



Global Obstetrical Services Payment Policy

Policy

Fallon Community Health Plan (FCHP) reimburses for obstetrical (OB) services when they are determined to be medically necessary and when they meet the medical criteria guidelines indicated below. In some instances, FCHP provider contracts may include the provision of global obstetrical services as defined in this policy.

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Reimbursement

The following services are included in the global obstetrical package related to both vaginal and Caesarean delivery and will not be reimbursed separately when performed by the OB provider.

- Pregnancy test (CPT codes 81025, 84702, 84703)
- All prenatal visits, including initial history and physical examinations
- Urinalysis, initial and subsequent (CPT codes 81000, 81001, 81002, 81003, 81005)
- Glucose tolerance test (82947)
- Specimen collection (CPT code 99000)
- Venipuncture and handling charges (CPT codes 36415 and 36416)
- Labor and delivery (vaginal or cesarean section) services including, but not limited to induction and any internal or external fetal monitoring performed and any obstetrical administered anesthesia except those services otherwise listed (CPT codes 59400, 59510, 59610, 59618)
- Initial evaluation and resuscitation of the newborn by the obstetrician
- Physician standby service (CPT code 99360)
- Episiotomy (CPT code 59300)
- All post-partum care through 6 weeks, including suture removal, Pap smears and discussions on birth control (CPT codes: Q0091 Pap and 99401 birth control counseling)
- Multiple vaginal or multiple cesarean deliveries are all reimbursed under the single global payment
- Supervision of labor
- Delivery of placenta CPT 59414

The following services are not included in the global obstetrical package and are reimbursed separately:

- Professional component of ultrasounds when deemed medically necessary (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76825, 76826, 76827, 76828, 76945, 76946)

- Technical component of ultrasounds (CPT code 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76825, 76826, 76827, 76828, 76945, 76946)
- Fetal biophysical profile (CPT code 76818, 76819)
- Fetal nuchal translucency (CPT code 76813, 76814)
- External cephalic version (CPT code 59412)
- Circumcision (CPT code 54150, 54160)
- RhoGAM™ injection (CPT code 90384, 90385, 90386)
- Cervical cerclage (CPT code 59320, 59325)
- Postpartum D&C (CPT code 59160)
- Antenatal inpatient medical care for **medical complications** of pregnancy. Bill the inpatient CPT codes 99221-99233 as appropriate.
- Other laboratory tests not including urinalysis
- Observation or inpatient hospital care (99217, 99218, 99219, 99220, 99234, 99235, 99236, G0378) not resulting in delivery during the same admission
- Payment for non-obstetrical services provided by an obstetrician during the pregnancy
- Tubal ligation performed alone (CPT codes 58600, 58605, 58611, 58615, 58671), or in conjunction with Caesarean or normal vaginal delivery in accordance with standard payment practice
- In those instances in which there is a vaginal and cesarean delivery, one global payment is reimbursed for the cesarean delivery (59510 or 59618) and one payment for the vaginal delivery only (59409 or 59612) is reimbursed
- Antepartum services:
 - Amniocentesis; diagnostic (CPT 59000)
 - Fetal non-stress test (CPT 59025)
 - Fetal contraction stress test (CPT 59020)
- Therapeutic amniotic fluid reduction, includes ultrasound guidance (CPT code 59001)
- Cordocentesis (intrauterine), any method (CPT 59012)
- Chorionic villus sampling, any method (CPT 59015)
- Fetal monitoring during labor by consulting physician

Referral/notification/preauthorization requirements

PCP referrals are not required for routine OB care when the member receives care with a specialist in the member's product network.

Billing/coding guidelines

Do not bill separately for services included in the global reimbursement. Only one claim should be submitted after the delivery, following all services by a single provider (example: provided pre-natal visits, a normal vaginal delivery, and post-partum services submit **only** CPT code 59400). Bill separately reimbursable tests and procedures (unrelated to the pregnancy) as they are performed with an evaluation and management code (99211-99215) along with problem diagnosis as primary. A secondary diagnosis of v22.x (pregnancy dx codes) and/or V24.2 (post-partum) is required for payment for all services billed for a pregnant patient.

If a physician or provider provides all of the services (e.g., pre-natal/post-partum) that are part of the global obstetrical package, submit claims using the following guidelines:

- CPT code 59400 for vaginal delivery
- CPT code 59510 for C-section delivery
- CPT code 59610 for vaginal delivery, after previous C-section; or
- CPT code 59618 for C-section delivery, following attempted vaginal delivery after previous C-section.

The CPT code for tracking pre-natal visits is 99024. Do not bill separately for services included in the global reimbursement. Bill separately reimbursable tests and procedures as they are performed.

If a physician or provider provides all or part of the antepartum/prenatal and/or postpartum patient care but does not perform the delivery, submit claims using the following guidelines:

- 1 to 3 antepartum care visits only have been performed, bill the appropriate evaluation and management code and the appropriate diagnosis (new 99201 – 99205, established 99211 – 99215)
- 4 to 6 antepartum care visits only have been performed, bill CPT code 59425 – antepartum care only; 4 to 6 visits. One unit of service is billed with code 59425 and is inclusive of all 4 to 6 visits. Bill one line of service with the last date of service.
- 7 or more antepartum visits are performed, bill CPT code 59426 - antepartum care only; 7 or more visits. One unit of service is billed with code 59426 and is inclusive of 7 or more visits. Bill one line of service with the last date of service.

If a physician or provider performs delivery only, submit claims using the following guidelines:

- CPT code 59409 for vaginal delivery
- CPT code 59514 for C-section delivery
- CPT code 59612 for vaginal delivery, after previous C-section; or
- CPT code 59620 for C-Section delivery, following attempted vaginal delivery after previous C-section

To bill for multiple birth deliveries when two different methods are used to deliver:

- CPT code 59510 or 59618. Reimbursement will be 100% of the global fee schedule.
- CPT code 59409-51 or 59612-51. Reimbursement will be 50% of delivery only fee schedule.

Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, and Midwife Services

Use modifier SB for all Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialist (CNS) services billed.

Use modifier BA for midwife services billed.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	03/01/01
Previous revision date(s):	01/08/08
Connection date and details:	September 2009 – moved to new template; updated language to indicate that services included in the global obstetrical package will not be reimbursed if billed separately; removed repeat glucose tolerance test (82947) from list of services that are reimbursed separately from the global.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.