REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Original Issue Date	Next Annual Review	Effective Date
06/10/2015	03/22/2018	05/03/17
Policy Name		**Policy Number**
Preferred Obstetrical Services		PY-0004
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.

Contents of Policy

A. SUBJECT

Obstetrical Services

Note: It is expected that the provider will use the appropriate Evaluation and Management (E/M) codes. Select level based upon the history, examination, and medical decision making documented in the record for that visit.

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 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 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 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.

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).
  - **Education**
    The model calls for all APRNs to be educated in an accredited graduate-level education program in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatric, neonatal, women's health/gender-related or psych/mental health.
  - **Certification**
    All APRNs must pass a national certification exam that measures APRN role and population-focused competencies. APRNs will be required to maintain continued competence as evidenced by recertification in the role and population through a national certification program. Under the new APRN regulatory model all CNSs will be educated and assessed through national certification processes across the continuum from wellness through acute care.
  - **Licensure**
    Advanced practice registered nurses will be licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Licensure will be required because these APRNs will be practicing in a role beyond that of the Registered Professional Nurse.
    2015 American Association of Critical-Care Nurses
- **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. *(ama-assn.org)*

- **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. 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.
- **Guidelines for perinatal care** - means the sixth edition of the "Guidelines for perinatal care" issued by the American academy of pediatrics and the American congress of obstetricians and gynecologists.
- **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."
- **Coding Guidelines -** The delivery date is used as the date of service for:
  - Any OB global code
  - Most antepartum care codes
  - Any delivery-only code
  - Any delivery + postpartum code
  - Any postpartum care only code
- **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)*
- **Modifier 22: Increased Procedural Services:** 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. 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).
  Note: This modifier should not be appended to an E/M service.
- **Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service:** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for

reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

- **Modifier 59: Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
  Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
- **Non-Obstetric (OB) E/M service:** Visit(s) occurring outside the regularly scheduled antepartum period whereby the Same Group Physician and/or Other Health Care Professional providing maternity care provides services for a condition such as bronchitis, flu, or upper respiratory infection.
- **Obstetric (OB) Related E/M service**: Additional visit(s) provided in addition to routine antepartum care for a high-risk or complicated pregnancy.
- **Physician** - means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.
- **Preconception care** - means Medicaid-covered preventive medicine services provided prior to a pregnancy for the purpose of achieving optimal outcome of future pregnancies.
- **Special delivery services** - means services provided by a freestanding children's hospital that does not offer typical obstetric services as a level I obstetric service, level II obstetric service, or level III obstetric service, but is licensed as a level III neonatal care service, and is designed and equipped to provide delivery services to pregnant women as part of a comprehensive multidisciplinary program of fetal and neonatal care when it is determined that the fetus, once delivered, will require immediate highly subspecialty neonatal intensive care or neonatal surgery typically provided by a level IIIB or level IIIC neonatal care service.

D. POLICY

I. Maternity Coverage

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 post-partum 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).

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.

1. Maternity services may include the following:
   1.1 Pregnancy testing/laboratory tests
   1.2 Office visits
   1.3 Ultrasounds

1.4 Fetal delivery
1.5 Post-Partum visits

B. Maternity Global Period

The CMS Physician Fee Schedule assigns maternity procedure codes a global days indicator of MMM, and does not identify the number of days for a Maternity global period. CareSource uses a Maternity Global Period of 56 days after the date of vaginal delivery and 60 days after the date of C-section delivery(date of delivery is day zero)

Criteria for Itemized Billing

1. Antepartum Care Only
   1.1 The CPT Editorial Board created codes 59425 (Antepartum care only; 4-6 visits) and 59426 (Antepartum care only; 7 or more visits) to accommodate for situations such as termination of a pregnancy, relocation of a patient or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global (OB) care may not be provided by Same Group Physician and/or Other /Health Care Professional.
   1.2 The antepartum care only CPT codes 59425 or 59426 should be reported by Same Group Physician and/or Other Health Care Professionals when:
   1.3 As described by ACOG and the AMA, the antepartum care only codes 59425 and 59426 should be reported as described below:
      a. A single claim submission of CPT code 59425 or 59426 for the antepartum care only, excluding the confirmatory visit that may be reported and separately reimbursed when the antepartum record has not been initiated.
      b. The units reported should be one.
      c. The dates reported should be the range of time covered. 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.
2. Delivery Services Only
   2.1 Per the CPT book, "Delivery services include 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."
   2.2 The following are the CPT defined delivery only codes:
      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
3. Items Included in the Delivery Services
   3.1 According to CPT and ACOG coding guidelines, the following services are included in the delivery services codes and should not be reported 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
   3.2 CareSource will not separately reimburse for these services when one of the delivery codes is reported.

3.3 CareSource considers insertion of cervical dilator (CPT 59200) to be included if performed on the same date of delivery.
3.4 Per ACOG coding guidelines, reporting of third and fourth degree lacerations should be identified by appending modifier 22 to the global OB (59400, 59610) or delivery only (59409, 59410, 59612 and 59614) 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 and CareSource's Increased Procedural Services policy.

4. Postpartum Care Only
4.1 The following is the CPT defined postpartum care only code:
a. 59430 - Postpartum care only (separate procedure)
4.2 CareSource follows ACOG guidelines and considers the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.
4.3 The following services are included in postpartum care and are not separately reimbursable services:
a. Uncomplicated outpatient visits related to the pregnancy
b. Discussion of contraception
c. The following services are not included in postpartum care and are separately reimbursable services, when reported subsequent to CPT code 59430:
(1) Evaluation and management of problems or complications related to the pregnancy

Note: The postpartum care only code should be reported by the Same Group Physician and/or Other Health Care Professional that 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 of policy) and postpartum care code (CPT code 59430).

5. Delivery Only including Postpartum Care
Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both of these services.
5.1 The following are CPT defined delivery plus postpartum care codes:
a. 59410 - Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
b. 59515 - Cesarean delivery only; including postpartum care
c. 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
d. 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
5.2 The delivery only including postpartum care codes should be reported by the Same Group Physicians and/or Other Health Care Professional for a single gestation when:
a. The delivery and postpartum care services are the only services provided
b. The delivery and postpartum care services are provided in addition to a limited amount of antepartum care (e.g., CPT code 59425)
5.3 The following services are included in delivery only including postpartum care code and are not separately reimbursable services:
a. Hospital visits related to the delivery during the delivery confinement
b. Uncomplicated outpatient visits related to the pregnancy
c. Discussion of contraception
6. Non-Obstetric Care During Antepartum Stage

Per ACOG guidelines, when a patient is seen for a condition unrelated to pregnancy (e.g., bronchitis, flu), these E/M visits are considered Non-Obstetric (OB) 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-OB condition being treated and/or evaluated. CareSource will reimburse non-OB related E/M services rendered during the antepartum stage of care only when the appropriate diagnosis code being used clearly identifies the condition is not related to pregnancy care.

7. Non-Obstetric Care During the Postpartum Stage
   CareSource will reimburse non-OB related office E/M services rendered during the postpartum care when submitted with modifier 24.

8. Risk Appraisal-Case Management Referral
   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.

   Any eligible woman who meets any of the risk factors listed on the form is eligible for case management for pregnant women services and should be referred to CareSource for further screening for case management services.

C. Delivery of Multiple Gestations

CareSource's reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries. See table below for appropriate code submission regarding delivery of twin births.

Vaginal	Baby A Baby B	59400 59409-59
VBAC*	Baby A Baby B	59610 59612-59
Cesarean Delivery	Baby A & Baby B	59510
Repeat Cesarean Delivery	Baby A & Baby B	59518
Vaginal Delivery + Cesarean Delivery	Baby B Baby A	59510 59409-51
VBAC + Repeat Cesarean Delivery	Baby B Baby A	59618 59612-51

*VBAC=vaginal birth after cesarean

If there is increased physician work involvement for delivery of the second baby, modifier 22 is added to the global cesarean code (CPT codes 59510 or 59618). Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier.

D. Fetal Non-Stress Test

Per coding guidelines multiple non-stress tests performed on a single fetus on the same day should be reported with CPT code 59025 for the initial test. Code 59025 should be reported subsequently with modifier 76, to identify the repeated procedure(s) by the same physician; or with modifier 77 appended, to identify that the repeated procedure(s) was performed by another physician.

1. Multiple non-stress tests performed on twin gestations should be reported in the following manner:

1.1 The initial test for the first fetus is reported using CPT code 59025; if subsequent testing is performed on the same fetus. CPT code 59025 is then reported a second time with modifier 76, to identify the repeated procedure by the same physician; or with modifier 77, to identify that the non-stress test was repeated by another physician.
1.2 The initial test for the second fetus is reported using CPT code 59025 with modifier 59 appended, to identify that a separate fetus is being evaluated. If subsequent testing is performed on the second fetus, CPT code 59025 with modifier 59 is reported a second time with modifier 76, to identify the repeated procedure by the same physician; or modifier 77, to identify that the non-stress test was repeated by another physician.

E. Increased Procedural Services

The determination to allow additional reimbursement for OB 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.

Accordingly, physicians and other health care professionals should submit supporting medical records whenever modifier 22 is utilized.

1. The following identifies some common OB situations that involve modifier 22; please note this is NOT an all-inclusive list:
   1.1 Per ACOG coding guidelines, modifier 22 can be used for increased services associated with delivery of twins; for further information, please refer to the Multiple Gestation section of this policy.
   1.2 Per ACOG coding guidelines, it is not appropriate to append modifier 22 to the global OB code when additional E/M services result in greater than the typical 13 routine antepartum visits. 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.

F. Assistant Surgeon and Cesarean Sections

Only a non-global cesarean section delivery code (CPT codes 59514 or 59620) is a reimbursable.

G. 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 are not eligible for payment.

H. Claims

Providers are to indicate “Maternity” as a diagnosis when billing any of the services listed in this policy that relate to Maternity. Providers are to complete the diagnosis code or the appropriate narrative, where applicable. In addition, providers should identify services related to the treatment of complications of Maternity.

Examples:

1. Surgical procedure such emergency C-Section due to fetal distress
2. Atypical office visits and laboratory tests needed due to member or fetal anomalies

Occasionally other services (including hospital, radiology, pharmaceutical, blood and blood derivatives) may be related to Maternity or to its complications, and should be properly identified.

I. Non-Comprehensive Maternity Visits

CareSource covers maternity management services including evaluation and management (office) visits and consultations for the purpose of health of the member and developing fetus for best outcomes.

J. Non-Covered Maternity Services

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
8. Home tocolytic infusion therapy

K. Reimbursement Guidelines

1. Delivery
   Labor and delivery services are based on the need of each individual patient and can include, but not limited to, the following types of services, fetal monitoring of any type of method, rupture of membranes, amnioinfusion, forceps and/or vacuum-assisted delivery, episiotomy and/or laceration repair, as well as fetal and maternal testing, and induction of labor services.
2. Vaginal Delivery Reporting
   2.1 Primary delivery service code: 59400 or 59610
   2.2 Each additional delivery code: 59409-51 or 59612-51
   2.3 If the additional service becomes a cesarean delivery, then report the primary delivery service as a cesarean delivery: 59510 or 59618
3. Cesarean Delivery Reporting
   3.1 Primary delivery service code: 59510 or 59618
   3.2 No additional procedural delivery code warranted
   3.3 Only a single cesarean delivery service is to be reported no matter how many live births
      a. Modifier 22 should be added to support substantial additional work
4. Postpartum Care
   Postpartum care includes hospital and office visits following any type of delivery, and can include any number of visits (usually extends over a six-week period). It is expected that the member will have postpartum care related to their medical needs, with the final postpartum visit at the conclusion of the postpartum period. Each of these visits can be reported with procedure code 0503F.
5. Maternity Management Services
   Providers must include the following information on claims for maternity management services:
   5.1 A valid current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) procedure code for each service provided

   AND

5.2 An appropriate ICD-10 diagnosis code to indicate an encounter for maternity management

6. Maternity services are considered medically necessary for women in the delivery of a fetus (including, multiple gestations). Therefore, reimbursement is available for the following codes:
   6.1 Obstetrical Reimbursement Codes
      a. 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
      b. 59514 - Cesarean delivery only
      c. 259612 - 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
   6.2 Fetal Gestational Age Determination
      a. Delivery prior to 39 weeks of gestation
      b. Delivery at 39 weeks of gestation or later
      c. Spontaneous obstetrical deliveries occurring between 37 and 39 weeks gestation

E. CONDITIONS OF COVERAGE

HCPCS

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)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
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)
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
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
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
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

CPT
AUTHORIZATION PERIOD
Prior Authorization
Members may seek maternity services from any qualified CareSource participating provider without prior authorization.

F. RELATED POLICIES/RULES

1. American Association of Critical Care Nurses Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, 2015.
2. OAC Rule 5160-1-10 Limitations on Elective Obstetric Deliveries
3. OAC Rule 5160-21 Preconception Care Services

G. REVIEW/REVISION HISTORY

DATE		ACTION
Date Issued	6/10/2015	
Date Revised	6/10/2016	
Date Effective	05/03/2017	

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-ElectiveIOLGuideline.pdf?dmc=1&ts=20150611T0857437601
3. Ohio Administrative Code. (2015). Retrieved June 11, 2015, from http://codes.ohio.gov/oac/3701-40-01

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