



## REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

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<b>Policy Name</b>				<b>Policy Number</b>	
Preferred Obstetrical Services				PY-0004	
<b>Policy Type</b>					
Medical		Administrative		Pharmacy	
<b>REIMBURSEMENT</b>					

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.

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## A. SUBJECT

### Obstetrical Services

**Ohio Medicaid does not currently reimburse for global obstetrical services coding and/or billing. Because of this, CareSource also does not reimburse for global obstetrical services coding and/or billing unless the provider's contract has been specifically negotiated to include those codes and rates.**

**This policy addresses reimbursement for obstetrical services for those providers whose CareSource contracts do not include negotiated global obstetrical services codes and rates.**

## B. BACKGROUND

Maternity care or obstetrical services refers to the health care treatment given in relation to pregnancy and delivery of a newborn child. Maternity care services include care during the prenatal period, labor, birthing, and the postpartum period. CareSource reimburses for 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 payment 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 Procedural 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

- **Advanced practice nurse** - The recently endorsed Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education defines four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN).
- **Current Procedural Terminology (CPT)** - The answer to most obstetrical billing questions can be found in the "Physician's Current Procedural Terminology (CPT)" manual or the CPT Assistant Archives (1990 – present). Maternity Care and Delivery is a subsection of the Surgery section of the CPT book codes. An understanding of the global package services is needed to code Maternity Care and Delivery Services correctly.
- **Elective Delivery** - is performed for a nonmedical reason. Some nonmedical reasons include wanting to schedule the birth of the baby on a specific date or living far away from the hospital. Some women request delivery because they are uncomfortable in the last weeks of pregnancy, or are past their due date and not naturally in labor yet. Some women request a cesarean delivery because they fear vaginal birth. (*American Congress of Obstetricians and Gynecologists, 2015*)
- **Fetal death** - means death prior to the complete expulsion or extraction from its mother of a product of conception, which after such expulsion or extraction, does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. "Fetal death" does not include termination of the pregnancy. (*OAC 3701-7-01 (L), "Fetal death"*)
- **High Risk Maternity** - Maternity care complicated by a documented condition during the patient's pregnancy requiring direct face-to-face practitioner care beyond the usual service.
- **Infertility** - is defined as the condition of (i) a presumably healthy woman of childbearing age who has been unable to conceive or (ii) a presumably healthy man who has been unable to



produce conception, in either case, after at least one year of trying to do so. (*CareSource internal definition*)

- **Lactation consultant** - means an individual who holds credentials as an "International board certified lactation consultant." (*OAC 3701-7-01 (Q), "Lactation consultant"*)
- **Maternity home** - means a facility for pregnant girls and women where accommodations, medical care, and social services are provided during the prenatal and postpartum periods. Maternity home does not include a private residence where obstetric or newborn services are received by a resident of the home. (*OAC 3701-7-01 (W), "Maternity home"*)
- **Maternity Period** - For billing purposes, the obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period (56 days after vaginal delivery, 60 days after C-section).
- **Medically necessary** - services are those health services that are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice. (*OAC 5160-10-02*)
- **Non-Obstetric E/M service:** Visit(s) occurring outside the regularly scheduled antepartum period during which the same physician or physician group and/or other health care professional providing maternity care, also provides services for a non-obstetric condition such as bronchitis, flu, or upper respiratory infection.
- **Physician** - means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. (*OAC 3701-55-01 (I), "Physician"*)
- **Physician group, Physician group practice** – means a clinic or an obstetric clinic either with an electronic health record (EHR), or where there is no EHR, but one member record and each physician/nurse practitioner/nurse midwife seeing that member has access to the same member record and makes entries into the record as services occur. All locations of a multi-location clinic with an EHR (or one patient record) are considered the same physician group practice.
- **Preconception care** - means Medicaid-covered preventive medicine services provided prior to a pregnancy for the purpose of achieving optimal outcome of future pregnancies.

## D. POLICY

### I. Prior Authorization

Prior authorization is not required for the preferred obstetrical and maternity services covered under this policy.

**NOTE:** Although the preferred obstetrical and maternity services covered by this policy do not require prior authorization, CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

### II. Maternity Coverage-General

A. Maternity services must be furnished under the supervision of a physician or certified advanced practice nurse midwife. Maternity services enable beneficiaries to voluntarily choose a provider within the CareSource network for maternity care and postpartum care. For billing purposes, the Maternity Obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period (56 days after vaginal delivery and 60 days after C-section).

1. Covered services include office visits for a complete exam, pharmaceuticals (including some over the counter ["OTC"] products with a prescription), such as prenatal vitamins or medication related to gestational diabetes, and fetal ultrasound services are provided by or under the supervision of a medical doctor, osteopath, or eligible maternity provider.
2. Maternity services may include the following:
  - 2.1 Pregnancy testing/laboratory tests.
  - 2.2 Office visits.



- 2.3 Ultrasounds
- 2.4 Fetal delivery.
- 2.5 Postpartum visits.

### III. Criteria for Itemized Billing

#### A. Antepartum Care Only

1. The CPT Editorial Board created codes 59425 (Antepartum care only; 4-6 visits) and 59426 (Antepartum care only; 7 or more visits) to account for the following situations when all of the routine antepartum care is not provided by the same physician, physician group, and/or other health care professional:
  - 1.1 The member has a change of insurer during her pregnancy.
  - 1.2 The member has received part of her antenatal care elsewhere e.g. from another physician or physician group practice.
  - 1.3 The member leaves her care with your group practice before the global obstetrical care is complete.
  - 1.4 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.
  - 1.5 The member has an unattended, precipitous delivery. Termination of pregnancy without delivery (e.g. miscarriage, ectopic pregnancy).
2. CareSource will reimburse for the antepartum care only CPT codes 59425 or 59426 when reported by same group physician and/or other health care professional as follows:
  - 2.1 A single claim submission of CPT code 59425 or 59426 for the antepartum care only (one unit).
  - 2.2 The initial, office visit in which the pregnancy is confirmed may be reported and separately reimbursed when the antepartum record has not been initiated.
  - 2.3 The dates should document the range of time covered by the visits. For example, if the patient had a total of 4-6 antepartum visits then the physician and/or other health care professional should report CPT code 59425 with the "from and to" dates for which the services occurred.

#### B. Delivery Services Only

1. Delivery begins with the passage of the fetus and the placenta from the womb into the external world.
  - 1.1 Delivery only codes are:
    - a. 59409 - Vaginal delivery only (with or without episiotomy and/or forceps).
    - b. 59514 - Cesarean delivery only.
    - c. 59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).
    - d. 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.
2. Items Included in the Delivery Services
  - 2.1 Labor and delivery services are based on the need of each individual patient and can include, but are not limited to the types of services listed in this section.
  - 2.2 The following services are included in the delivery services codes and will not be reimbursed separately:
    - a. Admission to the hospital.
    - b. The admission history and physical examination.
    - c. Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician.
    - d. Intravenous (IV) induction of labor via oxytocin (CPT codes 96365 - 96367).
    - e. Delivery of the placenta; any method.
    - f. Repair of first or second degree lacerations.



- 2.3 Insertion of cervical dilator (CPT 59200) is included in the delivery services and will not be separately reimbursed if performed on the same date of delivery.
  - 2.4 Third and fourth degree lacerations should be identified by appending modifier 22 to the delivery codes. Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier; please refer to the Increased Procedural Services section of this policy, Section III-I.
- C. Postpartum Care Only
1. The postpartum care only code should be reported by the physician, physician group, or other health care professional who provides the patient with services of postpartum care only. If a physician provides any component of antepartum along with postpartum care, but does not perform the delivery, then the services should be itemized by using the appropriate antepartum care code (see Antepartum Care Only Section III-A) and postpartum care code 59430.
  2. The CPT code for postpartum care only is 59430 - Postpartum care only (separate procedure).
  3. CareSource follows ACOG guidelines and considers the postpartum period to be six weeks following the date of the cesarean or vaginal delivery. Postpartum care includes hospital and office visits following any type of delivery, and can include any number of visits. Each of these visits can be reported with procedure code 0503F.
  4. The following services are included in postpartum care and are not separately reimbursable services:
    - 4.1 Uncomplicated outpatient visits related to the pregnancy.
    - 4.2 Discussion of contraception.
  5. Evaluation and management of problems or complications related to the pregnancy are services not included in postpartum care and will be reimbursed separately, in addition to code 59430.
- D. Delivery including Postpartum Care
1. Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, claims should include codes for vaginal and cesarean section deliveries that encompass both of these services.
  2. Delivery plus postpartum care codes are:
    - 2.1 59410 - Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care.
    - 2.2 59515 - Cesarean delivery only; including postpartum care.
    - 2.3 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care.
    - 2.4 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.
  3. The delivery only including postpartum care codes should be reported by the same physician, physician group, or other health care professional for a single gestation when:
    - 3.1 The delivery and postpartum care services are the only services provided
    - 3.2 The delivery and postpartum care services are provided in addition to a limited amount of antepartum care (e.g., CPT code 59425)
  4. The following services are included in delivery only including postpartum care code and are not separately reimbursable services:
    - 4.1 Hospital visits related to the delivery during the delivery confinement.
    - 4.2 Uncomplicated outpatient visits related to the pregnancy.
    - 4.3 Discussion of contraception.
- E. Non-Obstetric Care
- When a member is seen for a condition unrelated to pregnancy (e.g., bronchitis, flu), these E/M visits are considered Non-Obstetric E/M services and can be reported as they occur. The diagnosis code used in conjunction with the E/M service should support the non-obstetric condition being treated and/or evaluated. CareSource will reimburse non-



obstetric care and related office E/M services during the entirety of the pregnancy and maternal care; use appropriate diagnosis codes identifying the condition is not related to pregnancy care, and the appropriate modifiers (generally, modifier 24).

F. Risk Appraisal-Case Management Referral

1. Providers may complete the Pregnancy Risk Assessment Form and will be paid for the completion of the form a maximum of three times during the pregnancy. This form should be submitted one time during each trimester of pregnancy. Please use code H1000 on the associated claim to indicate that an assessment form was submitted.
2. Any eligible woman who meets any of the risk factors listed on the form is qualified for case management services for pregnant women and should be referred to CareSource for further screening for those case management services.

G. Delivery of Multiple Gestations

CareSource follows ACOG coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries of multiple births (twins, triplets, etc.). Use appropriate codes and modifiers regarding the delivery of and work associated with multiple births.

H. Fetal Non-Stress Test

CareSource will reimburse for fetal non-stress testing, including for multiple non-stress tests on a single fetus on the same day, or on multiple gestations, as medically necessary.

I. Increased Procedural Services

1. When the work required providing a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. The determination of reimbursement for obstetrical services submitted with modifier 22 is based on individual review of clinical documentation that supports use of the modifier identifying an increased procedural service per CPT modifier guidelines. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physician and mental effort required).
2. For information regarding additional payment of E/M services that go beyond the typical number encountered in an average pregnancy, please refer to the High Risk/Complications section of this policy.

J. Limitations on Elective Obstetric Deliveries

1. Payment for any cesarean section, labor induction, or any delivery following labor induction is subject to the following criteria:
  - 1.1 Gestational age of the fetus must be determined to be at least thirty-nine weeks; or,
  - 1.2 If a delivery occurs prior to thirty-nine weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery.

**NOTE:** Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to thirty-nine weeks gestation that are not considered medically necessary, will not be reimbursed.

K. Non-Comprehensive Maternity Visits

CareSource reimburses providers for maternity management services including E/M (office) visits and consultations for the purpose of health of the member and developing fetus for best outcomes.

L. Maternity Services Not Reimbursed

1. Home pregnancy tests;
2. Ultrasounds performed only for determination of sex of the fetus or to provide a keepsake picture;
3. Three and four dimensional ultrasounds;
4. Paternity testing;



5. Lamaze classes;
6. Birthing classes;
7. Parenting classes; and,
8. Home tocolytic infusion therapy.

### E. CONDITIONS OF COVERAGE

CODE	DESCRIPTION
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59514	Cesarean delivery only;
59515	Cesarean delivery only; including postpartum care
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care, report also date of visit and in a separate field, the last date of menstrual period LMP)
0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period - LMP (Note: If reporting 0501F prenatal flow sheet, it is not necessary to report 0500F initial prenatal care visit)
0502F	Subsequent prenatal care visit (excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care [e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care])
0503F	Postpartum care visit

### F. RELATED POLICIES/RULES

N/A

### G. REVIEW/REVISION HISTORY

DATE		ACTION
Date Issued	6/10/2015	



<b>Date Revised</b>	10/18/2017	Updated codes, template.
<b>Date Effective</b>	06/01/2018	

#### H. REFERENCES

1. Current Procedural Terminology. (2015, June 1). Retrieved June 11, 2015, from <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>
2. Guideline Suggestions for Elective Labor Induction. (2012). Retrieved June 11, 2015, from <http://www.acog.org/-/media/Districts/District-I/20120120-ElectiveOLGuideline.pdf?dmc=1&ts=20150611T0857437601>
3. Ohio Administrative Code. (2015). Retrieved June 11, 2015, from <http://codes.ohio.gov/oac/3701-40-01>
4. American Association of Critical Care Nurses Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, 2015.
5. OAC Rule 5160-1-10 Limitations on Elective Obstetric Deliveries.
6. OAC Rule 5160-21 Preconception Care Services.

**The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.**

Archived