



4350 E. Cotton Center Boulevard • Building D • Phoenix, AZ 85040 • (602) 263-3000 • (800) 624-3879

Provider Notification

| | | | |
|-----------------------------|------------------------------|----------------------|------------|
| Date of Notification | 9/1/11 | Revision Date | N/A |
| Plans Affected | All Lines of Business | | |
| Subject | Obstetrical Billing | | |

Referrals

As outlined in the Provider Manual, a woman may self-refer to an OB/GYN for obstetrical care and serves as the member’s PCP while pregnant. A member may also self-refer for gynecological services as well.

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant member may self-refer to any contracted Maternity Care Practitioner.
- A PCP may refer pregnant members to a contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the member’s maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MCP referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
 - Through twenty-eight weeks of gestation – once every four weeks
 - Between twenty-nine and thirty six weeks gestation every two weeks
 - After the thirty sixth week – once a week
 - Schedule first-time appointments within the required time frames
 - Members in first trimester – within seven calendar days
 - Members in third trimester – within three calendar days
 - High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

Prior Period Coverage (PPC)

Mercy Care is responsible for reimbursing providers for covered services rendered to recipients during the *prior period coverage* (PPC) time frame. The PPC is the period between the recipients starting date of AHCCCS eligibility and the date of enrollment with a contractor. If the Total OB Package falls within the prior period coverage timeframe, then it is applicable to the Total OB Package reimbursement rules.



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Payment of TOB Package

Effective with dates of service on or after October 1, 2011, Mercy Care will reimburse Obstetrics services on a fee for services basis. Billing should be in accordance with Current Procedural Terminology (CPT®) rules.

The services normally provided in uncomplicated maternity case include antepartum care, delivery and postpartum care. A TOB would normally be billed when a member sees only one OB provider through the pregnancy and has the same insurance coverage. CPT codes used for the TOB package include:

- **59400** – *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care*
- **59510** – *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care*
- **59610** – *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery*
- **59618** – *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery*

Descriptions of Service

The following descriptions of service and inclusive services come from CPT:

- **Antepartum Care** - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery. Any other visits or services within this time period should be coded separately.
- **Delivery Services** - includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only service (CPT codes 59410, 59515, 59614, or 59622) include delivery services and all inpatient and outpatient postpartum services.
- **Medical Problems** – medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and Evaluation and Management Services section in CPT, in addition to codes for maternity care.

Medical complications of pregnancy could include:

- Cardiac problems
- Diabetes
- Hyperemesis



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- Hypertension
- Neurological problems
- Premature rupture of membranes
- Pre-term labor
- Toxemia
- Other medical problems complicating labor and delivery

Surgical complications of pregnancy could include:

- Appendectomy
- Bartholin cyst
- Hernia
- Ovarian Cyst

Other medical complications, i.e., drug abuse

- **Postpartum Care Only Services (59430)** - include office or other outpatient visits following vaginal or cesarean section delivery.

Multiple Births

The initial delivery of the first baby will be payable at the appropriate fee for service rate and should be billed with the appropriate CPT delivery code that applies.

Subsequent delivery of each additional baby should be billed with appropriate **delivery only** code with a 51 modifier appended to each. Those CPT codes are as follows:

- **59409** – *Vaginal delivery only (with or without episiotomy and/or forceps)*
- **59612** – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)*
- **59514** – *Cesarean delivery only*
- **59620** – *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery*

The rate payable for each subsequent delivery will be 50% of the allowable amount for the above codes. The only exception to the above is if the provider's contract specifically addresses a different reimbursement methodology.

Broken TOB Package

There may be times when a transfer of care may occur from one provider to another during the course of a pregnancy. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to a referral to another physician for delivery, this would be considered a broken TOB package. Those cases require special billing and follow CPT code guidelines as follows:

- For 1 – 3 antepartum care visits, use appropriate E&M code, i.e. **99201 - 99215**.



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- For 4 – 6 antepartum care visits, use code **59425** – *Antepartum care only; 4-6 visits.*
- For 7 or more antepartum care visits, use code **59426** – *Antepartum care only; 7 or more visits.*
- Providers in group practices may not unbundle the global delivery code when a recipient receives OB services from more than one provider in the same group and delivery is performed by a provider in the same group.

Other codes available in CPT that represent broken TOB package include:

Delivery Only CPT Codes that Include Postpartum Care

Delivery codes including postpartum care CPT codes are as follows:

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

Delivery Only CPT Codes

The following CPT codes will be billed, if provider is only billing for delivery services:

- **59409** – *Vaginal delivery only (with or without episiotomy and/or forceps).*
- **59514** – *Cesarean delivery only.*
- **59612** – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).*
- **59620** – *Cesarean delivery only following attempted vaginal delivery after previous cesarean delivery.*

Postpartum Care Only CPT Code

A provider billing for postpartum care only should bill code **59430** – *Postpartum care only (separate procedure).*

If the provider only billed a portion of the global routine obstetric care, the service is reported with codes that describe that portion of the service as delivery only or postpartum care only, based on the delivery method.

Authorization is required for the TOB package. If there is a broken TOB package, it is incumbent upon the provider to notify Prior Authorization to end date the first provider's care and add an authorization for the second provider's care so that the appropriate broken TOB package can be tracked.



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Please refer to Mercy Care’s websites for additional prior authorization guidelines for each plan. Since services are paid at a fee for service rate, prior authorization guidelines will apply to all services that require prior authorization.

Appropriate Claim Billing Examples

Example 1: TOB Package Claims

| Dates of Service | | Place of Service | Procedures, Services or Supplies | | \$ Charges | Days or Units |
|------------------|-----------|------------------|----------------------------------|-----------|------------|---------------|
| From | To | | CPT/HCPCS | Modifiers | | |
| 5/3/2010 | 1/5/2011 | 11 | 99213 | | \$0.00 | 15 |
| 1/06/2011 | 1/06/2011 | 21 | 59409 | | \$2,200.00 | 1 |

The first line provides information regarding pre-natal care visits. The pre-natal care information is necessary in order for us to report these required statistics to AHCCCS. No dollar amount is billed, as payment is included in the delivery charge. The second line provides information regarding the delivery and contains the dollar amount for the TOB package.

Example 2: Broken OB Package Claims

Initial Provider – Services provided for greater than 7 visits for antepartum care.

| Dates of Service | | Place of Service | Procedures, Services or Supplies | | \$ Charges | Days or Units |
|------------------|------------|------------------|----------------------------------|-----------|------------|---------------|
| From | To | | CPT/HCPCS | Modifiers | | |
| 5/3/2010 | 12/31/2010 | 11 | 59426 | | \$800.00 | 1 |

Second Provider – Patient was out of town and another doctor not in the same practice delivered the baby and is providing postpartum care.

| Dates of Service | | Place of Service | Procedures, Services or Supplies | | \$ Charges | Days or Units |
|------------------|----------|------------------|----------------------------------|-----------|------------|---------------|
| From | To | | CPT/HCPCS | Modifiers | | |
| 1/6/2011 | 1/6/2011 | 11 | 59410 | | \$1,500.00 | 1 |

Maternal/Fetal – High Risk Pregnancy

A member may be referred to a maternal/fetal specialist at any time either due to a high risk pregnancy or as a high risk medical complication of pregnancy develops. **All services** provided by a maternal/fetal specialist are paid on a fee for service basis.

This Provider Notification should be referred to in conjunction with each specific plan’s Provider Manual.