



REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Obstetrical Care – Unbundled Cost		PY-0004	08/01/2020
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.

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A. Subject

Obstetrical Care – Unbundled 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.

Following Ohio Department of Medicaid's direction, unbundled codes are to be used by practitioners except for Freestanding Birthing Centers. Freestanding Birthing Centers must using total care obstetrical codes.

C. Definitions

- **Freestanding birthing center (FBC)** - Any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is not licensed under Chapter 3711 of the revised code as a level one, two, or three maternity unit or a limited maternity unit.¹
- **Prenatal profile** - Initial laboratory services.
- **Initial and prenatal visit** - Practitioner visit to determine member is pregnant
- **Unbundled obstetrical care** - The practitioner would bill delivery, antepartum care, and postpartum care independently of one another.
 - **Antepartum care** - Is for basic care (including taking and subsequent updating of medical history, physical examination, recording of vital signs, and routine chemical urinalysis) provided monthly up to 28 weeks gestation, biweekly therefore up to 36 weeks gestation, and weekly thereafter until delivery.
 - **Delivery** - Includes admission to facility, medical history during admission, physical examinations, management of labor (either vaginal delivery or by cesarean section)².
 - **Postpartum care** - The period that, "begins on the last day of pregnancy and extends through the end of the month in which the 60 day period following

¹ <http://codes.ohio.gov/orc/3702.141>

² <http://codes.ohio.gov/oac/5160-21-04v1>



termination of pregnancy ends³.” The American College of Obstetricians and Gynecologists (ACOG) recommends contact within the first 3 weeks postpartum.

- **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. 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.

C. Unbundled Obstetric Care - Report the services performed using the most accurate, most comprehensive procedure code 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 antenatal care elsewhere, e.g. from another group practice;
 - c. The member leaves your 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; and
 - f. Termination of pregnancy without delivery (e.g. miscarriage, ectopic pregnancy).

³ <https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=fabf1d19393c9f6586501c8e23999687&ty=HTML&h=L&mc=true&n=pt42.4.440&r=PART>



2. Antepartum care only – Antepartum care only does not include delivery or postpartum care:
- Use the appropriate CPT and trimester code(s):

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

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

Modifier	Description
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during the postoperative period

- E/M codes for antepartum care are limited to 3.
 - Only one code, either 59425 or 59426 can be billed per pregnancy.
 - Antepartum care only code includes the following (This list may not be all inclusive):
 - Monthly visits up to 28 weeks gestation
 - Biweekly visits to 36 weeks gestation
 - Weekly from 36 weeks until delivery
 - Fetal heart tones
 - Initial/subsequent history
 - Physical exams
 - Recording of weight/blood pressures
 - Physician/other qualified health care professional providing all or a portion of antepartum/postpartum care, but no delivery
 - Routine chemical urinalysis
 - Termination of pregnancy by abortion
 - Referral to another physician for delivery
3. Delivery only – Use if only a delivery was performed
- Deliveries must be greater or equal to 20 weeks gestation to be billed as a delivery.
 - 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
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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 deliveries 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	
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- d. Modifiers
01. Use the appropriate modifier (This list may not be all inclusive):

CPT Code	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.
80	Assistant surgeon - may be used for delivery only if no antepartum or postpartum care was performed

4. Delivery and postpartum care only – If only delivery and postpartum care were provided
a. Use the appropriate CPT and trimester 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. 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):
01. Admission history
 02. Admission to hospital
 03. Artificial rupture of membranes
 04. Care provided for uncomplicated pregnancy including delivery, antepartum, and postpartum care
 05. Hospital/office visits following cesarean section or vaginal delivery
 06. Management of uncomplicated labor
 07. Physical exam
 08. Vaginal delivery with or without episiotomy or forceps

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09. Cesarean 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. Cesarean delivery following unsuccessful vaginal delivery attempt after previous cesarean delivery
5. Postpartum care only- If postpartum care only was provided:
 - a. Use code 59430 postpartum care only.
 - b. Only one 59430 can be billed per pregnancy as this includes all E/M pregnancy related visits provided for postpartum care.
 - c. 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.
 - d. Postpartum care may include; and therefore are not allowed to be billed separately (This list may not be all inclusive) the following:
 01. Hospital, office, and outpatient visits following cesarean section or vaginal delivery; or
 02. 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.
 - e. The following are billable separately during the postpartum period (This list may not be all inclusive):
 01. Conditions unrelated to pregnancy i.e. respiratory tract infection; or
 02. 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 should 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
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
E/M	For antepartum care for 1-3 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.
Modifiers	Description
22	To support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.



24	Unrelated evaluation and management service by the same physician or other qualified health care professional during the postoperative period
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 procedure/service
80	Assistant surgeon - may be used for delivery only if no antepartum or postpartum care was performed

F. Related Policies/Rules

Obstetrical Care – Hospital Admissions MM-0897
Obstetrical Care – Total Cost PY-0939

G. Review/Revision History

	DATE	ACTION
Date Issued	06/10/2015	
Date Revised	10/18/2017 04/01/2020	Updated codes, template
Date Effective	08/01/2020	New title – was Preferred Obstetrical Services; policy broken into two policies. Updated definitions, reorganize topics, removed total care information, updated most content and codes.
Date Archived		

H. References

1. The American College of Obstetricians and Gynecologist. (2018, May). Presidential Task Force on Redefining the Postpartum 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. 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>
5. American Academy of Professional Coders. (2011, December). Code Obstetrical Care with Confidence. Retrieved on August 1, 2019 from <https://www.aapc.com>
6. EncoderPro.com for Payers Professional. (2019) Retrieved June 27, 2019, from <https://www.encoderprofp.com>
7. 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>
8. The American College of Obstetricians and Gynecologists. (n.d.). Reporting a Services with Modifier 22. Retrieved June 27, 2019, from <https://www.acog.org>



9. 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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14. Ohio Administrative Code. (2017). 3701-4-01 Definitions. Retrieved August 1, 2019, from <http://codes.ohio.gov>
15. Department of Ohio Medicaid. (2019, June). Modifiers Recognized by Ohio Medicaid. Retrieved August 1, 2019 from <https://www.medicaid.ohio.gov>
16. Ohio Administrative Code. (2015). 5160-1-10 Limitations on Elective Obstetric Deliveries. Retrieved August 1, 2019 from <http://codes.ohio.gov>
17. Ohio Administrative Code. (2018). 4723-8-01 Definitions. Retrieved August 1, 2019 from <http://codes.ohio.gov>
18. Ohio Administrative Code. (2019). 5160-26 Managed health care programs; definitions. Retrieved August 1, 2019 from <http://codes.ohio.gov>
19. Ohio Revised Code. (2012). 3702.141 Rules may apply to existing health care facility. Retrieved August 1, 2019 from <http://codes.ohio.gov>
20. Ohio Administrative Code. (2017). 5160-21-04 Reproductive health services; pregnancy-related services. Retrieved August 1, 2019 from <http://codes.ohio.gov>
21. Ohio Revised Code (2017). 4723.43 Scope of specialized nursing services. Retrieved August 1, 2019 from <http://codes.ohio.gov>

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