Payment Policy

Obstetric Care

Purpose

The purpose of this payment policy is to define how Minuteman Health, Inc (MHI) reimburses for Obstetric Care

Applicable Plans

☒ MHI MA Plans
☒ MHI NH Plans

Definitions

Antepartum Care:

- The initial visit to determine whether or not the member is pregnant should be billed with the appropriate E & M CPT code along with the code for the pregnancy test. Once the pregnancy is confirmed, visits are typically scheduled monthly up to 28 weeks gestation, biweekly up to 36 weeks gestation followed by weekly visits until delivery. Per The American Congress of Obstetricians and Gynecologists this amounts to approximately 13 - 15 antepartum visits (see www.acog.org). Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, initial glucose tolerance test, venipuncture or specimen collection performed in the office. (For extensive complications or unusual circumstances, MHI will consider payment on any of the above services outside the global reimbursement on an individual consideration basis after review of medical notes). There may be instances in which a member may see her obstetrician for a non-pregnancy related condition. These services will be paid on an individual basis when billed with the appropriate E & M CPT code and ICD-10 diagnosis code.

Intrapartum Care:

- Intrapartum care is the care rendered at the time of delivery. Delivery services include the admission to the hospital, admission history and physician examination, management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean delivery.

Postpartum Care:

- Postpartum care includes hospital and outpatient visits that are routine following a vaginal or cesarean section delivery up to six weeks post delivery.

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Requirements

Minuteman Health, Inc. reimburses obstetrical services to obstetrical providers using 25 weeks gestation to distinguish between global and non-global reimbursement. These services include antepartum care, intrapartum care and postpartum care.

When billing for global delivery, submit one claim for delivery with the appropriate CPT procedure codes:

- 59400 (vaginal delivery)
- 59510 (Cesarean delivery)
- 59610 (vaginal delivery after a previous Cesarean delivery)
- 59618 (Cesarean delivery after vaginal delivery attempt after a previous Cesarean delivery)

Multiple-Birth Deliveries:

Multiple vaginal or cesarean deliveries are reimbursed under the single global payment. When two different delivery methods are used, bill the first line with the appropriate CPT code for global obstetrical care and the second with the appropriate delivery only CPT code and modifier 59. MHI will reimburse the global obstetrical code at 100% of the provider's contracted rate and the delivery only code at 50% of the contracted rate. Please submit documentation when billing two different delivery methods.

Assistant Delivery:

MHI will reimburse assistant surgeons for cesarean deliveries based on 16% of the services paid to the delivering physician. The appropriate assistant surgeon modifier is required.

Services that are not included in the global fee include but are not limited to:

- CBC with differential/blood typing Rh antibody screening
- Hepatitis B, Rubella, Syphilis, HIV
- AFP – Alpha-fetoprotein screening
- Fetal Echocardiography
- Rho(D) immune globulin or administration of
- Fetal non-stress tests
- Obstetrical Ultrasound
- Cervical Cerclage
- Amniocentesis, CVS – chorionic villus sampling
- External cephalic version
- Circumcision
- Tubal Ligation

Please bill with the appropriate CPT codes for these services.

Non-Global Obstetrical Services

The provider may not follow the member for the duration of her pregnancy. These reasons may include the member moving to another physician (not associated with your practice), moving away prior to delivery, losing the pregnancy, or changing insurance. The billing must reflect the actual services rendered. Claims should be submitted for non-global services with the appropriate CPT procedure codes:

- 59425-59426 (antepartum visits)
  If the provider does not follow the member for the duration of her pregnancy, the billing must

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reflect the actual services that the provider has rendered. An example is if a member received prenatal care, but did not deliver, with that same provider. If the member had a total of 4-6 antepartum visits, the global CPT code 59425 with 1 unit should be used, and the last date of service reported. If the member has 7 or more visits, the code 59426 should be billed. This also should be submitted with 1 unit, and the last date of service reported.

- If 1-3 antepartum care visits only have been performed, bill each date of service separately. Claims should be submitted with the most appropriate E&M CPT procedures codes and the appropriate pregnancy diagnosis.
- 59409, 59514,59612 or 59620 (delivery only)
- 59410,59515,59614 or 59622 (the delivery and postpartum care only)
- 59430 (postpartum care only)

MHI NH Plans

Only an In-Plan Provider can provide prenatal care. Also, an In-Plan Provider must arrange all inpatient care.

1. **What is Covered**
   A. Prenatal visits and screening and postpartum care. This includes consultation for breast feeding support, equipment and counseling, screening for post-partum depression and parent education. There is no cost-sharing for routine prenatal visits and screening and postpartum care.
   B. Diagnostic tests
   C. Prenatal homemaker services for a woman who (1) is confined to bed rest or (2) whose normal functions of daily life are restricted. Services must be Medically Necessary, as determined by your In-Plan Provider, who shall consult with MHI's case manager, when applicable.
   D. Child Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother.
   E. Routine nursery charges. These include services commonly given to healthy newborns. To have MHI cover the child of the Subscriber or the Subscriber's spouse after birth, you must enroll the child as a Member within 31 days of birth. Coverage will not be provided for a newly born child of a Dependent beyond 31 days.
   F. Newborn hearing screening
   G. Postpartum homemaker services, when medically necessary, as determined by In- Plan Provider, who shall consult with MHI's case manager, when applicable.

2. **What is Not Covered**
   A. Routine maternity (prenatal and postpartum) care when you are traveling outside of the MHI Service Area
   B. Delivery out of the MHI Service Area after the 37th week of pregnancy. MHI also will not cover delivery out of the MHI Service Area if you have been told that you are at risk for early delivery.

Authorization Requirements

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The obstetrician must submit either the American College of Obstetricians and Gynecologists (ACOG) Antepartum Record Form or the Obstetrical Pre-registration Form following the member's first prenatal visit.

Attachments

None

Important Note About This Reimbursement Policy

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. MHI's reimbursement policy includes the use of Current Procedural Terminology (CPT®[1]), guidelines from the Centers for Medicare and Medicaid Services (CMS), and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

MHI may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to MHI enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the type of provider agreement and the terms of that agreement, the MHI Provider Manual, and/or the enrollee's benefit coverage documents.

MHI reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

Resources

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Massachusetts General Law M.G.L. 176g Section 4 New

Hampshire RSA 417-D:2-a

MHI Provider Manual

History

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1 CPT® is a registered trademark of the American Medical Association.

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