REIMBURSEMENT POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Obstetrical Care-Unbundled Cost-GA MCD-PY-0924	04/01/2023
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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.
CareSource 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Obstetrical Care – Unbundled Cost

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/International Classification of Disease-10 (ICD-10) code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Obstetrical care refers to the health care treatment given in relation to pregnancy and delivery of a newborn child. This includes 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 as 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 CPT codes, 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 is applicable to obstetricians-gynecologists (OB/GYNs), obstetricians (OBs), gynecologists (GYNs), and nurse-midwives. Also, this policy applies only to participating providers and facilities

C. Definitions

- **High risk delivery** - Labor management and delivery for an unstable or critically ill pregnant patient.
- **Initial and Prenatal Visit** - Practitioner visit to determine whether member is pregnant.
- **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.
- **Premature Birth** - Delivery before 37 weeks of pregnancy.
- **Prenatal Profile** - Initial laboratory services.
- **Unbundled (Partial) Obstetrical Care** - The practitioner bills delivery, antepartum care, and postpartum care independently of one another.

- **Antepartum Care (Prenatal)** - The initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and then weekly visits until delivery.
- **Delivery Services** - Admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.
- **Postpartum Care** - Hospital and office visits following vaginal or cesarean section delivery. The American College of Obstetricians and Gynecologists (ACOG) recommends contact within the first 3 weeks postpartum and ongoing care are needed, concluding with a postpartum visit no later than 12 weeks after birth.

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. Unbundled Obstetric Care - Report the services performed using the most accurate, most comprehensive procedure codes available based on what services the practitioner performed. The practitioner would bill delivery, antepartum care, and postpartum care independently of one another.

1. Unbundled obstetric care should be billed when any of the following occur:
   a. The member has a change of insurer during pregnancy
   b. The member has received part of the obstetrical care (antenatal care, deliver, or postpartum care) elsewhere (e.g. from another group practice)
   c. The member leaves the pratitioner's group practice before the global obstetrical care is complete
   d. The member must be referred to a provider from another group practice or a different licensure (e.g. midwife to MD) for a cesarean delivery
   e. The member has an unattended precipitous delivery
   f. Termination of pregnancy without delivery (e.g. miscarriage, ectopic pregnancy)
2. Antepartum care only – Antepartum care only does not include delivery or postpartum care:
   a. Use the appropriate CPT and trimester code(s):

CPT Code	Description
E/M	For antepartum care for 1-3 visits
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits

b. For E/M codes, bill with a diagnosis code O09.00 – O09.93, Z33.3; Z34.00-Z34.93.
c. E/M codes for antepartum care are limited to 3.
d. Use the appropriate modifier (This list may not be all inclusive):

NOTE: For Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC) members antepartum E/M visit limits do not apply.

Modifier	Description
24	To indicate that the E/M visit was not related to typical postpartum care during the global period

e. Only one code, either 59425 or 59426 can be billed per pregnancy.
f. Antepartum care only code includes the following (This list may not be all inclusive):
   01. Monthly visits up to 28 weeks gestation
   02. Biweekly visits to 36 weeks gestation
   03. Weekly from 36 weeks until delivery
   04. Fetal heart tones
   05. Initial/subsequent history
   06. Physical exams
   07. Recording of weight/blood pressures
   08. Physician/other qualified health care professional providing all or a portion of antepartum/postpartum care, but no delivery
   09. Routine chemical urinalysis
   10. Termination of pregnancy by abortion
   11. Referral to another physician for delivery.

3. Delivery only - Use if only a delivery was performed
   a. Deliveries must be greater or equal to 20 weeks gestation to be billed as a delivery.
   b. Use the appropriate CPT and delivery outcome code(s):

CPT Code	Description
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59514	Cesarean delivery only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

c. 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 and physical	Scalp blood sampling on newborn
Admission to hospital	External cephalic version
Management of uncomplicated labor	Administration of anesthesia
Physical exam	
Vaginal delivery with or without episiotomy or forceps	
Vaginal delivery after prior cesarean section	
Previous cesarean delivery who present with expectation of vaginal delivery	
Successful vaginal delivery after previous cesarean delivery	
Cesarean delivery following an unsuccessful vaginal delivery attempt after previous cesarean delivery	
Cesarean delivery	
Classic cesarean section	
Low cervical cesarean section	
Inducing labor using pitocin or oxytocin	
Injecting anesthesia	
Artificial rupturing of membranes prior to delivery	
Insertion of a cervical dilator for vaginal delivers when occurs on the same date as delivery	
Delivery of placenta unless it occurs at a separate encounter from the delivery	
Minor laceration repairs	
Inpatient management after delivery/discharge services	
E/M services provided within 24 hours of delivery	

d. Modifiers
   1. A modifier UB, UC, or UD appended to the billed delivery procedure code is REQUIRED or the delivery claim will be denied.

2. Deliveries with modifiers UB or UD must show medical necessity and medical documentation may be requested.

e. Use the appropriate modifier (This list may not be all inclusive):

CPT Code	Description
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)

4. Delivery and postpartum care only - If only delivery and postpartum care were provided
   a. Use the appropriate CPT and outcome code:

CPT Code	Description
59410	Vaginal delivery only (with or without episiotomy and/or forceps);including postpartum care
59515	Cesarean delivery only; including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery including postpartum care

b. Modifiers
   1. A modifier UB, UC, or UD appended to the billed delivery procedure code is REQUIRED or the delivery claim will be denied.
   2. Deliveries with modifiers UB or UD must show medical necessity and medical documentation may be requested.

c. Services included in the delivery only and postpartum care codes; and therefore are NOT allowed to be billed separately (This list may not be all inclusive):
   1. Admission history
   2. Admission to hospital
   3. Artificial rupture of membranes
   4. Care provided for uncomplicated pregnancy including delivery, antepartum, and postpartum care
   5. Hospital/office visits following cesarean section or vaginal delivery
   6. Management of uncomplicated labor
   7. Physical exam
   8. Vaginal delivery with or without episiotomy or forceps
   9. Caesarean delivery
   10. Classic cesarean section
   11. Low cesarean section
   12. Successful vaginal delivery after previous cesarean delivery

13. Previous cesarean delivery who present with the expectation of a vaginal delivery
14. Caesarean delivery following unsuccessful vaginal delivery attempt after previous cesarean delivery
    a. Postpartum care only - If postpartum care only was provided:
        1. Use code 59430 postpartum care only.
        2. Only one 59430 can be billed per pregnancy as this includes all E/M pregnancy related visits provided for postpartum care.
        3. There is no specified number of visits included in the postpartum code. This includes hospital and office visits following vaginal or cesarean section delivery. ACOG recommends contact within the first 3 weeks postpartum.
        4. Postpartum care may include; and therefore are NOT allowed to be billed separately (This list may not be all inclusive):
            a. Hospital, office and outpatient visits following cesarean section or vaginal delivery
            b. Qualified health care professional providing all or portion of antepartum/postpartum care, but no delivery due to referral to another physician for delivery or termination of pregnancy by abortion

5. The following are billable separately during the postpartum period (This list may not be all inclusive):
    a. Conditions unrelated to pregnancy i.e. respiratory tract infection
    b. Treatment and management of complications during the postpartum period that require additional services

II. Member Eligibility
    A. If a member was not eligible for Medicaid for the 9 months before delivery, the practitioner MUST use the appropriate delivery only or delivery and postpartum code to be reimbursed. Charges for hospital admission, history and physical or normal hospital evaluation and management services are not reimbursable.
    B. If a member becomes eligible for Medicaid due to a live birth, no prenatal services including laboratory services are reimbursable.

III. Multiple Gestations.
    A. Include diagnosis code for multiple gestations.
    B. Modifier 51 should be added to the second and any subsequent vaginal births identifying multiple procedures were performed.
    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 should be added to support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.

IV. High Risk Deliveries
    A. High risk pregnancy should be the first listed diagnosis for prenatal outpatient visits and from the category O09 Supervision of high-risk pregnancy.

B. Modifier 22 maybe 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.
- For antepartum care only (e.g. 59425, 59426) please bill only the final date of service rather than the full date span; failure to do so may result in a timely filing denial.
- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

CPT Code	Description
E/M	For antepartum care for 1-3 visits
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59514	Cesarean delivery only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59410	Vaginal delivery only (with or without episiotomy and/or forceps);including postpartum care
59515	Cesarean delivery only; including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery including postpartum care
59430	Postpartum care only.

F. Related Policies/Rules

Obstetrical Care - Hospital Admissions
Obstetrical Care - Total Cost

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 total care information, updated most content, included modifiers and updated codes.
	09/15/2021	Added Section E. For antepartum care only (e.g. 59425, 59426) please bill only the final date of service rather than the full date span; failure to do so may result in a timely filing

	10/12/2022	denial. Added reimbursement policy language. Removed duplicate modifiers. Update References. Approved at PGC. Added that E/M antepartum visit limitations do not apply to FQHC/RHC
Date Effective	04/01/2023	
Date Archived		

H. References

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