Obstetrics and Gynecology Payment Policy

Policy

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

Reimbursement

Global Obstetrical Package

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 routine prenatal visits, including initial history and physical examinations until delivery (typically 13 visits).
- 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.
- Observation or inpatient hospital care (99217-99220 Initial Observation, 99221-99223 Initial Hospital, 99231- 99233 Subsequent hospital, 99234-99236 Observation or Inpatient care 99238-99239 Hospital discharge, and G0378 Hospital Observation per hour).
- Physician standby service (CPT code 99360).
- Episiotomy (CPT code 59300).
- All postpartum 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).
- Professional component of 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.
- 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.
- Effective November 1, 2021, immediate post-partum insertion of long-acting reversible contraception (LARC)
    - CPT 11981 with modifier 51 for implant insertion and ICD-10 diagnosis code Z30.017
    - CPT 58300 with modifier 51 for IUD insertion and ICD-10 diagnosis code Z30.430

  Note: the LARC device is billed by the hospital when insertion occurs during an inpatient labor and delivery stay. Instructions for inpatient hospital billing of immediate postpartum LARC devices are in the Inpatient Medical Review and Payment Policy.

Obstetric Ultrasound

The Plan 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 code in the primary diagnosis position on the claim.

The Plan 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

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

The Plan will not reimburse OBGYN providers 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 (99202-99205; 99211-99215).

The Plan will not reimburse for Q0091 (screening Papanicolaou 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 (99202-99205; 99211-99215).

Intrauterine Devices (IUDs) and Contraceptive Implants

For commercial plan members, effective July 1, 2017, IUDs and contraceptive implants will be added to the Plan's Auxiliary Fee Schedule for professional charges. HCPCS codes J7297, J7298, J7300, J7301 and J7307 were added effective July 1, 2017. HCPCS code J7296 was added effective October 1, 2021. Outpatient hospitals must bill invoice cost for IUDs and contraceptive implants. The Plan reserves the right to request a copy of the invoice.

For MassHealth ACO and NaviCare plan members, IUDs and contraceptive implants will be reimbursed in accordance with Provider Regulations and Subchapter 6 of the MassHealth Provider Manual. A valid National Drug Code (NDC) is required on professional and outpatient

hospital claims for drugs and biologicals, including IUDs and contraceptive implants. When reporting an NDC, the NDC Qualifier (F4), NDC Unit of Measure Qualifier (F2, GR, ME, UN, ML) and NDC quantity must also be reported. Effective July 1, 2021, claims for drugs and biologicals, including IUDs and contraceptive implants, submitted without a valid NDC code will be denied. For additional information on NDC requirements refer to the Plan's Drugs and Biologicals Payment Policy.

Code	Description
J7296	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (Nexplanon)

IUDs and contraceptive implants are not covered for Medicare Advantage plan members per Medicare statute 1862(a)(1) (Medicare Benefit Policy Manual, Chapter 16 – General Exclusions From Coverage, Section 20 – Services Not Reasonable and Necessary).

Treatment of endometrial hyperplasia with the insertion of a hormone-eluting intrauterine device (IUD) is an accepted method to manage endometrial hyperplasia without atypia. Since the CPT code for IUD insertion (CPT 58300) is not payable by Medicare, providers should bill for this procedure for Medicare Advantage plan members using unlisted CPT code 58999 (Unlisted procedure, female genital system (nonobstetrical)) and ICD-10-CM code N85 (Endometrial hyperplasia, unspecified ot N85.01 (Benign endometrial hyperplasia). Unlisted codes require prior authorization by the Plan.

Reference: National Government Services, Inc. Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia – CPT 58999 (A58649).

Lactation Counseling

Lactation counseling services are not separately reimbursed when performed within the scope of an office visit. Please contact Customer Service to determine if the member has any additional lactation counseling coverage.

Referral/notification/prior authorization requirements

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 Procedure code look-up tool in the Provider Section of the Fallon Health website: https://www.fchp.org/providertools/ProcedureCodeLookup/ .

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or any other additional appointments or services that may not routinely be authorized or require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Global Obstetrical Package

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 group (example: provided pre-natal visits, a normal vaginal delivery, and postpartum 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 pregnancy diagnosis is required for payment for all services billed for a pregnant patient.

When the same Group Physician and/or other Health Care Professional provides all of the services components of the global obstetrical package, submit claims using one of the following codes.

- 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 Plan will reimburse for these global OB codes when all the antepartum, delivery and postpartum care is provided by the Same Group Physician and/or Other Health Care Professional.

The CPT code for tracking postpartum visits is 99024.

Antepartum Care or Postpartum Care Only

Antepartum care or postpartum care codes should be used when member's coverage changes or terminates, the member changes providers (in another Group Practice) or has a pregnancy loss.

If the patient is treated for antepartum and/or postpartum care only, submit codes 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 99202–99205, established 99211–99215). These services will be reimbursed at zero dollars, any requests for payment should be handled through appeals process with supporting documentation Please submit this documentation on a Request for Claim Review form.
- 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.
- Postpartum care only, bill CPT code 59430.

Delivery Only or Delivery Including Postpartum Care

If a 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.

If the provider performs delivery and post-partum care submit claims using the following guidelines:

- CPT code 59410: Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
- CPT code 59515: Cesarean delivery only; including postpartum care
- CPT code 59614: Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
- CPT code 59622: Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Multiple Births

When two different delivery methods are used bill the first line with the global obstetrical care CPT codes; bill the second line with the delivery only CPT code :

- CPT code 59510 (routine obstetric care including antepartum care, cesarean delivery, and postpartum care), or 59618 (routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery). Reimbursement will be 100% of the global fee schedule.
- CPT code 59409 (vaginal delivery only - with or without episiotomy and/or forceps) with modifier 51, or 59612 (vaginal delivery only, after previous cesarean delivery - with or without episiotomy and/or forceps) with modifier 51. Reimbursement will be 50% of delivery only fee schedule.

Obstetric Ultrasound

The Plan 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 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)

Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, and Midwife Services:
Use modifier SA for all Nurse Practitioner (NP), Physician Assistant (PA), and 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. 07/01/2011 - Corrected typo that incorrectly identified that modifier BA should be used for midwife services; corrected description for using CPT code 99024 for post partum 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. 05/01/2013 - Corrected lists of services included vs. not included in the obstetrical global. 05/01/2014 - Updated discussion about G0101 and removed the list of ICD-9 codes indicating service is routine in the Obstetrical ultrasound billing/coding guidelines. 11/01/2015 - Annual review and moved to new Plan template. 07/01/2016 - Updated to address IUD reimbursement. 03/01/2017 - Updated billing/coding guidelines. 07/01/2017 - Clarified circumcision coverage and updated IUD information.
Connection date & details:	November 2017 – Updated the reimbursement section. October 2018 – Clarified process for reimbursement of 1-3 ante-partum visits. Added observation codes to the not separately reimbursable list. January 2019 – Added codes related to delivery and post-partum combined care. April 2019 – Added code J7296 to IUD table, clarified billing guidelines. January 2020 – Updated billing/coding section. April 2021 – Clarified reimbursement for E & M services billed with global delivery; clarified reimbursement for contraceptive implants. July 2021 – Added information about NDC requirements for IUDs and contraceptive implants for MassHealth ACO and NaviCare plan members; removed J7296 from IUD/Contraceptive Implant table because the code was not added to the Plan's Auxiliary Fee Schedule. October 2021 – Updated to include reimbursement for insertion of long-acting reversible contraception (LARC); added J7296 to the Plan's Auxiliary Fee Schedule effective October 1, 2021. April 2022 – Documented noncoverage of IUDs and contraceptive implants for Medicare Advantage plan members per Medicare statute 1862(a)(1).

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. 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. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan 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.