the 5010 implementation and it identifies some of the major changes with Medicare transactions for 5010. Could Medicaid create a similar document to identify the major transactional changes providers can expect with 5010. If this already exists, please provide a reference to where this document is located.

- **IHCP Response:** HP has not created a checklist but will review that as a possibility. Providers are encouraged to continue to watch for information published in the bulletins, banner articles and newsletters on our website at www.indianamedicaid.com.

14. 5010 implementation will be a recurring item for the Medicaid Coalition Agenda. HP/FSSA is asked to provide an update on the implementation, testing, issues identified, etc., at each Medicaid Coalition meeting.

- **IHCP Response:** Providers will be reminded to prepare for upgrades to their systems for the final rule adopted by the CMS for submission of electronic healthcare and pharmacy transactions adopted under the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1998 (HIPAA).

  HIPAA-covered entities affected by the transition to 5010 are providers such as physicians, alternate site providers (rehabilitation clinics, as well as other inpatient and outpatient facilities), health plans, clearinghouses, billing/service agents, and vendors.

  The IHCP and HP will test transactions on a scheduled basis throughout 2011. Providers that exchange data with the IHCP using an approved software vendor will not need to test. Providers must contact their software vendor to ensure that they are in the process of upgrading the software to the 5010 version and are planning to test with the IHCP. The companion guide will be on the Web site in the near future.

Please watch for forthcoming information in future newsletters, banner pages, or bulletins.

MCE Questions

15. **BT201038 dated September 16, 2010 states, "Members may see any IHCP-enrolled provider when there is no PMP assignment in the Eligibility Verification System (EVS)." Please clarify this statement. Can members truly see ANY IHCP-enrolled provider or only any MCE NETWORK-enrolled providers when there is no PMP assignment in EVS?**
    - **MDwise Response:** Members who are assigned to MDwise but who have not picked a PMP or have not been auto-assigned to a PMP can see any IHCP enrolled provider (including non contracted providers). Non contracted providers must obtain authorization prior to the service being provided. Providers must contact MDwise at 1-800-356-1204 or 317-630-2831 in the Indianapolis area. The provider will then be –warm transferred‖ to the medical management department of the delivery system in the area the member resides in. The delivery system medical management department will then work with the provider to obtain an authorization.
    - **MHS Response:** Yes—unassigned members may see any IHCP-enrolled provider with MHS after selecting MHS as their MCE. However, all prior authorization processes remain in place.
    - **Anthem Response:** Anthem does allow a member to see any IHCP-enrolled provider, but would require an authorization for any out-of-network provider.
16. **Hoosier Alliance and their subcontract IUMG Family Planning are having a problem processing CPT code 58565, hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (and related anesthesia code 00952). When submitted to Hoosier Alliance the claim is denied as family planning. When submitted to IUMG Family Planning the claim is denied as not a family planning service. The provider has tried to resolve this through Hoosier Alliance and has been unsuccessful. This code is obviously a family planning service and should be on the list.**
    - **MDwise Response:** Providers who experience claim denials should contact their delivery system provider relations representative or MDwise Corporate so that we can work with the provider to resolve any claim questions. Please provide Chris Kern, MDwise Provider Relations with the claim information so that it can be researched and resolved.

    a. Please also provide a comprehensive list of the CPT codes which are considered family planning services.
        - **MDwise Response:** Providers who are contracted with a Catholic based delivery system and experience a claim denial for family planning claims must contact provider relations at MDwise for assistance. Providers who question whether a procedure code should or should not be considered family planning should also route those questions to MDwise Provider Relations for consideration by the MDwise medical directors. Providers are reminded that the determination of whether a service is considered family planning or not is the responsibility of MDwise's medical directors and is a clinical decision and not a billing determination.

PMP Panel Sizes and Administration

17. **How will each MCE handle PMP panels for Hoosier Healthwise and HIP; will the PMP set one panel size that applies to both plans or will the PMP set separate panel sizes for Hoosier Healthwise and HIP?**
    - **MDwise Response:** HHW and HIP panels will be separate. Panel sizes will be determined in the agreement between MDwise and the provider. For HIP, MDwise requires that each participating PMP sign up for a minimum panel of 25.
    - **MHS Response:** PMPs will have separate panels for HHW and HIP members, not a combined panel. PMPs can determine their own panel size availability within OMPP program guidelines.
    - **Anthem Response:** Panels will be separated by Hoosier Healthwise and Healthy Indiana Plan. Panel sizes are open and in agreement as outlined on the provider application.
18. **What are the minimum and maximum panel sizes allowable for each of the MCEs? If the plan requires the PMP to set separate panel sizes for Hoosier Healthwise and HIP, what is the minimum and maximum panel size for each plan for each member group (HHW vs HIP)?**
    - **MDwise Response:** For HIP, MDwise requires that each participating PMP sign up for a minimum panel of 25.

- **MHS Response:** All PMPs reserve the right to state the number of members they are willing to accept into their practice. The panel for HIP members will be set at 50 members, unless the provider otherwise requests an alternate panel size.
- **Anthem Response:** HHW and HIP panel sizes are open and in agreement as outlined on the provider application.

19. **How will each plan handle auto-assignments for members (algorithm)? In what circumstances will each plan over-ride a PMP's panel maximum to assign members?**
    - **MDwise Response:** MDwise's approach to auto-assignment will reflect the State's guidelines published in provider bulletin BT201038.

      Auto-assignment logic: If the member does not self-select a PMP within the first 30 days of enrollment with a plan, he or she will be auto-assigned by the MCE according to the following logic:

      – Previous PMP
      – Family member's current PMP
      – Family member's previous PMP
      – PMP in previous group
      – PMP in family member's current or previous group
      – Default MCE designed process with OMPP approval
    - **MHS Response:** MHS is required to follow OMPP direction and requirements regarding auto-assignment logic. Therefore, MHS' proposed auto-assignment logic mirrors that of the IHCP and is currently being reviewed by the OMPP for approval. Under the proposed logic, panel overrides would be applicable in the same circumstances as today.
    - **Anthem Response:** Anthem will look for prior PMP assignment, family PMP assignment, then PMPs are assigned utilizing a weight-based algorithm that looks at distance between PMP and member, provider language spoken, office staff language spoken, physician specialty match, physician type, clinic type, & PMP type. Anthem will not over-ride a PMP's maximum panel size without their permission.

20. **How will each plan handle a member's self-selection when the PMP's panel is full?**
    - **MDwise Response:** If a PMP's panel is full and the PMP requests via full panel add form that the PMP wishes to add the member to their panel, MDwise will allow the member to join that PMP's panel. Providers can access the MDwise Full Panel Add form at http://www.mdwise.org/. If the member wishes to select that PMP but the PMP's panel is full, MDwise will work with the member to help them select another PMP. If the member goes to auto-assignment because they didn't choose another PMP within 30 days, then the auto-assignment logic discussed in question three will prevail.
    - **MHS Response:** MHS will follow the same process as today, whereby the physician must agree to add the member and provide a signed document indicating approval (full panel request).
    - **Anthem Response:** In the event that a panel is full and a member has contacted customer service, then customer service will work with the member to locate an alternative provider. Customer service can also contact the provider to determine if the panel size can be increased to accept the member.

21. **Will each plan allow PMP's to submit a panel hold request? If so, define the process and the circumstances in which a panel hold will be approved.**
    - **MDwise Response:** As in the past, MDwise will recognize PMP requests to add a member to their panel when it is in hold. The PMP must complete the Hold Panel Add form and send it to MDwise for processing. Providers can access the Hold Panel Add form at http://www.mdwise.org/. If the member hasn't been added to the that PMP's panel within 30 days, then the auto-assignment logic outlined in question three will prevail.
    - **MHS Response:** MHS will follow the same process as today, whereby the practitioner notifies MHS of the wish to place a hold on their panel.
    - **Anthem Response:** PMP can place a hold or block on their panel. A PMP would need to notify the MCE of the request for processing.

22. **What is the policy, for each plan, for hold panel addition requests and full panel addition requests?**

- **MDwise Response:** Please see questions four and five.
- **MHS Response:** Please see the responses to questions 4 and 5 above. These processes are directed by the OMPP and outlined in OMPP's Policy and Procedure Manual.
- **Anthem Response:** For hold panels, contact is made with the provider for acceptance of them member.

23. Will each plan continue to allow an OB provider to serve as a PMP for pregnant members only?

- **MDwise Response:** Yes. In order to meet OMPP guidelines for providing women's health services, a woman who is pregnant may select an OB to serve as her PMP. The OB can also see the woman during her pregnancy as a specialist if necessary. A HIP member may select a gynecologist as a PMP but not an OB.
- **MHS Response:** Pregnant HHW MHS members may select an OB provider as their PMP. HIP members may select a gynecologist as their PMP (Please note that HIP does not cover pregnancy-related services).
- **Anthem Response:** OB providers can serve as PMP for HHW members, but our systematic assignment cannot limit to pregnant members only.