REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Obstetrical Care–Unbundled Cost-OH MCD-PY-0004	02/01/2023-02/29/2024
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 a 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 procedures performed. The billed codes must be fully supported in the medical record. Unless otherwise noted, this policy applies only to participating providers and facilities.

This policy is for practitioners who meet either of the following:

- Obstetrical practitioners not part of a Free Standing Birthing Center;
  or
- Obstetrical practitioners part of a Free Standing Birthing Center when any of the following occur:
  - It is the preferred method of billing;
  - The member has a change of insurer during pregnancy;
  - The member has received part of the antenatal care elsewhere (e.g., from another group practice);
  - The member leaves the practitioner's group practice before the global obstetrical care is complete;
  - 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; or
  - The member has an unattended precipitous delivery; and
  - Termination of pregnancy without delivery (e.g., miscarriage, ectopic pregnancy).

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C. Definitions

- **Freestanding Birthing Center (FBC)** - Birth centers are freestanding facilities that are not considered hospitals, providing peripartum care for low-risk women with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth**.**
- **Prenatal Profile** - Initial laboratory services.
- **Initial and Prenatal Visit** - A practitioner visit to determine whether member is pregnant.
- **Unbundled Obstetrical Care** - The practitioner bills delivery, antepartum care, and postpartum care independently.
  - **Antepartum Care** - Defines basic care (including obtaining and updating subsequent medical history, physical examination, recording of vital signs, and routine chemical urinalysis) provided monthly up to 28 weeks gestation, biweekly thereafter up to 36 weeks gestation, and weekly thereafter until delivery.
  - **Delivery** - Includes admission to facility, medical history during admission, physical examinations, and management of labor (either by vaginal delivery or by cesarean section).
  - **Postpartum Care** - The time period that begins on the last day of pregnancy and extends through the end of the month in which the 60 day period following termination of pregnancy ends. 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.
- **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 is completed.

D. Policy

I. Obstetrical Care

A. Initial Visit and Prenatal Profile. Evaluation and management (E/M) codes are utilized for the initial visit, prenatal profile, and antepartum care.

B. Risk Appraisal - Case Management Referral

1. Providers may complete the Pregnancy Risk Assessment Form (PRAF) 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 Pregnancy Risk Assessment Form (PRAF) 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 - The practitioner will bill antepartum care, delivery, and postpartum care independently of one another.

1. Antepartum care only - does not include delivery or postpartum care:
   a. Use the appropriate E/M code and trimester code(s)
   b. Use the appropriate modifier, if applicable.

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2. 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	

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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	

3. 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
      09. Caesarean delivery
      10. Classic cesarean section
      11. Low cesarean section
      12. Successful vaginal delivery after previous cesarean delivery
      13. Previous cesarean delivery member who presents with the expectation of a vaginal delivery
      14. Caesarean delivery following unsuccessful vaginal delivery attempt after previous cesarean delivery

4. Postpartum care only, if postpartum care only was provided:
   a. Use code 59430 postpartum care only.
   b. Only one code 59430 can be billed per pregnancy as this includes all E/M pregnancy related visits provided for postpartum care.

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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 is not allowed to be billed separately for the following (not an all inclusive list):
   01. Office and outpatient visits following cesarean section or vaginal delivery; or
   02. Qualified health care professional providing all or a 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 (e.g. 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 REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

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The following list 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
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
59430	Postpartum care only.
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
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

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 07/22/2020 09/15/2021 10/10/2022	Updated codes, template New title – was Preferred Obstetrical Services; policy broken into two policies. Updated definitions, reorganize topics, removed total care information, updated most content and codes. Clarified who can bill unbundled charges. Revised antepartum language for clarity. Removed modifiers. Updated references. Approved at PGC. Editorial changes and reference updates only.
Date Effective	02/01/2023	
Date Archived	02/29/2024	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.

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H. References

1. The American College of Obstetricians and Gynecologist. (2018, May). Presidential Task Force on Redefining the Postpartum Visit. Retrieved October 4, 2022 from 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 October 4, 2022 from www.aapc.com
5. American Academy of Professional Coders. (2011, December). Code Obstetrical Care with Confidence. Retrieved on October 4, 2022 from www.aapc.com
6. The American College of Obstetricians and Gynecologists. (n.d.). Coding for Postpartum Services (The 4th Trimester). Retrieved October 4, 2022 from www.acog.org
7. American College of Obstetricians and Gynecologists. (2011, December). Patient Safety Checklist: Scheduling Induction of Labor. Retrieved October 4, 2022 from www.acog.org
8. American College of Obstetricians and Gynecologists. (2011, December). Patient Safety Checklist: Scheduling Planned Cesarean Delivery. Retrieved October 4, 2022 from www.acog.org
9. American College of Obstetricians and Gynecologists. (2018, May, reaffirmed 2021). Optimizing Postpartum Care. Retrieved October 4, 2022 from www.acog.org
10. American College of Obstetricians and Gynecologists. (2019, January). Preterm Labor and Birth. Retrieved October 4, 2022 from www.acog.org
11. Department of Ohio Medicaid. (2022, January). Modifiers Recognized by Ohio Medicaid. Retrieved October 4, 2022 from www.medicaid.ohio.gov
12. Ohio Administrative Code. (2018). 4723-8-01 Definitions. Retrieved October 4, 2022 from www.codes.ohio.gov
13. Ohio Administrative Code. (2018). 5160-18-01 | Freestanding birth center services. Retrieved October 4, 2022 from www.codes.ohio.gov
14. Ohio Administrative Code. (2015). 5160-1-10 Limitations on Elective Obstetric Deliveries. Retrieved October 4, 2022 from www.codes.ohio.gov
15. Ohio Administrative Code. (2022). 5160-26-01 Managed health care programs; definitions. Retrieved October 4, 2022 from www.codes.ohio.gov
16. Ohio Administrative Code. (2022). 5160-21-04 Reproductive health services; pregnancy-related services. Retrieved October 4, 2022 from www.codes.ohio.gov
17. Ohio Revised Code (2021). 4723.43 Scope of specialized nursing services. Retrieved October 4, 2022 from www.codes.ohio.gov

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