



# MONTHLY TIPS AND TRICKS:

## OBSTETRICAL SERVICES

### HEALTH CHOICE ARIZONA OBSTETRICAL SERVICES OVERVIEW

Health Choice Arizona (HCA) emphasizes the critical importance of prenatal health care. The Maternal Child Health department at Health Choice Arizona assists obstetrical members by facilitating access to community services and programs for pregnant women. Health Choice Arizona obstetrical providers must adhere to the American College of Obstetrics and Gynecology (ACOG) standards of care which includes referrals to community resources, patient education, and maintenance of the medical record.

### PRIMARY CARE OBSTETRICIAN (PCO) RESPONSIBILITY

The PCO must notify Health Choice Arizona of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Health Risk Assessment for Total OB Pre-Authorization form. This form is a critical component of coordinating care between Health Choice Arizona and the obstetrician or Maternal Fetal Medicine provider and MUST be completed and submitted promptly after the member's first visit. A copy of the member's ACOG notes may be submitted in lieu of the clinical documentation requested on the Maternal Health Risk Assessment form, as long as all of the requested information is included in the notes. The form should be faxed to Health Choice Arizona at (480) 760-4762.

Upon receipt of the Maternal Health Risk Assessment form, the Maternal Child Health department will issue a Total OB Notification number to the PCO. The PCO will use this number for all professional services related to the pregnancy. See HCA Provider Manual Chapter 16: Women and Children's Services for additional information, at <http://www.healthchoiceaz.com/provider-manual>.

### GLOBAL OBSTETRICAL CARE

As defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the same group physician and/or other health care professional (of same Tax Identification Number) provides all components of the OB package, report the global OB package code.

The *Current Procedural Terminology* (CPT®) codebook identifies the global OB codes as:

*Routine obstetric care including antepartum care:*

... vaginal delivery with or without episiotomy, and/or forceps) and postpartum care	59400
... cesarean delivery and postpartum care	59510
... vaginal delivery (with or without episiotomy, and/or forceps) & postpartum care, after previous cesarean delivery	59610
... cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	59618

HCA reimburses for these global OB codes when all of the antepartum, delivery and postpartum care is provided. Claims should not be submitted until after the delivery of the newborn or the care is transferred to another provider.

**Example 1: Global OB (TOB) Package Claim, provider is rendering all OB visits prior to delivery, labs, the delivery itself and all services associated with the admission and discharge from the hospital**

24. A. DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES OR SUPPLIES	E. DIAGNOSIS POINTER	F. BILLED CHARGES	G. UNITS
01/01/2018 - 01/01/2018	11		99213	1	\$0.01	1
02/01/2018 - 02/01/2018	11		99213	1	\$0.01	1
03/01/2018 - 03/01/2018	11		99213	1	\$0.01	1
04/01/2018 - 04/01/2018	11		99213	1	\$0.01	1
05/01/2018 - 05/01/2018	11		99213	1	\$0.01	1
06/01/2018 - 06/01/2018	11		99213	1	\$0.01	1
07/01/2018 - 07/01/2018	11		99213	1	\$0.01	1
08/01/2018 - 08/01/2018	11		99213	1	\$0.01	1
09/01/2018 - 09/01/2018	11		99213	1	\$0.01	1
09/13/2018 - 09/13/2018	21		59400	1	\$2,000.00	1

All prenatal care visits must be reported on separate lines in order for Health Choice to report these required statistics to AHCCCS. Enter a charge of \$0.00 or \$0.01 as the amount for the prenatal visits, as payment is included in the delivery. Only the delivery CPT code would have a billed amount.

This billing is necessary to report these required statistics to AHCCCS. There is no additional compensation for itemized OB service codes submitted with the Global OB Delivery Code, as their value is already included in the Global Code. To avoid an error during claims processing enter a charge of \$0.00 or \$0.01.

All pregnancy-related claims must be submitted with the appropriate ICD-10 related diagnosis codes. In addition, each provider should submit all prenatal services, ancillary services, and delivery of the newborn on a CMS 1500 form using the OB authorization number, and submit the appropriate service codes as itemized services when using Global OB Delivery Codes:

- CPT Evaluation and Management (E/M) codes 99201-99205, 99211-99215
- All prenatal care visits must be reported on separate lines of the claim form with the corresponding date of service.





# MONTHLY TIPS AND TRICKS: OBSTETRICAL SERVICES

## GLOBAL OBSTETRICAL CARE *continued*

Per CPT guidelines and the American College of Obstetricians and Gynecologists (ACOG), the following services are included in the global OB package (CPT codes 59400, 59510, 59610, 59618):

- Routine prenatal visits until delivery
- Recording of weight, blood pressures & fetal heart tones
- Routine chemical urinalysis and laboratory test
- Admission to the hospital including history & physical
- Administration/induction of intravenous oxytocin (CPT codes 96365 - 96367)
- Insertion of cervical dilator on same date as delivery (CPT code 59200)
- Management of uncomplicated labor
- Vaginal or cesarean section delivery (limited to single gestation; for further information, see Multiple Gestation section)
- Delivery of placenta (CPT code 59414)
- Repair of first or second degree lacerations
- Simple removal of cerclage (not under anesthesia)
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services provided within 60 days of delivery
- Postpartum care only (CPT code 59430)

## OB ULTRASOUND

Your Total OB package authorization number can be used to bill for the two (2) routine OB ultrasounds included with the TOB. Your office does not need to obtain authorization numbers from eviCore for those two (2) OB ultrasounds. CPT codes that can be used as routine OB ultrasounds are 76801/76802, 76805/76810, 76813/76814, 76815, 76816, and 76817. Please note that any additional OB ultrasounds require authorization by eviCore. If you have a pregnant member who presents with symptoms indicating an urgent or emergent need for an ultrasound, you may proceed with the ultrasound. Remember, you will need to contact eviCore within three (3) business days for an authorization of the ultrasound.

### eviCore contact information

Phone number: (888) 693-3211

Fax number: (888) 693-3210

Provider Portal:

<https://www.evicore.com/pages/providerlogin.aspx>

eviCore Clinical Guidelines are available at:

<http://www.evicore.com/resources/Pages/Providers.aspx>

## NON-GLOBAL OBSTETRICAL BILLING (BROKEN OB PACKAGE)

A provider performing prenatal services, but not delivery, must only bill using prenatal service codes.

Submit the appropriate service codes as itemized services when using Unbundled OB Service Codes:

USE:

CPT E/M codes 99201-99215, with all prenatal care visits reported on separate lines of the claim form with the corresponding date of service

OR

OB Service Code 59425 (when 4-6 prenatal visits are performed); report 1 unit and include the date span covered on 1 line, and submit the date of service for each prenatal care visit on separate lines of the claim form (see example, over)

OR

\*OB Service Code 59426 (when 7 or more prenatal visits are performed); report 1 unit and include the date span covered on 1 line, and submit the date of service for each prenatal care visit on separate lines of the claim form (see example, over)

The unbundled method also applies to FQHC/RHC billing according to the PPS Rate change effective April 1, 2015. *For further details regarding FQHC/RHC, please refer to your contract-specific guidelines.*



### DELIVERY SERVICES ONLY

Per the CPT codebook, "Delivery services include 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."

The following are the CPT-defined delivery-only codes:

- 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

The delivery only codes should be reported **by the same group physician and/or other health care professional** for a single gestation when:

- The total OB package is not provided to the patient **by the same single physician or group practice** and itemization of services needs to occur.
- Only the delivery component of the maternity care is provided; postpartum care is performed by another physician or group of physicians.

**Delivery Only, Including Postpartum Care:** Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT codebook has codes for vaginal and cesarean section deliveries that encompass both of these services. The following are CPT-defined delivery only, including postpartum care codes:

- 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 delivery after previous cesarean delivery; including postpartum care

The delivery only, including postpartum care codes should be reported **by the same group physician and/or other health care professional** for a single gestation when:

- The delivery and postpartum care services are the only services provided.

#### Example 2: Non-Global (Broken TOB) Package - Initial provider claim for greater than 7 visits for antepartum care

24. A. DATE(S) OF SERVICE FROM TO MM/DD/YY MM/DD/YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES OR SUPPLIES	E. DIAGNOSIS POINTER	F. BILLED CHARGES	G. UNITS
01/01/2018 - 01/01/2018	11		99213	1	\$0.01	1
02/01/2018 - 02/01/2018	11		99213	1	\$0.01	1
03/01/2018 - 03/01/2018	11		99213	1	\$0.01	1
04/01/2018 - 04/01/2018	11		99213	1	\$0.01	1
05/01/2018 - 05/01/2018	11		99213	1	\$0.01	1
06/01/2018 - 06/01/2018	11		99213	1	\$0.01	1
07/01/2018 - 07/01/2018	11		99213	1	\$0.01	1
08/01/2018 - 08/01/2018	11		99213	1	\$0.01	1
01/01/2018 - 08/01/2018	11		59426	1	\$800.00	1

All prenatal care visits must be reported on separate lines in order for Health Choice to report these required statistics to AHCCCS. Enter a charge of \$0.00 or \$0.01 as the amount for the prenatal visits, as payment is included in the delivery. Only the delivery CPT code would have a billed amount.

#### Second provider - is NOT within the same practice as initial provider, and is delivering the baby and providing postpartum care

24. A. DATE(S) OF SERVICE FROM TO MM/DD/YY MM/DD/YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES OR SUPPLIES	E. DIAGNOSIS POINTER	F. BILLED CHARGES	G. UNITS
10/01/2018 - 10/01/2018	21		59410	1	\$2,000.00	1
11/20/2018 - 11/20/2018	11		99213	1	\$80.00	1

All postpartum care visits must be reported on separate line(s) in order for Health Choice to report these required statistics to AHCCCS (date of performed postpartum visit).

#### Postpartum Care:

AHCCCS requires contractors to monitor and evaluate postpartum activities, with interventions to improve the utilization rate. As a HEDIS measure, Health Choice requires that postpartum services are provided to members within 57 days of delivery. To allow Health Choice to track the postpartum care visit(s) rendered, we allow our providers to bill for this service separately.