Obstetrics

Reimbursement Policy ID: RPC.0068.0100

Recent review date: 08/2024

Next review date: 01/2025

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes the reimbursement guidelines for submitting claims for obstetrical services, including antepartum, delivery and postpartum services.

Exceptions

N/A

Reimbursement Guidelines

A Primary Care Provider (PCP) can serve as the member's personal practitioner and is responsible for coordinating and managing the medical needs of Keystone First members. Advanced nurse practitioners, nurse midwives, and licensed physicians in the following specialties may serve as Plan PCPs:

- General Practice
- Pediatrics
- Internal Medicine
- Geriatrics

- Obstetrics/gynecology (OB/GYN)
- Family Practice

OB/GYN practitioner as PCP
Participating Obstetricians are responsible for medical services during the course of the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care may include:

- Treatment of minor colds, sore throat, or asthma
- Treatment of minor injuries
- Preventative health screenings and maintenance
- Routine gynecological care

Initial prenatal visit
For purposes of billing and reimbursement, each new pregnancy (270 days) is considered a new patient whether or not the patient has been seen previously by the provider/practice.

Prenatal visits
Keystone First requires the provider to submit the appropriate level evaluation and management (E/M) CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The reimbursement for these services shall include, but is not limited to:

- The obstetrical (OB) examination
- Routine fetal monitoring (excluding fetal non-stress testing)
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy
- Routine dipstick urinalysis

Delivery
Providers should bill the appropriate CPT code that describes the type of delivery (example: vaginal, cesarean section).

CPT Code	Description
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

Postpartum
Providers should submit CPT code 59430 for postpartum visit(s).

Anesthesia
Administration of obstetrical anesthesia using these CPT codes is reimbursable for

- Neuraxial analgesia for vaginal delivery (includes repeated subarachnoid needle placement, drug injection, and necessary epidural catheter replacement during labor); or

- Anesthesia for cesarean delivery.

CPT Code	Description
01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
+01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia

Definitions

Antepartum
The period of time between conception and the onset of labor.

Neuraxial Anesthesia
Neuraxial anesthesia and analgesia techniques include spinal, epidural, and combined spinal-epidural.

Postpartum
The period of time after the delivery of the baby.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI)
V. American Congress of Obstetricians and Gynecologists (ACOG)
VI. Pennsylvania Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0038.0000 Obstetric Ultrasound

Policy History

	Reimbursement Policy Committee Approval
08/2024	Updated to include anesthesia guidelines
04/2024	Revised preamble
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template Revised • Revised preamble

	• Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section