

OBSTETRICAL SERVICES-PROFESSIONAL

Policy

NHP reimburses participating providers for medically necessary obstetrical services provided to members for care during a confirmed pregnancy, labor, childbirth and the postpartum period.

Prerequisites

Authorization, Notification and Referral

Service	Requirement
Obstetrical Risk Form http://www.nhp.org/SiteCollectionDocuments/PDF_Providers/ObstetricalRiskForm.pdf	Providers are encouraged to submit this form to assist NHP in identifying members who might benefit from the obstetrical care management “For You Too” program.
Obstetrical Inpatient Admission	Notification is required within one (1) business day of the admission
Planned Cesarean Section Delivery	Prior Authorization Required
Notification of Birth (MassHealth, only)	Contractually required to submit notification of birth (NOB-1) form for MassHealth within 30 calendar days of the new born date of birth
Concurrent Days of Care	Authorization beyond the initial notification is required for days that exceed the length of stay as listed below: <ul style="list-style-type: none"> • Vaginal Delivery: ≥ 2 days post-delivery • Cesarean Section: ≥ 4 day post-delivery

Limitations

Obstetrical benefits available under NHP plans may vary.

NHP will reimburse providers for obstetrical services considered medically necessary and that are a covered benefit for Managed Care Organization (MCO) eligible recipients.

Member Cost-Sharing

The provider is responsible for verifying at each encounter, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

American College of Obstetricians and Gynecologists (ACOG): Founded in 1951 in Chicago, Illinois, ACOG is the nation's pre-eminent authority on women’s health, is a professional membership organization dedicated to advancing women’s health by building and sustaining the obstetric and gynecologic community and actively supporting its members.

Antepartum care: Initial and subsequent visits for evaluation, history and physical exam, including: monthly visits up to 28 weeks gestation, biweekly visits 29 to 36 weeks gestation, and

weekly visits 37 weeks gestation until delivery, specimen handling, and routine automated and chemical urinalysis.

Delivery services: Admission to the hospital, admission history and physical, management of uncomplicated labor including induction services, vaginal or cesarean delivery, delivery of placenta, episiotomy, initial evaluation and resuscitation of the newborn by the obstetrician, fetal scalp blood sampling, application of fetal scalp electrodes and electronic fetal monitoring, physician stand-by services.

Global obstetrical services: Services normally provided in uncomplicated maternity case including antepartum care, delivery, and postpartum care reported with one maternity care and delivery service code, including:

- First prenatal visit with initial history and physical exam
- Periodic visits for pregnancy evaluation and screening
 - Monthly visits up to 28 weeks gestation
 - Biweekly visits 29 to 36 weeks gestation
 - Weekly visits 37 weeks gestation until delivery
- Supervision of labor
- Episiotomy
- Delivery (vaginal or cesarean section)
- Delivery of placenta
- In-hospital post-partum care
- Two week post delivery check-up, including incision check, when applicable
- Postpartum visits 21-56 days following delivery*
- Urinalysis
- Specimen handling

**Note: ACOG recommends the postpartum visit to occur at 4-6 weeks following delivery. NHP allows an additional two week window to account for rescheduled visits.*

Intrauterine growth retardation (IUGR): The failure of a fetus to attain its expected growth potential at any gestational stage.

Obstetrical Services: Care rendered during the woman's pregnancy: antepartum care, delivery and postpartum care.

Obstetrical ultrasound: Ultrasound used to image pregnancy; often including evaluation of the uterus and adnexa. In early pregnancy (about five to seven weeks), ultrasound may determine the size of the fetus to confirm the suspected due date, detect multiple fetuses, confirm that the fetus is alive (viable) and confirm location of the pregnancy (intrauterine or ectopic). In the second trimester (about 16-20 weeks), the procedure can confirm fetal growth, reveal defects in the anatomy of the fetus, and check the placenta and amniotic fluid. Toward the end of pregnancy, it may be used to evaluate fetal size, position, growth, or to check the placenta. A screening ultrasound (fetal survey) is recommended at 16-20 weeks gestation.

Pay-To-Provider: The National Provider Identifier (NPI) number submitted on the CMS 1500 form in the primary provider identifier field by the entity (e.g. provider group) contracted with NHP to provide obstetrical services.

Postpartum care: Postpartum hospital and office visits during the postpartum period of 21-56 days following vaginal or cesarean delivery; lactation services provided by the physician up to 56 days following delivery.

Neighborhood Health Plan Reimburses

- Professional obstetrical services at a single all-inclusive global rate to the primary provider for total care including antepartum, delivery and postpartum visits. Clinicians in the same practice, or back-up physicians, coverage providers including physicians, nurse midwives, physician assistants, or nurse practitioners that are owners, partners, employees, or contracted staff at the practice may provide components of the care but are not separately reimbursed.
- One complete obstetric ultrasound exam (real time with image documentation, fetal and maternal evaluation) for routine anatomy screening and dating, per member, for a routine pregnancy.
- An additional ultrasound examination when performed for Down syndrome screening at about 12 weeks gestation, with submission of clinical documentation.
- Medically necessary laboratory studies and test for extensive complications or unusual circumstances outside the global reimbursement rate after review of medical records.
- Additional gynecological services not included in the complete post-partum care visit when diagnosis code V24.1, V24.2, V25.1, V72.3x or V76.2 is submitted.

Neighborhood Health Plan Does *Not* Reimburse

- Services included in the global reimbursement rate.
- Clinicians who may provide components of the global obstetrical services, during antepartum, delivery and postpartum visits, including physicians, nurse midwives, physician assistants, or nurse practitioners, and are owners, partners, employees, or contracted staff at the practice. (The primary provider is the only clinician who may claim payment for the global obstetrical code.)
- Fee-for-service coding for any component of the global obstetrical service if a primary provider bills using the global obstetrical code. These services would be included in the global obstetrical reimbursement.
- Separate antepartum care up to 3 visits, when billed in conjunction with antepartum care, 4 or more visits.
- More than one complete routine ultrasound per low risk pregnancy.
- For delivery of more than one baby delivered by the same method.
- Obstetric ultrasound for sex determination
- Obstetric ultrasound providing a “keep sake” picture
- Uterine artery Doppler screening which is considered to have questionable variables to predict preeclampsia, IUGR, or still birth

Procedures Codes

Note: This list of codes may not be all-inclusive.

Global Obstetrical Services

Code	Descriptor	Comments
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and	Bill for global obstetrical services when services begin prior to 25 weeks

	post partum care	gestation and both delivery and postpartum care are provided. Bill once at the completion of services.
59510	Routine obstetric care including antepartum care, cesarean delivery and post partum care	
59610	Routine obstetric care including antepartum care, vaginal delivery(with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	

Delivery Only, Services

Code	Descriptor	Comments
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	Bill for delivery only services.
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	

Antepartum Care, or Postpartum Care, Only

Code	Descriptor	Comments
	Antepartum care, ONLY 1-3 visits	<ul style="list-style-type: none"> Use the most appropriate E/M code with a count of one; bill for each visit separately. If a total of more than 3 antepartum visits, use only one of the codes below: 59425 OR 59426 which include visits 1-3. NHP will not separately reimburse antepartum care up to 3 visits when billed in conjunction with antepartum care 4+ visits.
59425	Antepartum care, 4-6 visits	Bill either 59425 OR 59426 per pregnancy, on one line, with a count of one, with the date of the final visit.
59426	Antepartum care, 7 or more visits	Bill either 59425 OR 59426 per pregnancy, on one line, with a count of one, with the date of the final visit.
59430	Postpartum care, only	Bill with a count of one, with the date of the final visit.

Delivery Services and Postpartum Care

Code	Descriptor	Comments
59410	Vaginal delivery only (with or without episiotomy and/or forceps) including postpartum care	Bill once, with a count of one at the completion of services.
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	

Modifiers

Modifier	Descriptor	Comments
SA	Nurse practitioner rendering services in collaboration with a physician	Submit for services provided by a nurse practitioner (NP).
SB	Nurse Midwife	Submit for services provided by a certified nurse midwife (CNM).

Provider Payment Guidelines and Documentation

One global obstetrical case payment for total obstetrical care will be made to the “pay to provider” regardless of who rendered the services during the perinatal period.

Services Unrelated to the Pregnancy

Bill separately reimbursable tests and procedures **unrelated to the pregnancy** as they are performed with an evaluation and management code (99211-99215) and the non-pregnancy diagnosis, including supporting documentation in the medical record. An additional diagnosis of V22.x (pregnancy diagnosis codes) and/or V24.2 (postpartum diagnosis codes) is required for payment of all services billed for a pregnant member.

Services Separately Reimbursable From the Global Service

When medically necessary and accompanied by supporting documentation, laboratory services and other services, including but not limited to the following, are separately reimbursed.

Submit bills for separately reimbursable services as they occur.

Laboratory Services Separately Reimbursable

Code	Descriptor
82105 82106	Alpha-fetoprotein (AFP) screening
86762	Rubella antibody screening
87340	Hepatitis B surface antigen
82947	Blood glucose
86900- 86901	Blood typing, ABO
87110 87270 87320	Chlamydia screening
86687	HIV testing/HTLV-1
87081 87084 87086 87088	Culture, bacterial (includes commercial kits and urine cultures)
80055	Obstetrical Panel
86317 86318	Immunoassay for infectious agent assay

85004	Complete blood counts
85007	
85025	
85027	
86593	Syphilis test
84443	Thyroid stimulating hormone testing (TSH)
87269	Giardia screening
87329	

Additional Services Separately Reimbursable

Code	Descriptor	Comment
59000	Amniocentesis, diagnostic	For multiple fetuses, bill 59000 on two lines. Use modifier 59 on line two. For ≥ 2 fetuses, bill with a count ≥ 1 on line 2. Submit documentation for multiple fetuses.
59001	Therapeutic amniotic fluid reduction, including ultrasound guidance	
59012	Intrauterine cordocentesis	
59015	Chorionic villus sampling	
59020	Fetal contraction stress test	
59025	Fetal non-stress test	
59030	Fetal scalp blood sampling	
59070	Transabdominal amnioinfusion with us guidance	
59072	Fetal umbilical cord occlusion, with us guidance	
59074	Fetal fluid drainage, with us guidance	
59076	Fetal shunt placement w us guidance	
59320	Cervical cerclage during pregnancy	
59412	External cephalic version w/wo tocolysis	
76801- 76812 76815- 76817	Ultrasound pregnant uterus	One complete ultrasound for routine screening per pregnancy is standard.
76813 76814	Fetal nuchal translucency	
76818 76819	Fetal biophysical profiles	
96040	Genetic counseling, 30 min	
90384 90385	RhoGAM injection	For administration, submit CPT 96372.
96372	Therapeutic/prophylactic/diagnostic injection, subcutaneous / intramuscular	Use with CPT 93084-93085

Assistant at Surgery

Submit services provided by an assistant at surgery for cesarean delivery with CPT code 59514 or 59620 and one of the following modifiers: 80, 81, or 82.

Individual Billing for Antepartum, or Delivery, or Delivery and Postpartum Care

Obstetrical services provided by a physician who does not perform the global obstetrical services; but performs only antepartum, or delivery, or delivery and postpartum, or postpartum only services are reimbursed with submission of the appropriate code.

Multiple-Birth Delivery

When two different methods are used to deliver the infants, bill the cesarean section under the global delivery CPT code, and the vaginal delivery only, code with modifier “59” appended (Distinct procedural service)*.

**NOTE: There is no additional reimbursement for delivery of more than one baby by the same method.*

The global delivery is paid at one hundred percent (100%) of the fee schedule. The delivery-only service is paid at fifty percent (50%) of the fee schedule. For the delivery-only service, a copy of the operative report must be submitted at the time of billing.

Postpartum Care

When billing a pregnancy diagnosis code (V22.x, V23.x), postpartum care is required for payment of all services billed and considered a component of the global payment. This presumes the post partum service is performed 21-56 days post-delivery. After 56 days, it would be considered a medical service.

NHP will separately reimburse for additional gynecological procedures not included in the complete postpartum check-up when submitted at the post partum visit. A diagnosis code associated with the additional gynecological procedure must be submitted and supported by documentation in the medical record. A complete post-partum diagnosis code: V24.1, V24.2, V25.1, V72.3x or V76.2, must also be submitted.

Related NHP Payment Guidelines

NHP Evaluation and Management Payment Guideline

NHP Modifier Payment Guideline

NHP Laboratory and Pathology Payment Guideline

References

American College of Obstetrics and Gynecology (ACOG) Education Pamphlet AP 133, Routine Tests in Pregnancy, ISSN 1074-860, and Copyright January 2009.

CPT Assistant Fall 94:21, Apr 97:11, Aug 02:3

MassHealth, Provider Manual Series, Community Health Center Manual, Transmittal Letter CHC-83, Section 605, Obstetrics and Surgery Service Codes and Descriptions, Dated 01/01/2009.

Tests During Pregnancy: Abdominal Ultrasound; Joan Lingen, Dept. of Obstetrics and Gynecology, Onely Community Health Center, Onancock, VA via Healthline.com

MassHealth Acute Inpatient Hospital Bulletin Number 136, dated May 2009; **Revised Notification of Birth (NOB-1) Form** available at the following link:

http://www.mass.gov/Eeohhs2/docs/masshealth/bull_2009/aih-136.pdf

Publication History

Topic: Obstetrical Services-Professional	Owner: Provider Network Management
January 19, 2010	<i>Original documentation.</i>
August 3, 2010	<i>Obstetrical anesthesia calculation updated.</i>
October 26, 2010	<i>OB global reimbursement providers updated to include physicians, nurse midwives, physician assistants, or nurse practitioners that are owners, partners, employees, or contracted staff at the practice. Modifier requirement added</i>
November 1, 2011	<i>CPT Assistant quoted re ante-partum care visit billing, disclaimer updated</i>

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Questions may be directed to Provider Network Management at prweb@nhp.org.