REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Original Issue Date	Next Annual Review	Effective Date
06/10/2015	06/01/2019	06/01/2018
Policy Name		**Policy Number**
Global Obstetrical Services		PY-0001
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

Global Obstetrical Services

This Global Obstetrical Services policy applies only to the CareSource contracted providers whose contracts specifically mention and include global obstetrical billing codes, with designated, negotiated rates.

If you are contracted as a CareSource provider but your contract does not have a section specifically for Global Obstetrical Services and/or does not list specifically negotiated rates for global obstetrical codes, this policy does not apply to you and you will not be reimbursed for global obstetrical codes under its guidelines.

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 as 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).
- **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.
- **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, or are past their due date and not naturally in labor yet. 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. *(OAC 3701-7-01 (L), "Fetal death")*
- **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." *(OAC 3701-7-01 (Q), "Lactation Consultant")*
- **Maternity Global -** Services provided in uncomplicated maternity cases including antepartum care, delivery and postpartum care. This is a fixed payment, billable upon delivery, and must meet guidelines for payment outlined below. The date of the delivery is the date of service to be used when billing the global prenatal codes **See Requirements regarding use of CPT II codes.** Global services must encompass the Antepartum/Delivery/Postpartum periods as defined below. Services considered part of the global obstetrical package will not be reimbursed separately. It may be appropriate to reimburse more than one provider for antepartum care when the patient transfers care during the antepartum period. If that happens, global billing is disallowed, and the providers then must use split global or partial global billing.
- **Maternity Split Global or Partial Global**- services provided by multiple providers during the Antepartum/Delivery/Postpartum periods of maternity care as defined in this policy. CPT codes for antepartum care only, delivery only, delivery including postpartum care, and postpartum care only, should be used when criteria is met for splitting the global obstetrical package. Report the services performed using the most accurate, most comprehensive procedure code available. **See circumstances that meet criteria for split global billing noted on page 7, section "Criteria for Splitting Global Obstetrical Services.**
  - **Split Global**: Delivery only or Medicaid antepartum
  - **Partial Global:** Delivery and postpartum or Medicaid antepartum
- **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)*
- **Physician** - means an individual authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. *(OAC 3701-55-01 (I), "Physician")*
- **Physician group, Physician group practice** - means a clinic or an obstetric clinic either with an electronic health record (EHR), or where there is no EHR, but one member record and each physician/nurse practitioner/nurse midwife seeing that member has access to the same member record and makes entries into the record as services occur. All locations of a multi-location clinic with an EHR (or one patient record) are considered the same physician group practice.
- **Preconception care** - means Medicaid-covered preventive medicine services provided prior to a pregnancy for the purpose of achieving optimal outcome of future pregnancies.

D. POLICY

I. Prior Authorization

Prior authorization is not required for the global obstetrical and maternity services covered under this policy.

NOTE: Although the global obstetrical services covered by this policy do not require a prior authorization, CareSource may request documentation to support medical

necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

II. Maternity Coverage-General
   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 ~~90~~ 60 days after C-section).
      1 . 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 when provided by or under the supervision of a medical doctor, osteopath, or eligible maternity provider.
      2. Maternity services may include the following:
         2.1 Pregnancy testing/laboratory tests
         2.2 Office visits
         2.3 Ultrasounds
         2.4 Fetal delivery
         2.5 Postpartum 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)
   C. Coding Guidelines
      The delivery date is used as the date of service for:
      1. Any obstetrical global code.
      2. Most antepartum care codes.
      3. Any delivery-only code.
      4. Any delivery + postpartum code.
      5. Any postpartum care only code.

III. Criteria for Global Billing and Summary of Bundled Services
   A. As part of the global, partial global/split requirements, providers must complete the Pregnancy Risk Assessment Form. Providers 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.
   B. 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. The global obstetrical package code may only be claimed when one physician, one certified advanced practice nurse midwife, or the same physician group practice provides all of the patient’s routine obstetric care, which includes the antepartum care, delivery, and postpartum care.
      1. Global services will be reimbursed only when care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, and care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, vaginitis).
      2. A single, assigned physician or certified advanced practice nurse midwife within the same physician group practice is responsible for overseeing patient care during the member’s pregnancy, delivery, and postpartum care. The group practice (or clinic)

should bill globally for all prenatal, delivery, and postpartum care services provided with the group practice (or clinic) using the primary care physician's individual National Provider Identifier (NPI) as the performing provider.

D. Billing for global services cannot be done until the date of delivery
E. Only one prenatal care code may be claimed per pregnancy.
F. Global Obstetrical Package – Stages
   1. Maternity care and the global obstetrical package have three (3) distinct stages: antepartum care, delivery, and postpartum care. The global obstetrical package includes a large number of services which are considered bundled into the global obstetrical code or the antepartum care, delivery, and postpartum care codes and are not eligible to be reported separately. The bundled services are:
      1.1 Stage I: Antepartum Care
         a. Antepartum care begins with conception and ends with delivery. Antepartum care includes the following services which may not be billed separately:
            (1) Initial history and physical, subsequent physical exams, and routine urinalysis.
            NOTE: Please report the initial prenatal visit with CPT code (category II code) 0500F (Initial prenatal care visit) with a date of service of the initial prenatal visit as a no-charge line item.
            (2) Monthly visits up to 28 weeks of gestation.
            (3) Biweekly visits to 36 weeks gestation.
            (4) Weekly visits from 36 weeks until delivery.
            (5) Pap smear at first prenatal visit. This applies only to the Pap smear procedure. The laboratory processing is separately identifiable and payable.
            (6) Education on breast feeding, lactation and pregnancy (HCPCS level II codes S9436–S9438, S9442–S9443)
            (7) Exercise consultation or nutrition counseling during pregnancy (HCPCS level II codes S9449–S9452, S9470)
         b. At each of these visits, the recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis (code 81000 or 81002) are included as part of the global obstetrical package. Therefore, these services are not reported separately.
         c. The initial visit to establish pregnancy is covered under the member's medical benefit.
         d. Once the pregnancy has been confirmed, the global maternity period begins.
         e. Only one antepartum care code may be billed per pregnancy.

      1.2 Stage II: Intrapartum Care or Delivery
         a. Delivery begins with the passage of the fetus and the placenta from the womb into the external world.
         b. Delivery care includes the following services which may not be billed separately:
            (1) Admission to hospital
            (2) Admission history and physical exam
            (3) Management of labor including fetal monitoring
            (4) Placement of internal fetal and/or uterine monitors
            (5) Catheterization or catheter insertion
            (6) Preparation of the perineum with antiseptic solution
            (7) Delivery, any method:
               i. Vaginal delivery with or without forceps or vacuum extraction.
               ii. Cesarean delivery.

(8) Delivery of the placenta, any method (59414, Delivery of placenta (separate procedure)), may not be separately coded in addition to the code for the delivery service). (AMA1, 3)
(9) Injection of local anesthesia.
(10) Induction of labor with pitocin or oxytocin. This is considered an inherent part of the delivery service(s) provided. There is no separate procedure code assignment for this service. (AMA1, 6)
(11) Artificial rupture of membranes (AROM) before delivery. This is an inclusive component of the delivery code reported. Therefore, it would not be appropriate to report a separate code for this service. (AMA1, 9)

1.3 Stage III: Postpartum Care
a. Postpartum care begins after delivery. Postpartum care includes the following services which may not be billed separately:
(1) Exploration of uterus.
(2) Episiotomy and repair.
(3) Repair of cervical, vaginal or perineal lacerations. (AMA1, 4, 5)
(4) Placement of a hemostatic pack or agent.
(5) Recovery room visit.
(6) Hospital visits.
(7) Office visits or home visits (e.g. midwife care) during the Maternity Global Period.
(8) Education and assistance with lactation, breast and nipple care, and breast feeding.
b. CareSource will reimburse:
(1) One provider for delivery
(2) One provider for postpartum CareSource
(3) One assistant surgeon for a cesarean delivery, if documented
c. The postpartum visit should be reported as a no-charge line item with the date of service.

IV. Criteria for Splitting the Global Obstetrical Services:
A. Maternity care and delivery may be billed as a single code except when the following circumstances occur which require the package to be broken into components.
1. The member has a change of insurer during her pregnancy
2. The member has received part of her antenatal care elsewhere, e.g. from another group practice
3. The member leaves her care with your group practice before the global obstetrical care is complete
4. The member must be referred to a provider from another group practice or a different licensure (e.g. midwife to MD) for a cesarean delivery
5. The member has an unattended, precipitous delivery
6. Termination of pregnancy without delivery (e.g. miscarriage, ectopic pregnancy)
B. Billing a Split Obstetrical Package
1. CPT codes for antepartum care only, delivery only, delivery including postpartum care, and postpartum care only are provided for use when criteria is met for splitting the global obstetrical package. Report the services performed using the most accurate, most comprehensive procedure code available.

V. Delivery of Multiple Gestations
A. Global billing for multiple gestations should include one global procedure code and a “delivery only” code for each subsequent delivery. The specific codes submitted depend on the method of delivery and number of infants delivered. For deliveries of more than one newborn, submit all delivery charges, any global services, and any additional surgical services from the date of delivery on the same claim, with the appropriate

diagnosis code for the multiple gestations.

B. Multiple surgery fee reductions apply to multiple delivery services for multiple gestations. The code submitted for the second delivery and any subsequent deliveries should include a modifier 51 and a modifier 59 to indicate separate newborn.
C. In most cases the delivery of the first newborn is considered primary and allowed at 100% and the delivery of all subsequent newborns are considered secondary and reimbursed at 50% of the contracted allowable. An exception to this rule may occur if the global obstetrical service cannot be billed for the first newborn and the subsequent newborn is delivered by cesarean.

VI. Limitations on Elective Obstetric Deliveries
A. Reimbursement for any cesarean section, labor induction, or any delivery following labor induction is subject to the following criteria:
1. Gestational age of the fetus must be determined to be at least 39 weeks;
2. If a delivery occurs prior to 39 weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery.
B. Any labor inductions or cesarean sections prior to 39 weeks gestation that are not properly documented as medically necessary are not eligible for reimbursement.

VII. Maternity Services Not Reimbursed to Provider
A. Home pregnancy tests
B. Ultrasounds performed only for determination of sex of the fetus or to provide a keepsake picture
C. Three and four dimensional ultrasounds
D. Paternity testing
E. Lamaze classes
F. Birthing classes
G. Parenting classes
H. Home tocolytic infusion therapy

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting pre-negotiated global obstetrical CPT codes where applicable, and Ohio Medicaid-approved HCPCS and CPT codes along with appropriate modifiers. Please refer to your CareSource provider contacts for the global obstetrical codes, and the Ohio Medicaid fee schedule.

http://medicaid.ohio.gov/Portals/0/Providers/FeeScheduleRates/App-DD.pdf

The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced source for the most current coding information.

I. CareSource requires that all delivery charges, antepartum care, postpartum care, and any additional surgical services from the date of delivery (e.g., 58611 tubal at time of cesarean delivery) be submitted on the same claim.

II. For antepartum care only (1 to 3 visits) 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.

III. 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. For example:

A. Surgical procedure such emergency C-Section due to fetal distress
B. Atypical office visits and laboratory tests needed due to member or fetal anomalies
C. Other services (such as hospital, radiology, pharmaceutical, blood and blood derivatives).

IV. Delivery

Labor and delivery services are based on the need of each individual patient and can include 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.

A. Vaginal Delivery Reporting
   1. Primary delivery service code: 59400 or 59610
      1.1. Each additional delivery code: 59409-51 or 59612-51
      1.2. If the additional service becomes a cesarean delivery, then report the primary delivery service as a cesarean delivery: 59510 or 59618
B. Cesarean Delivery Reporting
   1. Primary delivery service code: 59510 or 59618
      1.1. No additional procedural delivery code should be used; only a single cesarean delivery service is to be reported no matter how many live births.
      1.2. Modifier 22 should be added to support substantial additional work
C. 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.
D. Maternity Management Services

   Claims for maternity management services should record a valid CPT or HCPCS procedure code for each service provided and an appropriate ICD-10 diagnosis code to indicate an encounter for maternity management

Codes	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) may not be separately coded in addition to the code for the delivery service). (*AMA1, 3*)
59425	Antepartum care only; 4-6 visits (Units = 1)
59426	Antepartum care only; 7 or more visits (Units = 1)
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

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	06/10/2015	Policy created.
Date Revised	10/18/2017	Revised to include updated criteria and codes.
Date Effective	06/01/2018	

H. REFERENCES

1. CPT ® Current Procedural Terminology. American Medical Association. (2017). Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page
2. Labor Induction: Resource Overview - ACOG. (2017, September). Retrieved from https://www.acog.org/Womens-Health/Labor-Induction
3. Ohio Administrative Code. (2015). Retrieved June 11, 2015, from http://codes.ohio.gov/oac/3701-40-01
4. OAC Rule 5160-1-10 Limitations on Elective Obstetric Deliveries
5. American Association of Critical Care Nurses Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, 2015.
6. American Academy of Pediatrics, American College of Obstetrics and Gynecologists. Guidelines for perinatal care. 7th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetrics and Gynecologists; 2012.

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