Obstetrical Services Payment Policy

Policy Statement

Obstetrical services include prenatal care, labor and childbirth, and postpartum care. Services include: prenatal examinations, routine tests, diet regulation, delivery and hospital care for childbirth, miscarriage, and complications of pregnancy.

Scope

This policy applies to

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- EOHHS recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Neighborhood will reimburse for the following:

A. Global Maternity Coverage

A provider should file global maternity care when they provide prenatal care, labor and delivery and postpartum care.

Per CPT guidelines, the following services are included in the global OB package (CPT codes 59400, 59510, 59610, 59618).

- Initial and subsequent history
- Physical examination
- Recording of weight
- Blood pressure checks
- Monitoring of fetal heart tones
- Routine chemical urinalysis
- Routine prenatal visits
- Management of uncomplicated labor and delivery services, including admission
- Postpartum hospital and office visits following vaginal and cesarean delivery

Confirmation of Pregnancy Visits:

The "confirmation of pregnancy visit" is typically a minimal visit. The physician may draw blood and prescribe prenatal vitamins if the test results are positive.

- If the pregnancy has been confirmed by another physician or qualified health care professional (i.e. ultrasound, blood test) you would not bill a confirmation of pregnancy visit.
- If the OB record is started on the same day, the confirmation of pregnancy visit would be included in the global package and not separately reimbursable.

B. <u>Prenatal, Delivery and/or Postpartum Services Billed Separately</u>

It would be appropriate for the provider to file prenatal, delivery and/or postpartum services separately if:

1. The member's coverage started after the onset of pregnancy
2. The coverage terminates prior to delivery
3. The pregnancy does not result in delivery
4. Another provider in a different practice assumes care of the member prior to completion of global services
5. During the member's pregnancy, there was a change in the member's benefit package.

Maternity Service	**Number of Visits**	**CPT Coding**
Antepartum Care Only	1-3 visits	Use E&M Codes
Antepartum Care Only	4-6 visits	Use CPT 59425
Antepartum Care Only	7 or more visits	Use CPT 59426
Postpartum Care		Use CPT 59430

C. Single Birth

1. **Vaginal Delivery only**
    a. File the appropriate "Vaginal delivery only" code.
2. **Cesarean delivery only**
    a. File the appropriate "Cesarean delivery only" code.
3. **Global Delivery**
    a. File the appropriate "Global vaginal delivery" or "Global cesarean delivery" code.

D. Multiple Births

The correct method of reporting multiple deliveries is as follows:

1. **Vaginal deliveries only**
    a. Baby A: File the appropriate global vaginal delivery code or vaginal delivery only code.
    b. Babies B and beyond: File appropriate vaginal delivery only code with modifier 51 appended.

    Claims will be reimbursed according to multiple procedure payment policy.

2. **Cesarean delivery only**
    a. Baby A and beyond: File only once for appropriate global cesarean delivery code or cesarean delivery only code with modifier – 22 appended.

3. **Vaginal delivery, followed by Cesarean delivery**

    Claims should be billed according to guidelines above. Cesarean delivery should be billed as primary procedure.

E. Services unrelated to pregnancy, but performed by the provider rendering global maternity care should be documented and reported separately with the appropriate inpatient or outpatient Evaluation and Management code, using the condition unrelated to pregnancy as the primary diagnosis code. These services are separately reimbursed outside of the global obstetrical package.

F. Medical complications including but not limited to: hypertension, toxemia, hyperemesis gravidarum, congenital and genetic defects, cardiac or neurological abnormalities should be documented in the record and coded appropriately. These services are separately reimbursed outside of the global obstetrical package.

G. Obstetric Ultrasounds
Neighborhood will reimburse for up to three (3) routine standard ultrasounds during each pregnancy.

Additional limited/follow up ultrasounds will be reimbursed only when a diagnosis or condition is suspected that represents an abnormality of pregnancy or represents a threat to the fetus or the delivery:

Indications for First- Trimester Ultrasound

- To confirm the presence of an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To diagnosis or evaluate multiple gestations
- To confirm fetal cardiac activity
- As adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in patients at high risk
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy
- To evaluate suspected hydatidiform mole

Indications for Second and Third Trimester Ultrasound

- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of a pelvic mass
- Evaluation of suspected fetal death
- Evaluation of abdominal or pelvic pain
- Determination of fetal presentation
- Adjunct to cervical cerclage placement
- Evaluation of suspected multiple gestation
- Evaluation of fetal well-being
- Adjunct to external cephalic version
- Evaluation of suspected ectopic pregnancy
- Examination of suspected hydatidiform mole
- Adjunct to amniocentesis or other procedure
- Significant discrepancy between uterine size and clinical dates
- Evaluation of suspected uterine abnormality
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Evaluation for premature rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow- up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa
- Evaluation for those with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- To assess findings that my increase the risk of aneuploidy

A detailed anatomic ultrasound is allowed when performed to evaluate for suspected anomaly based on history, laboratory abnormalities, or clinical evaluation; or when there are suspicious results from a limited or standard ultrasound.

H. Early Maternity Discharge Services Upon discharge from the hospital within forty eight (48) hours of a vaginal delivery and ninety six (96) hours of a caesarean delivery members may receive:

- One (1) home visit from an RN or pediatric nurse practitioner and up to four (4) hours per day for four (4) days post discharge of Home Health Assistance (HHA).

Exclusions:

The following services are not covered:

- 3D and 4D ultrasounds are considered investigational and are therefore not medically necessary.
- Pre-planned home births
- Water births
- Services provided by a doula (birthing assistant)
- Routine ultrasound to determine the gender of the fetus in the absence of a concern about a gender related genetic disorder
- Ultrasound for a "picture" of the fetus

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Coding

This policy may apply to the follow codes. Inclusion of a code in this policy does not guarantee coverage or reimbursement.

CPT Code	Description
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
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
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
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation

76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

Codes below in Table 2 must be billed with one of these diagnosis codes for Early Maternity Discharge Services:

- Z00.121, Z00.129, Z39.0, Z39.2

CPT Code	Description

99501	Home visit for postnatal assessment and follow-up care
99502	Home visit for newborn care and assessment
T1001	Nursing assessment/evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1030	Nursing care, in the home, by registered nurse, per diem

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
08/01/21	Policy update (ultrasound and multiple birth language), format change, committee review date.
12/1/14	Format change, minor edits
9/1/13	Format change, minor edits
9/1/10	Policy effective date