



Obstetrics/Gynecology Payment Policy

Policy

Fallon Community Health Plan (FCHP) reimburses for obstetrical (OB) and gynecology (GYN) 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

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care
- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®
- NaviCare®

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 Caesarean 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, G0101, and 99401)
- 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

Obstetrical Ultrasound

FCHP will reimburse one complete ultrasound exam (real time with image documentation, fetal and maternal evaluation) for routine anatomy screening and dating per member per routine pregnancy. Subsequent ultrasound examinations will be denied as not medically necessary unless billed with a non-routine ICD-9 code in the primary diagnosis position on the claim.

FCHP will not reimburse ultrasound in maternity care for:

- Sex determination
- Providing a keepsake picture of the fetus
- To view the fetus only
- More than one complete examination performed in the absence of specific clinical indications

Nuchal Translucency Testing

FCHP reimburses nuchal translucency testing (76813, +76814) based upon the member's medical risk factor and medical necessity as determined by the OB/GYN.

FCHP will **not** reimburse for G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) when billed on the same date of service as an E&M service (99201-05; 99211-15).

FCHP will **not** reimburse for Q0091 (screening Pap smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) when billed on the same date of service as an E&M service (99201-05; 99211-15).

Referral/notification/prior authorization requirements

Summit ElderCare requires prior authorization for all non-emergency outside services. Please contact the referring Summit ElderCare PACE site for assistance.

NaviCare® requires that all non-emergency services be authorized in advance. Please contact an Enrollee Service Representative at 1-877-700-6996 for assistance.

PCP referrals are not required for most OB or GYN care when the member receives care with a specialist in the member's product network. The ordering physician is required to obtain prior authorization for:

- Unlisted CPT codes
- The applicable codes found on the List of Procedures Requiring Prior Authorization located in the Managing Patient Care section of the *Provider Manual* under PCP Referral and Plan Prior Authorization Process.

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.
- Do not bill separately for services included in the global reimbursement. Bill separately reimbursable tests and procedures as they are performed.

The CPT code for tracking postpartum visits is 99024.

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.

Obstetrical ultrasound

FCHP will reimburse one complete ultrasound exam (real time with image documentation, fetal and maternal evaluation) for routine anatomy screening and dating per member per routine pregnancy. Subsequent ultrasound examinations will be denied as not medically necessary unless billed with a non-routine ICD-9 code in the primary diagnosis position on the claim.

Procedure code	Description
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)

ICD-9 Codes indicating service is routine:

ICD-9 Code	Description
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.3	Pregnancy with grand multiparity
V23.7	Insufficient prenatal care
V23.84	Supervision of high-risk pregnancy of young multigravida
V23.85	Pregnancy resulting from assisted reproductive technology
V28.3	Antenatal screening for malformation using ultrasonics
V28.9	Unspecified antenatal screening

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

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

Use modifier SB 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 11/01/2009 - 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.
Connection date & details:	May 2011- Corrected typo that incorrectly identified that modifier BA should be used for midwife services; added G0101 to list of services included in the global OB payment; corrected description for using CPT code 99024 for postpartum rather than pre-natal tracking visits; added language discussing limited reimbursement for routine OB ultrasounds; and renamed policy to reflect discussion of services beyond those included in the global reimbursement.

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. FCHP routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.