

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals

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This section contains information to help hospitals that are reimbursed under the diagnosis-related groups (DRG) model to accurately bill for inpatient obstetrical (OB) delivery and newborn accommodation services.

### Diagnosis-Related Groups Reimbursement Method

Refer to the *Diagnosis Related Groups (DRG): Inpatient Services* section in this provider manual for information about the DRG reimbursement methodology.

### DRG-Focused OB/Newborn Revenue Charts

The charts on the following pages match revenue codes with DRG-focused policy and billing guidelines.

### No TAR for Healthy OB Admission Outcome

Obstetric admissions associated with a delivery do not require either an admit or daily *Treatment Authorization Request* (TAR) in cases where both the mom and newborn remain healthy. Refer to the “Admit TAR and Daily TAR” entry in the *Diagnosis-Related Groups (DRG): Inpatient Services* section of this provider manual.

### Sick Mom or Sick Newborn

If the newborn becomes sick, an admit TAR must be submitted for the entire hospital stay. The “From” date on the TAR and claim is the date of the admission. Refer to the “Admit TAR and Daily TAR” entry in the *Diagnosis-Related Groups (DRG): Inpatient Services* section of this provider manual.

**OB Admission  
Authorization Guidelines**

OB admission authorization guidelines are as follows:

- Inpatient delivery services are reimbursable without authorization regardless of the type of delivery (vaginal or cesarean).
- The no-TAR period begins the day the mother is admitted to the hospital.
- *Welfare and Institutions Code*, Section 14132.42, mandates that a minimum of 48 hours of inpatient hospital care following a normal vaginal delivery and 96 hours following a delivery by cesarean section are reimbursable without authorization.
- For TARs (and claims processing purposes) it is necessary to use calendar days instead of hours.
- An admit TAR is required if a delivery does not occur during the hospital stay. Refer to “No Delivery” in this section for more information.
- Also see the previous entry: “No TAR for Healthy OB Admission Outcome.”

**Separate Claim for  
Mother and Newborn**

The mother’s delivery and hospital stay are billed on one claim. The newborn’s services and hospital stay are billed on a second claim separate from the mother’s claim. All newborn claims will use an admit type “4” (newborn) for healthy babies (revenue code 170 or 171) and an admit type “1” (emergency) for a sick baby (revenue codes 172, 173 or 174).

**Billing Well Newborn  
Services**

Hospitals paid according to the DRG model are reimbursed for inpatient care of a well newborn (revenue code 171) upon admission of the newborn to the hospital regardless of the mother’s status.

**ID Number on Claims for Well and Sick Newborns**

Claims for the newborn must be billed using the same ID number for the entire length of the hospital stay. Hospitals are encouraged to complete the *Newborn Referral Form* and submit it to the County Welfare Office to expedite assignment of the newborn's ID number.

**Interim Newborn Claim**

If separate claims (interim claims) are submitted for services rendered to the newborn, each claim must contain the same recipient ID number from the date of admission through the final discharge claim.

**Newborn Birth Weight and Gestation Period**

Newborn birth weight should be indicated on the claim by an ICD-9-CM diagnosis code, not a value code, when applicable. Birth weight can be a critical indicator of whether the newborn needs additional care. Similarly, ICD-9-CM diagnosis codes are used to indicate weeks of gestation, which can be another critical indicator of needed care.

**Fetal Demise**

No TAR is required in the event of fetal demise, if the physician determines the event constituted delivery. Once a delivery for fetal demise has been determined, providers should use ICD-9-CM Volume 3 procedure codes 72.0 to 73.99 for vaginal deliveries and codes 74.0 to 74.4, 74.91 and 74.99 for cesarean deliveries. If any of these procedure codes are billed, the system will apply the no-TAR policy.

**ICD-9-CM Procedure and Admit Type Code Requirements**

Claims submitted for OB admissions must include an ICD-9-CM Volume 3 procedure code in the *Principal Procedure Code and Date* field (Box 74) of the *UB-04* claim form. These procedure codes are entered on the claim to indicate the surgical procedure that was performed and to ensure the claim will reimburse at the appropriate level under the DRG reimbursement methodology.

Providers use ICD-9-CM Volume 3 procedure codes 72.0 to 73.99 for vaginal deliveries and codes 74.0 to 74.4, 74.91 and 74.99 for cesarean deliveries. Claims also must include either admit type code "1" (emergency) or "3" (elective).

**No Delivery**

If hospitalization does not result in delivery (false labor or failed induction) and the patient is discharged on the same day as admitted (that is, before midnight), services should be billed following the outpatient billing instructions in the *UB-04 Completion: Outpatient Services* section of the *Medi-Cal Outpatient Services – Clinics and Hospitals Provider Manual*.

When billing for this admission the provider must not bill with a delivery ICD-9-CM Volume 3 procedure code. This admit must be billed with a procedure code other than 72.0 – 73.99, 74.0 – 74.4, 74.91 or 74.99. These claims must be billed with Type of Admission code “3” (elective). If the patient was transferred from another facility, “4”, “5” or “6” is entered in the *Source Admission* field (Box 15) to indicate the source of the elective transfer.

**Delivery Prior to Admission**

If the delivery was outside of the hospital place admit type code “4” (newborn) in the *Type of Admission* field (Box 14) and admission source code “4” (extramural birth) in the *Source of Admission* field (Box 15). Revenue code 119, 129, 139 or 159 in conjunction with ICD-9-CM Volume 3 procedure code 73.99 (other operations assisting delivery, other) is used to bill OB-related room and board services when vaginal delivery occurs prior to the mother’s admission to a hospital. Also refer to the Revenue Code 171 portion of the chart on subsequent pages in this section.

**Emergency Services**

Emergency hospital services do not require authorization prior to admission if hospitalization is for services that meet the definition of emergency services. All hospitalizations resulting from emergency admissions, except labor and delivery, are subject to approval by the Medi-Cal consultant and require justification and an approved TAR for reimbursement.

**Emergency Transfers**

If the patient was transferred from another facility, enter in the *Source of Admission* field (Box 15), “4,” “5” or “6” to indicate the source of emergency transfer.

**Emergency Neonatal Intensive Care Services**

Neonatal intensive care services performed within the first 24 hours of life are considered emergency services and processed as such. This includes hospital admissions (Type of Admission code "1"), transfers, ambulance and other related services otherwise requiring authorization. This policy includes transfers from one acute care hospital to another which has the level of care necessary to meet the patient's medical needs. After the first 24 hours of life, requests for these services require an approved admission TAR for the service to be reimbursed.

**Day of Discharge or Death**

Refer to the "Day of Discharge or Death: Emergency or Elective Admission" information in the *UB-04 Special Billing Instructions for Inpatient Services* section of this provider manual. Also see the "Discharge/Death on Day of Admission" entry in the same section.

**Second Pregnancy or Multiple Deliveries Within Six Months**

Reimbursement for obstetrical deliveries is limited to once in a six-month period unless pregnancy recurs. Providers billing delivery services for a second pregnancy within six months of a previous pregnancy must enter "pregnancy recurred within six months" in the *Remarks* field of the claim. For multiple deliveries occurring within six months of a previous delivery, providers also must indicate in the *Remarks* field "multiple births," the birth date of each newborn and whether the deliveries are from the current or previous pregnancy.

**Low Birth-Weight  
Newborns May Qualify  
for SSI and SSI-Linked  
Medi-Cal**

Providers can assist parents of premature newborns in applying for immediate Supplemental Security Income (SSI) benefits and related SSI-linked Medi-Cal benefits. Premature infants born before or at 37 weeks and weighing less than 2 pounds and 10 ounces, regardless of medical impairment, qualify for the Social Security Administration (SSA) "Presumptive Disability" (PD) category. Though subject to SSA review, PD infants usually qualify for benefits.

Parents must file an SSI application through the SSA office. Since SSI payments and SSI-linked Medi-Cal benefits are not retroactive to dates prior to the SSI application date, providers should encourage parents to apply for SSI benefits as soon as it is determined their newborn meets PD standards.

The parent's income and resources are not used to determine SSI benefit eligibility until the month following the month that the infant is released from the hospital. The infant's independent income and resources, however, are used to determine benefits. For example, an infant bequeathed a legacy may not qualify for these SSI benefits.

**DRG-Focused OB-Newborn Revenue Code Chart**

This chart is designed to match revenue codes with instructions for how to bill OB- and newborn-related revenue codes on the *UB-04* claim form.

Using the Chart

Providers must apply policy stated on the previous pages of this section in addition to the policy highlighted in the charts. "Procedure code" in the following table refers to ICD-9-CM Volume 3 procedure codes.

Out-of-State Hospitals

The chart includes some instructions for Out-of-State hospitals.

**Revenue Codes 112, 122, 132, 152: Billing OB-Related Room and Board for Mother**

Revenue Code	Description	Policy
112	Room & Board: Private – OB	<u>WITH DELIVERY</u>  These four revenue codes are used to bill OB-related room and board services for the <u>mother</u> only.
122	Room & Board – Semi-Private 2 Beds – OB	Must be billed with one of the following procedure codes: 72.0 – 73.99, 74.0 – 74.4, <b>74.91</b> or 74.99.
132	Room & Board – Semi-Private; 3 and 4 Beds – OB	<u>WITHOUT DELIVERY, FULL-SCOPE MEDICAL</u>  TAR approval is required for the admission to the hospital only. Claims require procedure code other than a delivery procedure code – if a procedure code is applicable – in the <i>Principal/Other Procedure</i> fields (Boxes 74 and 74A).
152	Room & Board – Ward – OB	<u>WITHOUT DELIVERY, RESTRICTED AID CODE</u>  TAR approval is required for the admission to the hospital and each day of the stay. Claims require procedure code other than a delivery procedure code – if a procedure code is applicable – in the <i>Principal/Other Procedure</i> fields (Boxes 74 and 74A).

Revenue Code 170: Care for Well or Sick Newborn

Revenue Code	Description	Policy
170	Nursery, General Classification	<p>Used to bill care for well or sick newborns (other than newborns in the NICU) delivered by a mother who is ineligible for Medi-Cal when both the newborn and the ineligible mother are in the hospital. The ineligible mother either has no other medical insurance coverage, or has medical coverage that does not provide coverage for the newborn. No claims may be submitted to Medi-Cal for services provided to the ineligible mother.</p> <p>If the ineligible mother no longer remains in the hospital, but the newborn remains in the hospital, providers should bill outstanding hospital days for the newborn using revenue code 172, 173 or 174, as appropriate.</p> <p>Requires a TAR for admission of a sick newborn only. No TAR required for admission of a well newborn.</p> <p>Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes in the <i>Diagnosis Codes</i> fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate V30.00 – <b>V39.2</b> code for the birth episode.</p> <p>Hospitals should always list the diagnosis code related to gestational age of the newborn.</p> <p>Claim for the newborn requires a procedure code other than a delivery procedure code – if a procedure code is appropriate – in the <i>Principal/Other Procedure</i> fields (Boxes 74 and 74E). Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable procedure codes (up to six on a paper claim) in the <i>Principal/Other Procedure</i> fields so the claim will reimburse at the appropriate level.</p>

Revenue Code 171: Admission of Newborn Delivered Inside/Outside Hospital

Revenue Code	Description	Policy
171	Nursery, Newborn; Level I	<p>Used to bill for admission of a newborn, whether newborn was delivered in the hospital or outside the hospital.</p> <p>No TAR is required for admission of a well newborn.</p> <p>Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes in the <i>Diagnosis Codes</i> fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate V30.00 – <b>V39.2</b> code for the birth episode.</p> <p>Hospitals should always list the diagnosis code related to gestational age of the newborn.</p> <p>Claim for the newborn requires a procedure code other than a delivery procedure code – if a procedure code is appropriate – in the <i>Principal/Other Procedure</i> fields (Boxes 74 and 74E). Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable procedure codes (up to six on a paper claim) in the <i>Principal/Other Procedure</i> fields so the claim will reimburse at the appropriate level.</p> <p><b><u>DELIVERY OUTSIDE OF THE HOSPITAL</u></b></p> <p>The actual time and day of delivery is established from a combination of the mother’s statement, records of auxiliary personnel involved in the care and transport of the mother, and the attending physician’s assessment. Also refer to “Delivery Prior to Admission” on an earlier page in this provider manual section.</p> <p><b><u>WELL NEWBORN BECOMES SICK NEWBORN: REQUIRES TAR</u></b></p> <p>If the newborn becomes ill within the same hospital stay, an admission TAR is required beginning on the day the newborn is admitted.</p> <p><b><u>OUT-OF-STATE HOSPITALS</u></b></p> <p>Are reimbursed according to DRG-reimbursed methodology.</p>

Revenue Code 172: Sick Newborn (Not Neonatal Intensive Care)

Revenue Code	Description	Policy
172	Nursery, Newborn; Level II (Sick newborn)	<p>Used to bill care rendered to a sick newborn (but not neonatal intensive care).</p> <p>A TAR is required for admission of a sick newborn.</p> <p>Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable <u>diagnosis</u> codes in the <i>Diagnosis Codes</i> fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate V30.00 – <b>V39.2</b> code for the birth episode.</p> <p>Hospitals should always list the diagnosis code related to gestational age of the newborn.</p> <p>Claim for the newborn requires a procedure code other than a delivery procedure code – if a <u>procedure</u> code is appropriate – in the <i>Principal/Other Procedure</i> fields (Boxes 74 through 74E). Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable procedure codes (up to six on a paper claim) in the <i>Principal/Other Procedure</i> fields so the claim will reimburse at the appropriate level.</p>

Revenue Code 173: Sick Newborn (Lower Staffing Ratio)

Revenue Code	Description	Policy
173	Nursery, Newborn; Level III <i>(Sick newborn, lower staffing ratio)</i>	<p>Used to bill care rendered to a sick newborn when staffing ratio is one staff to three or more patients (but not neonatal intensive care).</p> <p>A TAR is required for admission of a sick newborn.</p> <p>Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes in the <i>Diagnosis Codes</i> fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate V30.00 – <b>V39.2</b> code for the birth episode.</p> <p>Hospitals should always list the diagnosis code related to gestational age of the newborn.</p> <p>Claim for the newborn requires a procedure code other than a delivery procedure code – if a procedure code is appropriate – in the <i>Principal/Other Procedure</i> fields (Boxes 74 and 74E). Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable procedure codes (up to six on a paper claim) in the <i>Principal/Other Procedure</i> fields so the claim will reimburse at the appropriate level.</p>

Revenue Code 174: Medically Necessary Neonatal Intensive Care (NICU)

Revenue Code	Description	Policy
174	Nursery, Newborn; Level IV (NICU)	<p>Used to bill medically necessary Neonatal Intensive Care (NICU) services for the newborn whether or not the hospitalization is associated with a delivery.</p> <p>A TAR is required for admission of a sick newborn.</p> <p>Hospitals reimbursed under the DRG payment method are encouraged to enter <u>all</u> applicable diagnosis codes in the <i>Diagnosis Codes</i> fields (Boxes 67 through 67Q) so the claim will reimburse at the appropriate level. The primary diagnosis should be the appropriate V30.00 – <b>V39.2</b> code for the birth episode.</p> <p>Hospitals should always list the diagnosis code related to gestational age of the newborn.</p> <p>Claim for the newborn requires a procedure code other than a delivery procedure code – if a procedure code is appropriate – in the <i>Principal/Other Procedure</i> fields (Boxes 74 and 74E). Hospitals reimbursed under the DRG payment method are encouraged to enter all applicable procedure codes (up to six on a paper claim) in the <i>Principal/Other Procedure</i> fields so the claim will reimburse at the appropriate level.</p>