Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.029
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Subject **Obstetrical Services (EHP/USFHP)**	*Supersedes Date*	N/A
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JOHNS HOPKINS HEALTH PLANS

This document applies to the following Participating Organizations:

EHP US Family Health Plan

Keywords: Maternal Global Services, Obstetrical Services, Postpartum, Prenatal

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry

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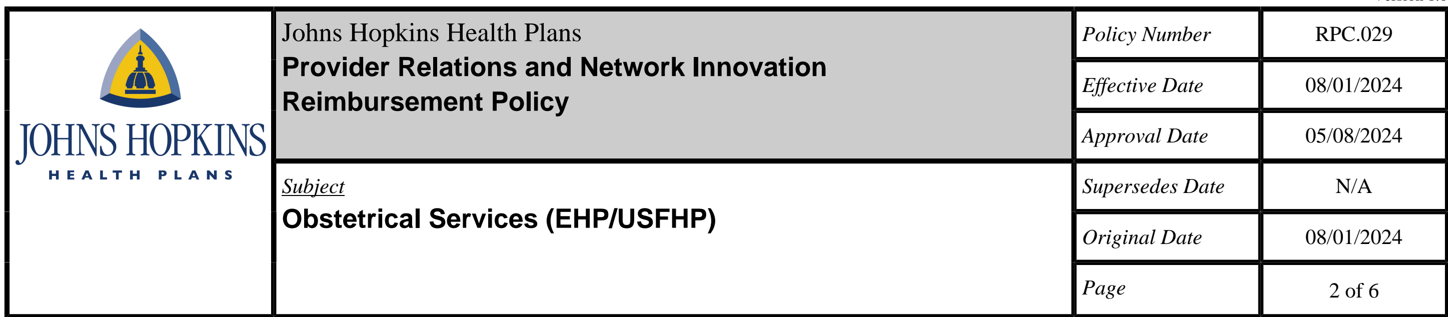

standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic billing and reimbursement guidance applies to JHHP Commercial (EHP) and USFHP claims, for Obstetrical (OB) services when rendered by a person who is legally authorized to perform such services in accordance with state and federal laws. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATEMENT

This reimbursement policy applies to professional, Obstetrical services, rendered to JHHP members for maternity care and delivery services, reported on a CMS-1500 claim form or its electronic equivalent, by network and non-network providers in the state where services are rendered. Providers are responsible to verify the individual member's contract for specific plan benefits and to obtain a prior authorization/ reauthorization before an item, procedure or service is rendered, if required

Providers are responsible to review the ***"EXCEPTIONS & EXCLUSIONS" Sections*** *below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES and PAYMENT METHODOLOGY

1. JHHP will reimburse global obstetric (maternity care) package code(s) when the same provider/provider group renders the antepartum care, deliver and postpartum care.
2. JHHP considers the postpartum/postnatal period to be 12 weeks (84 days) following the date of the cesarean or vaginal delivery. After the initial postpartum period, subsequent care should not be covered by the global maternity codes but should be billed using the appropriate Evaluation and Management (E/M) or procedure codes, when applicable.
3. When rendering global maternity care, providers should bill under the appropriate global maternity care code rather than unbundling services (i.e., reporting antepartum, delivery and postpartum services separately), when applicable.
4. In order to appropriately capture HEDIS data measurements, JHHP requires providers to report the following information on their claim forms as a "no charge" line item:
    i. When submitting claim for an **initial** pregnancy diagnosis visit (e.g., urine test, ultrasound), always include CPT 0500F or 0501F, as a **no-charge** line item with pregnancy related diagnosis code.
    ii. When submitting claim for the **first** office post-partum visit, always include CPT 0503F, as a **no-charge** line item with appropriate Z-code diagnosis.
    iii. When submitting claim for a **subsequent** post-partum visit, include CPT 0502F, as a **no-charge** line item with appropriate Z-code diagnosis.

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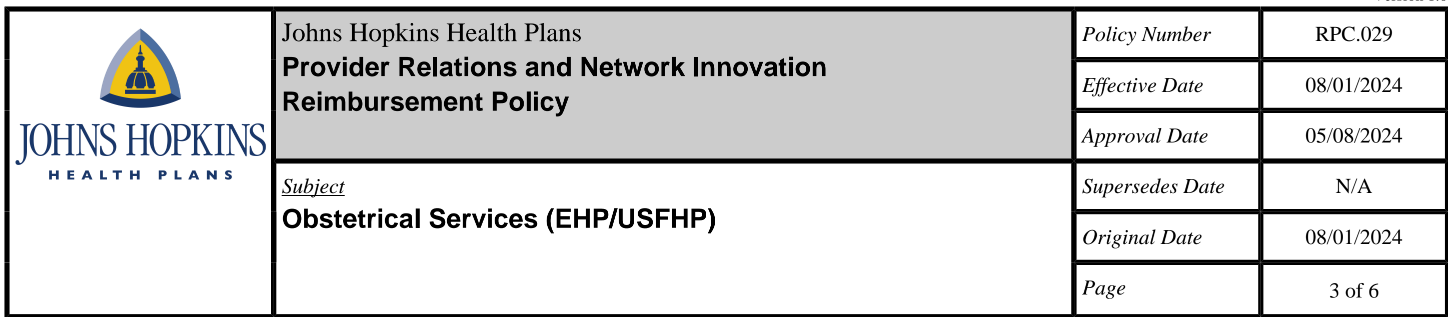

5. Per ACOG guidelines, when a patient is seen for a condition unrelated to pregnancy (e.g., bronchitis, flu), these visits are considered Non-OB E/M services and must be reported with the appropriate diagnosis code that clearly identifies the condition not related to pregnancy care.
6. Providers must bill only for the actual service(s) they personally rendered. In the event that global maternity care is divided between practitioners not in the same group practice, each qualified health care provider should bill the code that represents the care s/he personally provided.
7. JHHP does not consider a maternal-fetal medicine (MFM) specialist to be the same provider as regular OB/GYN physician, when services are rendered due to a high-risk or complicated pregnancy, as these services would fall outside the routine global OB package. When the MFM specialist reports with the same federal tax identification number (TIN) as the OB/GYN physician, the specialist should report an E/M service, as the visit would not be considered part of the routine antepartum care supplied by the same physician group.
8. Providers are to report the appropriate place of service (POS) code when billing for OB services.
9. Refer to JHHP's Assistant-at-Surgery policy for additional information regarding applicable modifiers and reimbursement guidance, when a non-global cesarean section delivery code (CPT codes 59514 or 59620) is reported.
10. Consistent with ACOG coding guidelines, JHHP will not reimburse providers who report prolonged physician services (99415 – 99418, G0316 – G0318, G0320 – G0321, and G2212) for labor and delivery management.

V. ICD–10 OB CODING

1. In alignment with CMS and the National Center for Health Statistics (NCHS), JHHP follows guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
2. Obstetric cases require codes from chapter 15, codes in the range O00-O9A, Pregnancy, Childbirth, and the Puerperium.
   i. Refer to Chapter 15 for sequencing priority over codes from other chapters.
3. Chapter 15 codes may be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider documents that a condition is pregnancy related. Codes from this chapter are to be used only on the maternal record, never on the record of the newborn.
4. Only certain Z codes may be used as first-listed or principal diagnosis.
5. A code from category Z37 (Outcome of delivery), should be included on every maternal record when a delivery has occurred.
6. A corresponding procedure code must accompany a Z code to describe any procedure performed.

VI. DOULA SERVICES

Doulas provide three kinds of services: prenatal visits, attendance at labor and delivery, and postpartum visits.

1. Doula services are covered in accordance with State laws and regulations and under the member's plan benefits and coverage, for those providers who are legally authorized to perform doula services in the state which they are rendered.
2. Providers are responsible to verify coverage and benefits, or if a prior authorization or other requirements are mandatory, prior to services being rendered.
3. Doula's must bill with their group or individual NPI.

VII. OB ULTRASOUNDS

1. When benefits are provided under the member's contract, medically necessary prenatal obstetrical ultrasounds are covered outside the maternity global fee.
2. JHHP expects providers to report the appropriate obstetric abdominal/pelvic ultrasound codes in conjunction with an OB diagnosis, or the claim may be denied.

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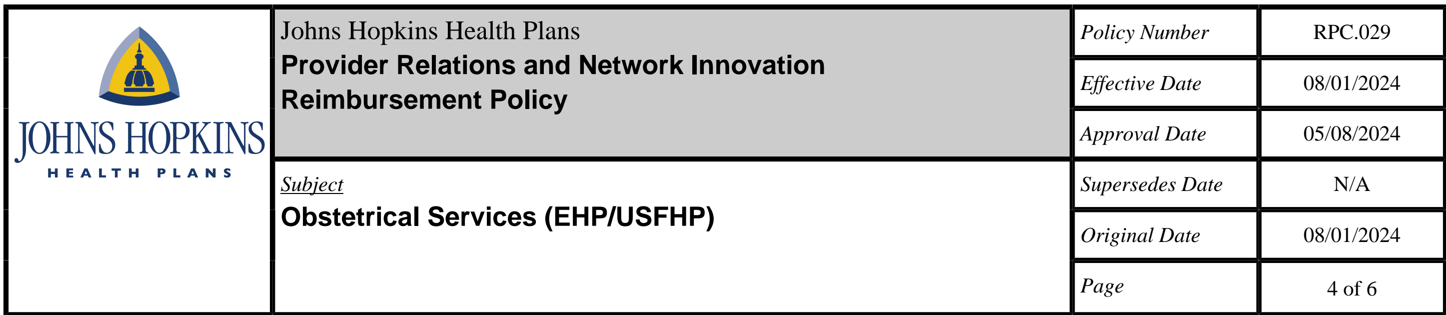

3. For non-obstetric gynecological conditions, providers are to report non-obstetric abdominal/pelvic ultrasound codes instead of the pregnancy related ultrasound codes.
4. For more information on Prenatal Obstetrical Ultrasounds, please refer to the JHHP Medical Policy CMS16.19.

VIII. EXCEPTIONS and EXCLUSIONS

1. **USFHP:** Please consult the authoritative guidance found in TRICARE Manuals- Chap 1 Sect 18 (Professional Services: Obstetrical Care) to obtain specific information on billing, reimbursement, benefits, and coverage for OB services, not listed in this policy.
   i. In alignment with TRICARE guidance, childbirth and/or breastfeeding support and services are not covered. Claims for these services will be denied.
   ii. Services billed by doulas and lactation consultants or counselors, for USFPH members, will be denied.
   iii. Medically necessary postpartum office visits in excess of two may be considered for an additional allowance only for the management of a complication of pregnancy.
   iv. For test-related charges by the attending professional (except for medically necessary ultrasounds), no separate allowance may be made for the examination, analysis, interpretation, or application of diagnostic or laboratory test results by the attending obstetrician or attending CNM. These activities are considered to be the responsibility of the attending professional and included in the global fee of the attending obstetrical care professional.
   v. Charges for global care with and without natural childbirth classes and training is already included CPT 59400.

IX. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Antepartum/Prenatal Care	The health care a woman receives during pregnancy.
CMS-1500/Professional Claim Form	The CMS-1500 Form is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned. Professional claim means any claim submitted using the HIPAA mandated transaction ASC X12 837 professional claim or the CMS-1500 paper claim form.
Doula	A trained, non-clinician professional, who provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.
Global Obstetrical Care/Global Maternity Package	Includes all the services (antepartum care, delivery, and postpartum care) normally provided in an uncomplicated maternity case.

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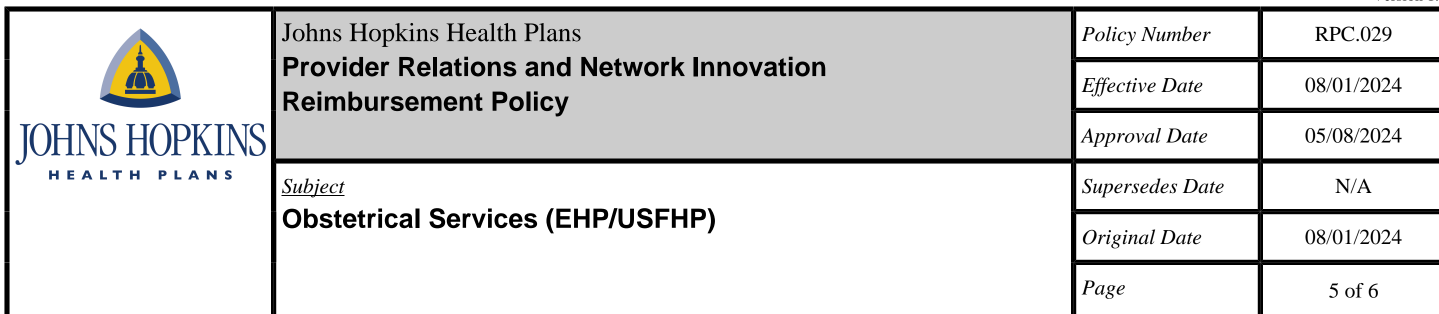

Physician or Other Qualified Health Care Professional	A physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Postpartum/Postnatal Care	For the purpose of this policy, JHHP considers the postpartum or postnatal period begins immediately after the birth of the baby and typically extends up to 12 weeks (84 days) after birth.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

CPT Codes

CPT Code	Definition
0500F	Initial prenatal care visit
0501F	Prenatal flow sheet documented in medical record by first prenatal visit.
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care.
59409	Vaginal delivery only (with or without episiotomy and/or forceps).
59430	Postpartum care only (separate procedure).
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care.
59514	Cesarean delivery only.
59515	Cesarean delivery only; including 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
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).

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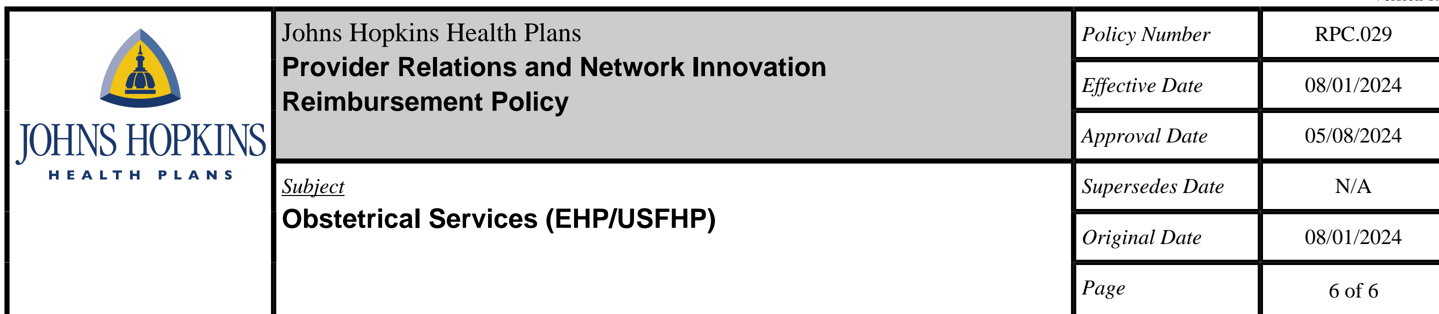

59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.
9920-99499	Please refer to the AMA CPT manual for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details.

ICD-10 Diagnosis Codes

Code	Definition
O00-09A	Pregnancy, Childbirth, and the Puerperium
Z00-Z99	Factors influencing health status and contact with health services

X. REFERENCES

This policy has been developed through consideration of the following:

- American Academy of Family Physicians
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- ICD-10-CM Official Guidelines for Coding and Reporting
- PPC - Prenatal and Postpartum Care | Johns Hopkins Medicine
- Medicare Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set
- TRICARE Reimbursement Manual

XI. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
5/8/2024	New Policy	N/A	Reimbursement Authorization and Coding Committee (RAC)

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