REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Obstetrical Care-Total Cost for Freestanding Birthing Centers-OH MCD-PY-0939	02/01/2024
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.

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 2
E. Conditions of Coverage 3
F. Related Policies/Rules 4
G. Review/Revision History 4
H. References 4

A. Subject

Obstetrical Care-Total Cost for Freestanding Birthing Centers

B. Background

Obstetrical care refers to 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 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.

The total obstetrical care code is only to be used by Freestanding Birthing Centers. All other practitioners must not bill and will not be reimbursed for 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**.**
- **Initial and Prenatal Visit** - Practitioner visit to determine 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 or 40 weeks.
- **Prenatal Profile** - Initial laboratory services.
- **Total Obstetrical Care** - Includes antepartum care, delivery, and postpartum care.

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 once during the pregnancy. Use HCPCS 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.
3. Total obstetrical care code:
   a. Total obstetrical care code is CPT 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
   b. A corresponding obstetrical diagnosis with appropriate trimester must be listed on the claim. An ICD-10 code from category Z34 should be listed as the first diagnosis for routine obstetric care.
4. Services included that are not to be billed separately (this list may not be all inclusive):
   a. admission history
   b. admission to hospital
   c. artificial rupture of membranes
   d. care provided for an uncomplicated pregnancy including delivery as well as antepartum and postpartum
   e. visits each month up to 28 weeks gestation
   f. visits every other week from 29-36 weeks gestation
   g. visits weekly from 36 weeks until delivery
   h. fetal heart tones
   i. hospital/office visits following vaginal delivery
   j. initial/subsequent history
   k. management of uncomplicated labor
   l. physical exams
   m. recording of weight/blood pressures
   n. routine chemical urinalysis
   o. routine prenatal visits
   p. successful vaginal delivery after previous cesarean delivery
   q. vaginal delivery with or without episiotomy or forceps.

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

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

H1000	Prenatal care, at risk assessment

F. Related Policies/Rules
Obstetrical Care-Unbundled Services

G. Review/Revision History

	DATE	ACTION
Date Issued	7/22/2020	
Date Revised	10/26/2022 10/11/2023	Annual review with editorial changes. References updated. Annual review. Updated references. Approved at Committee.
Date Effective	02/01/2024	
Date Archived		

H. References

1. *2023 OB/GYN Coding Manual: Components of Correct Coding*. American College of Obstetricians and Gynecologists; 2023. Accessed September 20, 2023. www.acog.org
2. ACOG committee opinion 736: presidential task force on redefining the postpartum visit. *Obstet Gynecol*. 2018;131(5):e140-e150. Reaffirmed 2021. Accessed September 19, 2023. www.acog.org
3. *Cesarean Delivery on Maternal Request*. American College of Obstetricians and Gynecologists; 2019. Committee Opinion No. 761. www.acog.org
4. Definitions, OHIO ADMIN. CODE 4723-8-01 (2021).
5. Freestanding birth center services, OHIO ADMIN. CODE 5160-18-01 (2023).
6. Limitations on Elective Obstetric Deliveries, OHIO ADMIN. CODE 5160-1-10 (2015).
7. Managed Care: Definitions, OHIO ADMIN. CODE 5160-26-01 (2022).
8. *Management of Late-Term and Postterm Pregnancies*. American College of Obstetricians and Gynecologists*; 2014.* Practice Bulletin No. 146*.* Accessed September 20, 2023. www.acog.org
9. *Medically Indicated Late-Preterm and Early-Term Deliveries*. American College of Obstetricians and Gynecologists; 2021. Committee Opinion No. 831. www.acog.org
10. Mind these modifier 22 do's and don'ts. American Academy of Professional Coders. April 10, 2006. Accessed September 20, 2023. www.aapc.com
11. Reproductive Health Services: Pregnancy-Related Services, OHIO ADMIN. CODE 5160-21-04 (2022).
12. *Safe Prevention of the Primary Cesarean Delivery*. American College of Obstetricians and Gynecologists; 2014. Obstetric Care Consensus No. 1. www.acog.org
13. Scope of Specialized Nursing Services, OHIO REV. CODE § 4723.43 (2020).

Approved by ODM 10/26/2023