REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Obstetrical Care – Total Cost		PY-0231	09/01/2020-03/31/2023
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Table of Contents

A. Subject

Obstetrical Care – Total cost

B. Background

Obstetrical care refers to the health care treatment given in relation to pregnancy and delivery of a newborn child. This include care during the prenatal period, labor, birthing, and the postpartum period. CareSource covers obstetrical services members receive in a hospital or birthing center as well all associated outpatient services. The services provided must be appropriate to the specific medical needs of the member. Determination of medical necessity is the responsibility of the physician. Submission of claims for reimbursement will serve as the provider's certification of the medical necessity for these services. Proper billing and submission guidelines must be followed. This includes the use of industry standard, compliant codes on all claims submissions. Services should be billed using Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote services and/or the procedure performed. The billed codes are required to be fully supported in the medical record. Unless otherwise noted, this policy applies to only participating providers and facilities.

C. Definitions

- **Prenatal profile** - Initial laboratory services.
- **Initial and prenatal visit -** Practitioner visit to determine member is pregnant.
- **Total obstetrical care -** Includes antepartum care, delivery, and postpartum care.
- **High risk delivery -** Labor management and delivery for an unstable or critically ill pregnant patient.
- **Premature birth -** Delivery before 39 weeks of pregnancy.
- **Pregnancy -** For the purpose of this policy, pregnancy begins on the date of the initial visit in which pregnancy was confirmed and extends for 280 days or 40 weeks.

D. Policy

I. Obstetrical Care

A. Initial Visit and Prenatal Profile

1. The initial visit and prenatal profile are reimbursed separately from other obstetrical care. These are to be billed immediately after first contact.
2. Evaluation and Management (E/M) codes are utilized when services were provided to diagnose the pregnancy. These are not part of antepartum care.

B. Total Obstetrical Care (for uncomplicated care provided to the member including antepartum, delivery, and postpartum care)

1. If a member meets all of the following criteria, the practitioner designated in the members medical record MUST bill for total obstetrical care under that practitioner's number:
   a. Is eligible for Medicaid for the duration of pregnancy;
   b. Is cared for by one practitioner or group practice for the antepartum care, delivery, and postpartum care; and
   c. Attending physician is designated in the medical record with services billed under that practitioner tax identification number.
2. Billing for total obstetrical care cannot be done until the date of delivery.

3. Total obstetrical care cannot be billed for a delivery of less than 20 weeks gestation.
4. Total obstetrical care codes
   a. A corresponding obstetrical diagnosis with outcome of birth must be listed on the claim. A code from category Z34 should be listed as the first diagnosis for routine obstetric care.
   b. Reimbursement is provided for one of the following codes per pregnancy:

CPT Code	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps and postpartum care), after previous cesarean delivery
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

5. Modifiers
   a. A modifier UB, UC, and UD, appended to the billed delivery procedure code is REQUIRED or the delivery claim will be denied.
   b. Deliveries with modifiers UB or UD must show medical necessity and medical documentation may be requested.
   c. Use appropriate modifiers (this list may not be all inclusive):

Modifier	Description
22	To support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.
52	To indicate reduced services i.e. patient begins antepartum care late in pregnancy.
UB	Medically-necessary delivery prior to 39 weeks of gestation
UC	Delivery at 39 weeks of gestation or later
UD	Non-medically necessary delivery prior to 39 weeks of gestation (Elective non-medically necessary deliveries less than 39 weeks gestation)

6. Services (this list may not be all inclusive):

Services included that may NOT be billed separately	Services excluded and therefore may be billed separately
Admission history	Greater than 13 antepartum visits due to high-risk condition
Admission to hospital	Complications of pregnancy
Artificial rupture of membranes	Surgical complications or other problems related to pregnancy
Care provided for an uncomplicated pregnancy including delivery as well as antepartum and postpartum	Cephalic version
Cesarean delivery	Ultrasonography
Cesarean delivery following an unsuccessful vaginal delivery attempt after previous cesarean delivery	Fetal nonstress test
Classic cesarean section	Maternal or fetal echography
Each month up to 28 weeks gestation	Fetal echocardiography procedures
Every other week from 29 to 36 weeks gestation	Fetal biophysical profile
Fetal heart tones	Amniocentesis, any method
Hospital/office visits following cesarean section or vaginal delivery	Chorionic villus sampling, any method
Initial/subsequent history	Fetal contraction stress test
Low cervical cesarean section	Hospital and observation care visits for premature labor prior to 36 weeks of gestation
Management of uncomplicated labor	High risk pregnancies requiring more visits or more laboratory data

Physical Exams	Conditions unrelated to pregnancy i.e. hypertension, glucose intolerance
Recording of weight/blood pressures	Treatment and management of complications during the postpartum period that require additional services
Routine chemical urinalysis	Laboratory tests outside of routine chemical urinalysis
Routine prenatal visits	Cordocentesis
Successful vaginal delivery after previous cesarean delivery	OB ultrasounds
Patients with previous cesarean delivery who present with the expectation of a vaginal delivery	RH immune globulin administration
Vaginal delivery with or without episiotomy or forceps	
Weekly from 36 weeks until delivery	

II. Multiple gestations.
   A. Include diagnosis code for multiple gestations.
   B. Total obstetrical care billing for multiple gestations should include one procedure code and a "delivery only" code for each subsequent delivery with the appropriate diagnosis code and modifier for the multiple gestations.
   C. When all deliveries were performed by a cesarean section, only a single cesarean delivery code is to be reported regardless of how many cesarean births.
   D. Modifier 22 may be added to support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.

III. High risk deliveries
   A. High risk pregnancy with appropriate trimester should be the first listed diagnosis for prenatal outpatient visits and from the category O09 supervision of high-risk pregnancy.
   B. Modifier 22 may be added to the delivery code to support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

Codes	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps and postpartum care), after previous cesarean delivery
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.
Modifiers	**Description**
22	To support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.
51	To indicate that a second and any subsequent vaginal births occurred identifying multiple procedures were performed
52	To indicate reduced services i.e. patient begins antepartum care late in pregnancy.
59	Distinct procedural services
UB	Medically-necessary delivery prior to 39 weeks of gestation
UC	Delivery at 39 weeks of gestation or later
UD	Non-medically necessary delivery prior to 39 weeks of gestation (Elective non-medically necessary deliveries less than 39 weeks gestation)

F. Related Policies/Rules

Obstetrical Care - Hospital Admissions MM-0850
Obstetrical Care – Unbundled Cost PY-0924

G. Review/Revision History

	DATE	ACTION
Date Issued	07/01/2017	New Policy.
Date Revised	04/01/2020	New title – used to be Global Obstetrical Services – policy broken into two policies. Updated definitions, reorganized topics, removed unbundled information, updated most content, included modifiers and updated codes.
Date Effective	09/01/2020	
Date Archived	03/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. The American College of Obstetricians and Gynecologist. (2018, May). Presidential Task Force on Redefining the Postpoartum Visit. Retrieved June 27, 2019, from https://www.acog.org
2. American Medical Association. (1997, April). Global OB Codes: Reporting and Use. *CPT Assistant*.
3. American Medical Association (2015, January). Maternity Care and Delivery. *CPT Assistant.*
4. Georgia Department of Community Health Division of Medicaid. (2019, April 1). PART II Policies and Procedures for Physician Services. Retrieved June 14, 2019 from https://www.mmis.georgia.gov
5. American Academy of Professional Coders. (2013, August 1). From Antepartum to Postpartum, Get the CPT® OB Basics. Retrieved June 14, 2019 from https://www.aapc.com
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7. EncoderPro.com for Payers Professional. (2019) Retrieved June 27, 2019, from https://www.encoderprofp.com
8. The American College of Obstetricians and Gynecologists. (n.d.). Coding for Postpartum Services (The 4th Trimester). Retrieved June 27, 2019, from https://www.acog.org
9. The American College of Obstetricians and Gynecologists. (n.d.). Reporting a Services with Modifier 22. Retrieved June 27, 2019, from https://www.acog.org
10. American College of Obstetricians and Gynecologists. (2011, December). Patient Safety Checklist: Scheduling Induction of Labor. Retrieved July 31, 2019, from https://www.acog.org
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12. American College of Obstetricians and Gynecologists. (2019), April Correct Coding Initiative Version 25.1. Retrieved June 14, 2019 from https://www.acog.org
13. American College of Obstetricians and Gynecologists. (2018, May). Optimizing Postpartum Care. Retrieved August 1, 2019, from https://www.acog.org
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The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

GA-MED-P-105010 Date Issued 07/01/2017 DCH Approved 06/09/2020