Reimbursement Policy

Obstetrical

**Policy Number:** WS 4.25  
**Version Number:** 6  
**Version Effective Date:** 07/01/2016

<table>
<thead>
<tr>
<th>Product Applicability</th>
<th>□ All Plan* Products</th>
</tr>
</thead>
</table>
| Well Sense Health Plan | □ New Hampshire Medicaid  
□ NH Health Protection Program |
| Boston Medical Center HealthNet Plan | □ MassHealth  
□ Qualified Health Plans/ConnectorCare/Employer Choice Direct  
□ Senior Care Options |

Note: Disclaimer and audit information is located at the end of this document.

**Policy Summary**

The Plan reimburses covered services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy. This policy applies to Physicians, Advanced Registered Nurse Practitioners, Midwives, and Freestanding Birthing Centers within their respective scope of practice.

**Prior-Authorization**


* Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
Definitions

Please note that these definitions are only applicable to global reimbursement and do not define a primary care provider for the purposes of participating with the Plan.

Primary Provider - A physician or independent nurse midwife who has assumed responsibility for performing or coordinating the prenatal, delivery, and/or postnatal care for a member. The Primary Provider is not required to perform all the components of the global code directly, and may refer components of care to a Coverage Provider. However, the Primary Provider is the only clinician that may claim payment for a global obstetrical code.

Coverage Provider - Clinicians in the same practice, or back-up physicians, are considered a Coverage Provider for the purpose of this policy. Coverage Providers may be physicians, nurse midwives, physician assistants, or nurse practitioners that are owners, partners, employees, or contracted staff at the practice in which the Primary Provider practices. Coverage Providers may also be physicians who have special arrangements with a Primary Provider to provide practice coverage.

Non-Coverage Provider - A Non-Coverage Provider is any provider that has no employment, contractual, or practice-coverage relationship with the Primary Provider, or his or her practice.

Freestanding Birthing Centers

Freestanding birthing centers are reimbursed a one-time fee per delivery inclusive of all facility services and supplies. Services must be reported with 59409.

When a member is transferred from a freestanding birthing center to a hospital, the freestanding birthing center must report modifier 52.

Practitioner Global Reimbursement

The Plan utilizes the most currently published global coding system developed by the AMA to identify different components of obstetrical care. Failure to provide these minimal requirements when billing the below obstetrical global codes will result in claim denial or retractions.

Antepartum, Delivery and Postpartum Global Codes

The following Criteria must be met in order for Antepartum, Delivery and Postpartum Global Codes to be billed:

- The Primary Provider or an associated Coverage Provider must render at minimum 3 prenatal visits, the delivery, and one postpartum visit.
- The first prenatal visit must occur on or before the 28th week of gestation.
- Providers must bill the Plan using the date of delivery as the date of service. All claims must be billed to the Plan after the date of delivery or the claim will deny.
• When a member is enrolled into the Plan during a pregnancy, and the number of visits that will occur is less than the number required to bill a global code (at least 3 visits, the delivery and a postpartum visit), the provider must bill using the fee-for-service method described later in this policy.
• ICD-10-CM code Z32.01 (Encounter for pregnancy test, result positive) should be reported for the initial obstetric visit when the pregnancy is confirmed but the antepartum record is not initiated. Reimbursement for the pregnancy test is only allowed if the member’s primary care provider hasn’t already informed the obstetrician of a pregnancy. Once pregnancy is identified, any subsequent tests are included in the global reimbursement amount.

Payment for the following services is included in the payment for the antepartum, delivery and postpartum global code, and neither the primary provider, nor any coverage providers should bill the Plan for any procedure or service listed below if a global delivery code is used:

• Hygiene and nutrition
• Infant feeding and breast care
• Obstetrical anesthesia
• Physiology of Labor
• Transportation plans
• Home assistance during the postpartum period
• Newborn care plans
• All prenatal visits, including initial history and physical examinations (E&M services)
• 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 anesthesia performed except those otherwise identified
• Local anesthesia
• Episiotomy or vaginal repair, by other than attending physician
• Insertion of cervical dilator
• All in hospital postpartum care and outpatient postpartum visits through six weeks, including suture removal and pap smears – Note: One postpartum skilled nursing home visit is paid separately from all global coding. Reference the Home Health reimbursement policy for further guidance.
• Any service code used as a replacement to those identified in this policy, or which is used to perform the same function
• Urinalysis by dip stick

**Antepartum Only Global Coding**

Antepartum global codes should be used, in accordance with CPT guidelines. One unit of service is billed. Bill one line of service and identify the last date of service rendered. This code is allowed once per member per pregnancy episode.

---

*Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.*
Services Included in Antepartum Only Global Codes:
- Hygiene and nutrition
- Infant feeding and breast care
- Obstetrical anesthesia
- Physiology of labor
- Transportation plans
- Home assistance during the postpartum period
- Newborn care plans
- All prenatal visits, including initial history and physical examinations (E&M services)

Delivery and Postpartum Care Only Coding
If a physician performs both the delivery and postpartum care, but not the prenatal care, claims should be submitted using the delivery and postpartum care only codes. Only one unit of service is billed. All claims must be submitted with the date of delivery as the date of service.

Services Included in Delivery and Post-Partum Only Coding:
- Transportation plans
- Home assistance during the postpartum period
- Pediatric care plans
- 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 anesthesia performed except those otherwise identified
- Local anesthesia
- Episiotomy or vaginal repair, by other than attending physician
- Insertion of cervical dilator
- All in hospital postpartum care and outpatient postpartum visits through six weeks, including suture removal and pap smears – Note: One postpartum skilled nursing home visit is paid separately from all global coding

Multiple Vaginal Deliveries and Global Coding
When billing for multiple vaginal births providers should bill the global delivery code on one claim line, and bill a second claim line that includes the delivery only code for a vaginal delivery, with the modifier 51 appended. Report multiple gestations with the applicable diagnosis code. All delivery services must be billed on the same claim form.

- Example: Twins
  Line 1: 59410 with 1 unit
  Line 2: 5940951 with 1 unit

Claims submitted to the Plan for vaginal delivery of multiple births will be reimbursed at 100% of the contractual rate for the global code, and 50% of the contractual rate for the second delivery (billed with the delivery only code and modifier 51).

*Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
Multiple Cesarean-Section Deliveries and Global Coding
When billing the Plan for multiple deliveries that do not include a vaginal delivery global code, providers may not submit additional coding for the second or subsequent deliveries since only one incision is made. For complicated deliveries involving multiple births, providers must submit with the global code and modifier 22, as well as submit supporting documentation that identifies the complexity of the procedure. The Plan will evaluate the medical documentation submitted and determine an appropriate reimbursement rate where applicable.

Separately Billable Services
Separately billable services may include, but are not limited to the following:

- Payment for non-obstetrical services provided by an obstetrician, a Coverage Provider, or the Primary Provider during the pregnancy
- Anesthesia services according to the guidelines established in the Plan’s Anesthesia Payment Policy
- Counseling specific to high-risk members (e.g. antepartum genetic counseling)
- Evaluation and testing (for example, amniocentesis and ultrasounds)
- Specialized care (for example, treatment of premature labor)
- Childbirth classes

Providers may now be reimbursed for identifying overall needs of pregnant women, and are encouraged to use standardized risk assessment forms. This service may be billed once per pregnancy, in addition to global or individual services, and must:

- Address risk status relative to overall health, family/social support, and the use of alcohol, tobacco and other substances.
- Be provided by an MD or ARNP during the first 14 weeks of pregnancy.
- Be documented by an assessment form retained in the medical record.
- Be billed with procedure code H1000.

Practitioner Fee-For-Service Billing Guidelines
Providers may bill for antepartum, the delivery, and postnatal services separately when a global code is not applicable. The following guidelines apply to fee-for-service billing and must be followed to avoid claim denials or retractions. At no time should fee-for-service services for a routine pregnancy be billed in combinations that result in reimbursement that is higher than the global reimbursement amount. Additionally, coverage providers cannot use the fee-for-service coding method to bill for any component service if a primary provider bills using a global code.
Claims submitted to the plan with a diagnosis of Routine Pregnancy will be audited to determine if payments exceed the amount that would have been paid using global coding. If the Plan detects an overpayment upon review of the documentation submitted, the overpayment will be retracted.

**Antepartum Only Services**
If only one to three antepartum care visits have been performed, bill the appropriate evaluation and management code and the appropriate diagnosis. Each claim billed should identify the actual date(s) of service rendered.

**Delivery Only Services**
If a physician performs only the delivery, submit claims using the actual delivery date of service.

- **Multiple Births (Delivery Only)**
  When billing for multiple vaginal births, the first delivery should be billed with the delivery only code applicable to the form of delivery. Second and subsequent vaginal deliveries should be billed on separate lines using the same delivery code used for the primary birth, with modifier 51 appended. Providers may not submit additional coding for the second or subsequent cesarean deliveries, since only one incision is made. All deliveries must be billed on the same claim form and contain the same date of service.

  - Example: Twins
    Line 1: 59409 with 1 unit
    Line 2: 5940951 with 1 unit

  **Note:** If the case requires additional services, the provider should submit modifier 22 with the delivery only code applicable to the delivery type, and submit supporting documentation substantiating any additional reimbursement sought by the provider.

**Postpartum Care Only Services**
When a physician renders only postpartum care, CPT code 59430 should be used, irrespective of the type of delivery. The actual date of service of the postpartum office visit should be billed on the claim form.

**Service Limitations**
The following services shall not be reimbursed:

- Any service for which there is no medical necessity or for which the medical necessity has not been established
- Services which are not medical in nature, except for transportation
- Experimental or investigational procedures
- Services that have not been proven to be safe or effective, as documented in medical peer review literature

*Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.*
• Services which are more costly than other services which could be expected to provide the recipient with the same outcome

**Applicable Coding and Billing Guidelines**

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antepartum, Delivery and Postpartum Global Coding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59400</td>
<td>Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</td>
<td>Primary Provider must render a minimum of 3 prenatal visits, the delivery and one postpartum visit. The first prenatal visit must occur before the 28th week of gestation. All claims must be submitted with the date of delivery as the date of service.</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetrical care including antepartum, cesarean delivery, and postpartum care</td>
<td></td>
</tr>
<tr>
<td>59610</td>
<td>Routine obstetrical care including antepartum, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery</td>
<td></td>
</tr>
<tr>
<td>59618</td>
<td>Routine obstetrical care including antepartum, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery</td>
<td></td>
</tr>
<tr>
<td>Antepartum Only Global Coding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59425</td>
<td>Antepartum care only; between 4 and 6 visits</td>
<td>One unit of service is billed. Bill one line of service and identify the last date of service rendered. This code is allowed once per member per pregnancy episode.</td>
</tr>
<tr>
<td>59426</td>
<td>Antepartum care only; 7 or more visits</td>
<td></td>
</tr>
<tr>
<td>Delivery and Postpartum Care Only Coding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59410</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care</td>
<td>Only one unit of service is billed. All claims must be submitted with the date of delivery as the date of service.</td>
</tr>
<tr>
<td>59515</td>
<td>Cesarean delivery only; including postpartum care</td>
<td></td>
</tr>
<tr>
<td>59614</td>
<td>Vaginal delivery after previous cesarean (with or without episiotomy and/or forceps); including postpartum care.</td>
<td></td>
</tr>
</tbody>
</table>

*Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.*
Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59622</td>
<td>Cesarean delivery following attempted vaginal delivery after previous cesarean delivery; including postpartum care</td>
</tr>
</tbody>
</table>

**Delivery Only Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean delivery only</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery</td>
</tr>
</tbody>
</table>

**Postpartum Care Only Code**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59430</td>
<td>Postpartum care only (separate procedure)</td>
</tr>
</tbody>
</table>

The actual date of service of the postpartum office visit should be billed on the claim form.

**Policy History**

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/06/2012</td>
<td>12/01/2013</td>
<td>Payment Policy</td>
<td>Payment Policy Committee</td>
</tr>
</tbody>
</table>

**Policy Revisions History**

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/2014</td>
<td>Added ICD-10 coding</td>
<td>03/01/2014</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>04/03/2014</td>
<td>Added Freestanding birthing center reimbursement; Removed home birth exclusion</td>
<td>04/03/2014</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>07/31/2014</td>
<td>Updated revision effective date to 9/1/2014 and added New Hampshire Health Protection Program check box</td>
<td>07/31/2014</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>12/22/2014</td>
<td>Annual Review</td>
<td>01/01/2015</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>06/15/2016</td>
<td>Annual Review, new template</td>
<td>07/01/2016</td>
<td>Payment Policy Committee</td>
</tr>
</tbody>
</table>

* Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.
Next Review Date

2018

Other Applicable Policies

- General Billing and Coding, policy number WS 4.17
- General Clinical Editing and Payment Accuracy Review Guidelines, policy number WS 4.18
- Physician and Non-Physician Practitioners, policy number WS 4.28
- Modifier, policy number WS 4.23

References

- Contract between New Hampshire Medicaid Care Management, and Boston Medical Center HealthNet Plan MassHealth
- General Court of New Hampshire Chapter He-W 500 Medical Assistance Section 548, Extended Services to Pregnant Women

Disclaimer Information

This Policy provides information about the Plan’s reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member’s benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan’s discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan’s audit policies, refer to the Provider Manual.