| **Billing and Reimbursement Guideline:** | **Obstetrical Guidelines** |
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| **Guideline Publication Date:** | **September 1, 2010** |
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Key coding, documentation and reimbursement points include:

- **Routine** care is generally defined as:
    - Initial and subsequent history
    - Physical examination
    - Recording of weight
    - Blood pressure checks
    - Monitoring of fetal heart tones
    - Routine chemical urinalysis
    - Routine visits
    - Management of uncomplicated labor and delivery services, including admission
    - Postpartum hospital and office visits following vaginal and cesarean delivery
- Any high risk visits or visits for an unrelated diagnosis must be billed with supporting diagnosis codes for separate reimbursement to be considered.
- Obstetrical care is considered included in the obstetrical package from the date that the obstetrical medical record is established.
- If multiple vendors are reimbursed for routine care, Neighborhood will reimburse up to the total allowed global package amount.
- Appropriate Modifiers should be used to indicate a separately identifiable service. Notes may be required to support separate reimbursement.

**Nutritional Education and Counseling Rendered within the Global Period:**

- Neighborhood will reimburse for nutritional counseling on the same day as an Evaluation and Management service rendered by the same provider.

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9/1/2013, 12/1/2014 Format change, minor edits

- A pregnancy related diagnosis must be billed on the claim.

- Appropriate modifiers

- should be used to indicate a separately identifiable service. Notes may be required to support separate reimbursement.

**Obstetrics, Multiple Deliveries:**

- The types of billing for multiple births will follow the scenarios for twin births. It is important that the determination is based on information regarding the mode of delivery.

  • Both vaginal delivery – Twin A (first born) 59400 and Twin B 59409-51

  • Both cesarean delivery – Only one cesarean section surgical procedure is done; 59510 is billed once with modifier -22

  • One birth vaginal and one birth cesarean - 59510 (primary procedure) for cesarean delivery and 59409-51 for vaginal delivery

  • If more than two newborns are delivered, each additional baby is coded by type of delivery with the appropriate modifier.

- Medical complications including hypertension, toxemia, hyperemesis gravidarium, congenital and genetic defects, cardiac or neurological abnormalities should be documented in the record and coded appropriately.

- This guideline applies to both CMS-1500 and UB-92 claim submissions.

**Confirmation of Pregnancy Visits:**

- The" confirmation of pregnancy visit" is typically a minimal visit. The physician may draw blood and prescribe prenatal vitamins if the test results are positive.

- If the pregnancy has been confirmed by another physician or qualified health care professional (i.e. ultrasound, blood test) you would not bill a confirmation of pregnancy visit.

***Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.***

***This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.***

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