Obstetrical Services - Professional

Policy

Mass General Brigham Health Plan reimburses participating providers for medically necessary obstetrical services during a confirmed pregnancy, labor, childbirth, and postpartum period.

Reimbursement

Providers are reimbursed in accordance with the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Service	Requirement
Obstetrical Inpatient Admission	Notification is required within one (1) business day of the admission
Planned Cesarean Section Delivery	Prior Authorization Required
Notification of Birth (MassHealth, only)	Contractually **required** to submit notification of birth (NOB-1) form to MassHealth within 30 calendar days of the newborn's date of birth
Concurrent Days of Care	Authorization beyond the initial notification is required for days that exceed the length of stay as listed below: • Vaginal Delivery: ≥ 2 days post-delivery • Cesarean Section: ≥ 4 day post-delivery

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan's reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

MassHealth members:

MassHealth, Provider Manual Series, Community Health Center Manual, Transmittal Letter CHC-109, Payable Obstetrics Service Codes, Dated 01/01/2009.

Revised 10/14 Notification of Birth (NOB-1) Form available at the following link: MassHealth Provider Forms by Provider Type

Commercial members:
Entire policy applies

Mass General Brigham Health Plan Reimburses

- Professional obstetrical and maternity care at a single, all-inclusive (global) contract rate when all the components of the global services are provided by the same clinician or group
- Care delivery includes antepartum care; delivery; and postpartum care, consistent with and as described by AMA CPT and by American Congress of Obstetricians and Gynecologists (ACOG) guidelines
- Clinicians in the same practice; back-up physicians; coverage providers including physicians, nurse midwives, physician assistants, or nurse practitioners who are owners, partners, employees, or contracted staff at the practice may provide components of the care delivery

but are not separately reimbursed

- One complete obstetric ultrasound exam (real time with image documentation, fetal and maternal evaluation) for routine anatomy screening and dating, per member, for a routine pregnancy
- An additional ultrasound examination when performed for Down syndrome screening at about 12 weeks' gestation, with submission of clinical documentation

Mass General Brigham Health Plan Does *Not* Reimburse

Note: This list of services is intended to provide guidance, and may not be comprehensive

- Clinicians who may provide components of the global obstetrical services, during antepartum, delivery and postpartum visits. The primary provider is the only clinician who may claim payment for the global obstetrical code.
- Fee-for-service coding for any component of the global obstetrical service if a primary provider bills using the global obstetrical code.
- More than one complete routine ultrasound per low-risk pregnancy
- Obstetric ultrasound for sex determination
- Obstetric ultrasound providing a "keep sake" picture
- Separately for more than one baby delivered by the same method

Multiple-Birth Delivery

When two different methods are used to deliver the infants, report the cesarean section under the global delivery CPT code; report the vaginal delivery only code with modifier "59" appended (Distinct procedural service).

The global delivery service is reimbursed at one hundred percent (100%) of the fee schedule. Delivery- only service is reimbursed at fifty percent (50%) of the fee schedule. For delivery-only service, submit a copy of the operative report at the time of billing.

Mass General Brigham Health Plan makes no additional reimbursement for delivery of more than one baby by the same method.

Procedure Codes

Note: *This list of codes may not be all-inclusive. Inclusion of a code does not imply or guarantee reimbursement for that code. For a comprehensive list of related and required codes, refer to the most current AMA CPT Manual.*

Code	Descriptor	Comments
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Report for global obstetrical services when services begin prior to **25** weeks' gestation and both delivery and postpartum care are provided. Report once, with a count of one, upon completion of services.
59409	Vaginal delivery (with or without episiotomy, and/or forceps)	Report if rendering delivery-only services
59410	Vaginal delivery only (with or without episiotomy, and/or forceps) and postpartum care	Report if rendering deliver-only services. Report once, with a count of one, upon completion of services.
59425	Antepartum care only; 4-6 visits	Report **either** 59425 **OR** 59426 per pregnancy, on one line, with a count of one, with the date of the final visit.
59426	Antepartum care only; 7 or more visits	Report **either** 59425 **OR** 59426 per pregnancy, on one line, with a count of one, with the date of the final visit.
59430	Postpartum care only (separate procedure)	Report with a count of one, with the date of the final visit. Mass General Brigham Health Plan will not separately reimburse antepartum care (up to 3 visits) when reported in conjunction with antepartum care (4+ visits).
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	Report for global obstetrical services when services begin prior to **25** weeks' gestation and both delivery and postpartum care are provided. Bill once at the completion of services.

Code	Descriptor	Comments
59514	Cesarean delivery only	Report if rendering delivery-only services
59515	Cesarean delivery only; including postpartum care	Report if rendering deliver-only services. Report once, with a count of one, upon completion of services.
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	Report for global obstetrical services when services begin prior to **25** weeks' gestation and both delivery and postpartum care are provided. Bill once at the completion of services.
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	Report if rendering delivery-only services
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Report if rendering deliver-only services. Report once, with a count of one, upon completion of services.
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	Report for global obstetrical services when services begin prior to **25** weeks' gestation and both delivery and postpartum care are provided. Report once, with a count of one, at the completion of services.
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	Report if rendering delivery-only services
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	Report if rendering deliver-only services Report once, with a count of one, upon completion of services.

Modifiers

Modifier	Descriptor	Reimbursement
SA	Nurse practitioner rendering services in collaboration with a Physician	Submit for services provided by a nurse practitioner (NP).

SB	Nurse Midwife	Submit for services provided by a certified nurse midwife (CNM).

Related Mass General Brigham Health Plan Documents

Anesthesia
General Coding and Billing
Imaging Services
Inpatient Hospital Admissions
Laboratory and Pathology Services
Modifiers

References

ACOG – The American College of Obstetricians and Gynecologists-
CPT Assistant Fall 94:21, Apr 97:11, Aug 02:3
MassHealth Notification of Birth Form
MassHealth Provider Manual Series, Community Health Center Manual, CHC-119, Section 605,
Obstetrics and Surgery Service Code and Descriptions
Mass Health Physician Manual

Publication History

Topic: **Obstetrical Services**	**Owner:** **Network Management**

January 19, 2010	*Original documentation.*
August 3, 2010	*Obstetrical anesthesia calculation updated.*
October 26, 2010	*OB global reimbursement providers updated to include physicians, nurse midwives, physician assistants, or nurse practitioners that are owners, partners, employees, or contracted staff at the practice. Modifier requirement added*
November 1, 2011	*CPT Assistant quoted re: ante-partum care visit billing, disclaimer updated*
November 13, 2017	*Template update; spelling errors corrected; streamlining of code list; removal of reference(s) to obsolete program(s); update to Notification of Birth form link*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
January 1, 2023	*Document rebrand*
January 1, 2024	*Annual review, no policy change*
January 1, 2025	*Annual review, no policy change*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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