	03/01/2024
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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.

A. Subject

Obstetrical Care -Unbundled Cost

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a P H P E H U ¶ V H O L J L E L O L W \

It is the responsibility of the submitting provider to submit the most accurate and appropriate Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/International Classification of Disease-10(ICD-10) code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply a right to reimbursement or guarantee claims payment.

Obstetrical care refers to the health care treatment given in relation to pregnancy and delivery of a newborn child. This includes 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 reimbursement will serve as the S U R Y L G H U ¶ V F H U W L I L F D W L R Q 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 CPT codes, HCPCS codes and/or revenue codes. The codes denote services and/or procedures performed. The billed codes must be fully supported in the medical record. Unless otherwise noted, this policy applies only to participating providers and facilities.

This policy is for practitioners who meet either of the following:

- obstetrical practitioners not part of a free standing birthing center
- obstetrical practitioners part of a Free Standing Birthing Center when any of the following occur:
  - It is the preferred method of billing
  - The member has a change of insurer during pregnancy
  - The member has received part of the antenatal care elsewhere (eg, from another group practice)
  - The member leaves W K H S U D F W L F H before the global obstetrical care is complete
  - The member must be referred to a provider from another group practice or a different licensure (eg, midwife to medical doctor) for a cesarean delivery
  - The member has an unattended precipitous delivery

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

- Termination of pregnancy without delivery (eg, miscarriage, ectopic pregnancy)

C. Definitions

- Initial and Prenatal Visit - A practitioner visit to determine whether a member is pregnant.
- Freestanding Birthing Center (FBC) - Birth centers are freestanding facilities that are not considered hospitals, providing peripartum care for low-risk women with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth.
- High Risk Delivery - Labor management and delivery for an unstable or critically ill pregnant patient.
- Pregnancy - For the purpose of this policy, pregnancy begins on the date of the initial visit in which pregnancy was confirmed and extends for 280 days.
- Premature Birth - Delivery before 37 weeks of pregnancy is completed.
- Prenatal Profile - Initial laboratory services.
- Unbundled Obstetrical Care - The practitioner bills delivery, antepartum care, and postpartum care independently.
  - Antepartum Care - Defines basic care (including obtaining and updating subsequent medical history, physical examination, recording of vital signs, and routine chemical urinalysis) provided monthly up to 28 weeks gestation, biweekly thereafter up to 36 weeks gestation, and weekly thereafter until delivery.
  - Delivery - Includes admission to a facility, medical history during admission, physical examinations, and management of labor (either by vaginal delivery or by cesarean section).
  - Postpartum Care - The time period that begins on the last day of pregnancy and extends through the end of the month in which the 60 day period following termination of pregnancy ends. The American College of Obstetricians and Gynecologists (W* n-4(386.are)12( )] TJ ET Q q 0T Q q TJicians (el)8(i)1.04 Tf 1 s 0T Q

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2. Any eligible woman who meets any of the risk factors listed on the Pregnancy Risk Assessment Form (PRAF) is qualified for case management services for pregnant women and should be referred to CareSource for further screening for those case management services.

C. Unbundled Obstetric Care - The practitioner will bill antepartum care, delivery, and postpartum care independently of one another.
   1. Antepartum care only - does not include delivery or postpartum care:
      a. Use the appropriate E/M code and trimester code(s).
      b. Use the appropriate modifier, if applicable.
   2. Delivery only - Use if only a delivery was performed
      a. Deliveries must be greater or equal to 20 weeks gestation to be billed as a delivery.
      b. Use the appropriate CPT and delivery outcome code(s):

      c. Services (This list may not be all inclusive):

Services included that0 g 0 GMsa

14. caesarean delivery following unsuccessful vaginal delivery attempt after previous cesarean delivery

4. Postpartum care only, if postpartum care only was provided:
   a. Use code 59430 postpartum care only.
   b. Only one code 59430 can be billed per pregnancy as this includes all E/M pregnancy related visits provided for postpartum care.
   c. There is no specified number of visits included in the postpartum code. This includes hospital and office visits following vaginal or cesarean section delivery. ACOG recommends contact within the first 3 weeks postpartum.
   d. Postpartum care may include and therefore is not allowed to be billed separately for the following (not an all inclusive list):
      01. office and outpatient visits following cesarean section or vaginal delivery
      02. qualified health care professional providing all or a portion of antepartum/postpartum care, but no delivery due to referral to another physician for delivery or termination of pregnancy by abortion
   e. The following are billable separately during the postpartum period (This list may not be all inclusive):
      01. conditions unrelated to pregnancy (eg, respiratory tract infection)
      02. treatment and management of complications during the postpartum period that requ g 0 G elated to pregnancy

B. Modifier 22 should be added to the delivery code to support substantial additional work. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

The following list of codes is provided as a reference. This list may not be all inclusive and is subject to updates.

CPT Code	Description
E/M	For antepartum 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

Obstetrical Care ±