

Obstetrics

Introduction

Purpose

The purpose of this module is to provide an overview of basic Medi-Cal Obstetrics (OB) billing. General billing and claim form documentation requirements will be discussed.

Module Objectives

- Clarify Medi-Cal OB benefits and limitations
- Identify when and how to bill the initial comprehensive office visit
- Define both per-visit and global services
- Review claim form billing completion requirements
- Discuss ultrasound benefits and billing documentation
- Explain OB ancillary services
- Highlight commonly used modifiers for OB services

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

Medi-Cal Billing and Policy Provider Manual References

Part 2

Pregnancy Determination (preg determ)

Pregnancy: Early Care and Diagnostic Services (preg early)

Pregnancy Examples: CMS-1500 (preg ex cms)

Pregnancy: Global Billing (preg glo)

Pregnancy: Per-Visit Billing (preg per)

Pregnancy: Share of Cost (preg share)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTE

Interim codes Z1032, Z1034 and Z1038 are being converted to HIPAA-compliant codes. As they become available, code conversions and effective dates will appear in the Medi-Cal provider bulletins. Please refer to the *Special Appendix* section at the end of this module to learn more about the code conversion.

Description

This training module outlines the CPT-4 and HCPCS codes used to bill for services for providers who render obstetrical care.

Obstetrics Billing Guidelines

Refer to the *Pregnancy Determination* (preg determ) section in the appropriate Part 2 provider manual for the topics below.

Billing for Initial Pregnancy

Office Visit

Brainteasers: True or False

1. When a patient is first seen, an office visit code (CPT-4 codes 99201 – 99215) should be billed with ICD-10-CM diagnosis code N91.2 (amenorrhea, unspecified) to reflect the actual reason the patient was seen to confirm pregnancy.
True False
2. Evaluation and Management office visit codes 99201 – 99215 are reimbursable with a pregnancy-related diagnosis.
True False

Verification of Pregnancy

County welfare departments accept as verification of pregnancy a written statement from the physician, physician's assistant, certified nurse midwife, nurse practitioner or designated medical or clinic personnel with access to the patient's medical records.

Brainteaser: True or False

3. Pregnant patients applying for Medi-Cal must submit the written verification of pregnancy statement that provides the estimated date of delivery and sufficient information to verify the pregnancy diagnosis.
True False

Answer Key: 1) True; 2) False; 3) True

Refer to the *Pregnancy: Early Care and Diagnostic Services* section (preg early) in the appropriate Part 2 provider manual regarding these topics.

Pregnancy Related Office Visit (HCPCS Code Z1032)

HCPCS Code Z1032:

1. Is billed after the pregnancy has been confirmed and is considered to be the first prenatal visit.
2. Must be billed with a pregnancy associated diagnosis codes O09.0 – O48.1, O098.011 – O9A.519, Z34.00 – Z34.93.
3. Is billed separately in conjunction with per-visit or global care.
4. Is limited to once in six months per provider, unless care is transferred to another physician during the same pregnancy, or the provider certifies that pregnancy has recurred within a six-month period.
5. Must indicate date of transfer or date of fetal demise and document in the *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form, or in the *Remarks* field (Box 80) on the *UB-04* claim form.

Co-management Pregnancy Policy (HCPCS Code Z1032)

6. Consultants who co-manage a pregnancy without _____ should not bill with HCPCS code Z1032 (initial pregnancy-related office visit). Providers must bill HCPCS code Z1034 (per-visit antepartum office visit).

NOTES

Answer Key: 6. complete transfer of care

Per-Visit Billing for Pregnancy

Refer to the *Pregnancy: Per-Visit Billing* section (preg per) in the appropriate Part 2 provider manual regarding this topic.

Policy

Providers who do not render total obstetrical care during the recipient's entire pregnancy or who render fewer than 13 antepartum visits must bill each visit or procedure separately. The initial pregnancy-related office visit (HCPCS code Z1032) may not be counted as one of the 13 visits. Each visit is subject to the six-month billing limit, and recipient eligibility must be verified for each month of service.

Antepartum, Referrals for Specialty Care and Postpartum Visit Policy Clarification

Antepartum HCPCS Code Z1034

- Documentation for primary obstetrical providers must conform to current standards equivalent to those defined by the American Congress of Obstetricians and Gynecologists (ACOG) for antepartum visits.
- Documentation by consultants, including those who co-manage a pregnancy, should be consistent with CPT-4 guidelines for consultation services and document the appropriate history, physical examination and medical decision making.
- Services must be separately identifiable from the professional and/or technical components of any diagnostic study performed.

Referrals for Specialty Care (High-Risk)

- Medi-Cal allows consult codes (99241 – 99245) when the service is rendered to an obstetrics patient by a perinatologist or an OB/GYN. Code Z1032 or Z1034 is to be used for any antepartum visit.
- Include a pregnancy diagnosis code on the claim to ensure reimbursement.
- A nurse practitioner may see the patient, but the perinatologist must personally visit and evaluate every high-risk patient and sign off on the patient's chart.

Postpartum HCPCS Code Z1038

- The postpartum visit normally occurs four to six weeks after delivery and must conform to current standards equivalent to those defined by ACOG.
- An office visit seven to 14 days after delivery may be advisable after a cesarean delivery or to follow-up on a complicated gestation. This care is part of the delivery follow-up and is not separately reimbursable.
- More than one postpartum visit is reimbursable in six months if there is documentation of a postpartum complication in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim form or on an attachment.

Per-Visit Obstetrical Codes

HCP/CS/ CPT-4 Code	Definition	Frequency Limit
Z1032	Initial comprehensive pregnancy-related office visit	1 in 6 months
Z1034	Antepartum office visit	13 in 9 months
Z1038	Postpartum office visit	1 in 6 months
59409; 59514	Vaginal delivery only; cesarean delivery only	1 in 6 months
59525	Subtotal or total hysterectomy after cesarean delivery	1 in 6 months
59612	Vaginal delivery only, after previous cesarean with/without episiotomy, and/or forceps	1 in 6 months
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	1 in 6 months

Brainteasers: Per-Visit

1. Reimbursement for antepartum visit (HCP/CS code Z1034) is limited to _____ visits in a nine-month period.
a) eight b) thirteen c) ten

Exception: More than 13 antepartum visits (HCP/CS code Z1034) are allowed in nine months if the provider documents a second pregnancy occurring within those nine months.

2. If providers bill one antepartum HCP/CS code Z1034, they _____ bill globally.
a) must b) cannot
3. If providers bill per-visit CPT-4 code 59409 or 59612 (vaginal delivery only) or 59514 or 59620 (cesarean delivery only), they must bill all antepartum visits separately.
True False
4. Postpartum visit HCP/CS code Z1038 may be billed by the primary maternity care provider or by the provider who saw the patient for only the postpartum office visit.
True False
5. Reimbursement for postpartum visit HCP/CS code Z1038 is limited to _____ in a six-month period.

Answer Key: 1) b; 2) b; 3) True; 4) True; 5) one visit

Per-Visit Billing Example: CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM													
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12													
<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER 9000000A95001			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JANE				3. PATIENT'S BIRTH DATE 06 12 86 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				8. RESERVED FOR NUCC USE		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY ANYTOWN		STATE CA		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
ZIP CODE 958235555		TELEPHONE (Include Area Code) (916) 555-5555		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				10d. CLAIM CODES (Designated by NUCC)		d. INSURANCE PLAN NAME OR PROGRAM NAME				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
b. RESERVED FOR NUCC USE				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
c. RESERVED FOR NUCC USE				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 01 08 15 QUAL.						15. OTHER DATE QUAL.			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 10 12 15 TO 10 13 15				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0													
A. D1D1D1D B. _____ C. _____ D. _____													
E. _____ F. _____ G. _____ H. _____													
I. _____ J. _____ K. _____ L. _____													
22. RESUBMISSION CODE ORIGINAL REF. NO.													
23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #													
1 10 01 15 11 Z1034 10000 1 NPI													
2 10 12 15 21 59409 AG 8900 1 NPI													
3 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
4 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
5 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
6 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____													
25. FEDERAL TAX I.D. NUMBER			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 18900		29. AMOUNT PAID \$		30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED John Doe DATE 10/30/15				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN CA 958765555				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555					
a. 1234567890				b. 0123456789									

Sample: Per-Visit Billing – Vaginal Delivery and Antepartum Office Visit

NOTE

When billing with Place of Service 21, you must indicate in the *Service Facility Location Information* field (Box 32) the name and address where the service took place. Use field 32a to indicate the NPI # that represents the facility in which the service was rendered.

Per-Visit Billing Example: Initial OB visit and Antepartum Office Visit

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTL. # 3b MED. REC. #		4 TYPE OF BILL 731	
8 PATIENT NAME b DOE, JANE				9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR	
17 STATE		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACCT STATE		30		31 OCCURRENCE CODE		32 OCCURRENCE DATE	
33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	
101		102		103		104	
105		106		107		108	
109		110		111		112	
113		114		115		116	
117		118		119		120	
121		122		123		124	
125		126		127		128	
129		130		131		132	
133		134		135		136	
137		138		139		140	
141		142		143		144	
145		146		147		148	
149		150		151		152	
153		154		155		156	
157		158		159		160	
161		162		163		164	
165		166		167		168	
169		170		171		172	
173		174		175		176	
177		178		179		180	
181		182		183		184	
185		186		187		188	
189		190		191		192	
193		194		195		196	
197		198		199		200	
201		202		203		204	
205		206		207		208	
209		210		211		212	
213		214		215		216	
217		218		219		220	
221		222		223		224	
225		226		227		228	
229		230		231		232	
233		234		235		236	
237		238		239		240	
241		242		243		244	
245		246		247		248	
249		250		251		252	
253		254		255		256	
257		258		259		260	
261		262		263		264	
265		266		267		268	
269		270		271		272	
273		274		275		276	
277		278		279		280	
281		282		283		284	
285		286		287		288	
289		290		291		292	
293		294		295		296	
297		298		299		300	
301		302		303		304	
305		306		307		308	
309		310		311		312	
313		314		315		316	
317		318		319		320	
321		322		323		324	
325		326		327		328	
329		330		331		332	
333		334		335		336	
337		338		339		340	
341		342		343		344	
345		346		347		348	
349		350		351		352	
353		354		355		356	
357		358		359		360	
361		362		363		364	
365		366		367		368	
369		370		371		372	
373		374		375		376	
377		378		379		380	
381		382		383		384	
385		386		387		388	
389		390		391		392	
393		394		395		396	
397		398		399		400	
401		402		403		404	
405		406		407		408	
409		410		411		412	
413		414		415		416	
417		418		419		420	
421		422		423		424	
425		426		427		428	
429		430		431		432	
433		434		435		436	
437		438		439		440	
441		442		443		444	
445		446		447		448	
449		450		451		452	
453		454		455		456	
457		458		459		460	
461		462		463		464	
465		466		467		468	
469		470		471		472	
473		474		475		476	
477		478		479		480	
481		482		483		484	
485		486		487		488	
489		490		491		492	
493		494		495		496	
497		498		499		500	
501		502		503		504	
505		506		507		508	
509		510		511		512	
513		514		515		516	
517		518		519		520	
521		522		523		524	
525		526		527		528	
529		530		531		532	
533		534		535		536	
537		538		539		540	
541		542		543		544	
545		546		547		548	
549		550		551		552	
553		554		555		556	
557		558		559		560	
561		562		563		564	
565		566		567		568	
569		570		571		572	
573		574		575		576	
577		578		579		580	
581		582		583		584	
585		586		587		588	
589		590		591		592	
593		594		595		596	
597		598		599		600	
601		602		603		604	
605		606		607		608	
609		610		611		612	
613		614		615		616	
617		618		619		620	
621		622		623		624	
625		626		627		628	
629		630		631		632	
633		634		635		636	
637		638		639		640	
641		642		643		644	
645		646		647		648	
649		650		651		652	
653		654		655		656	
657		658		659		660	
661		662		663		664	
665		666		667		668	
669		670		671		672	
673		674		675		676	
677		678		679		680	
681		682		683		684	
685		686		687		688	
689		690		691		692	
693		694		695		696	
697		698		699		700	
701		702		703		704	
705		706		707		708	
709		710		711		712	
713		714		715		716	
717		718		719		720	
721		722		723		724	
725		726		727		728	
729		730		731		732	
733		734		735		736	
737		738		739		740	
741		742		743		744	
745		746		747		748	
749		750		751		752	
753		754		755		756	
757		758		759		760	
761		762		763		764	
765		766		767		768	
769		770		771		772	
773		774		775		776	
777		778		779		780	
781		782		783		784	
785		786		787		788	
789		790		791		792	
793		794		795		796	
797		798		799		800	
801		802		803		804	
805		806		807		808	
809		810		811		812	
813		814		815		816	
817		818		819		820	
821		822		823		824	
825		826		827		828	
829		830		831		832	
833		834		835		836	
837		838		839		840	
841		842		843		844	
845		846		847		848	
849		850		851		852	
853		854		855		856	
857		858		859		860	
861		862		863		864	
865		866		867		868	
869		870		871		872	
873		874		875		876	
877		878		879		880	
881		882		883		884	
885		886		887		888	
889		890		891		8	

Global Billing for Pregnancy

Refer to the *Pregnancy: Global Billing* (preg glo) section in the appropriate Part 2 provider manual regarding this topic.

Global OB Billing Policy

Effective for dates of service on or after January 1, 2016, the requirement for global obstetrical (OB) billing has changed from a minimum of eight to 13 antepartum visits.

Global OB billing is only allowed if the provider renders at least 13 antepartum visits (HCPCS code Z1034). The initial comprehensive pregnancy-related office visit (HCPCS code Z1032) may not be counted as one of the 13 visits. Global OB billing is never to be used for recipients who have transferred care and have already received OB care and billing by another Medi-Cal provider.

The intent of global billing is to offer a convenient means of billing for providers. Global billing consists of antepartum, delivery and post-partum care. Global billing also includes the following: hospital admission, patient history, physical examination, labor management, postpartum office visit, vaginal or cesarean delivery, hospital discharge and all applicable postoperative care.

Non-Reimbursable Global OB Services

- Antepartum visits (Z1034) reimbursed to the same provider, for dates of service within the from-through period of the global billing or within 270 days prior to the global OB delivery date
- Hospital visits
- Postpartum visits (Z1038) that are related to the delivery, reimbursed to the same provider and within the 45-day follow-up period of the global OB delivery date

Global Obstetrical Codes

HCPCS/ CPT-4 Code	Definition	Frequency Limit
59400 *	Global antepartum care, vaginal delivery and postpartum care	1 in 6 months
59510 *	Global antepartum care, cesarean delivery and postpartum care	1 in 6 months
59525 *	Subtotal or total hysterectomy after cesarean delivery	1 in 6 months (subtotal) or once in a lifetime (total)
59610 *	Routine OB care vaginal delivery w/without episiotomy and/or forceps and postpartum care after previous cesarean delivery	1 in 6 months
59618 *	Routine OB care cesarean delivery and postpartum care following attempted vaginal delivery after cesarean delivery	1 in 6 months

* Refer to the CPT-4 codebook for complete procedure descriptions.

Global billing/ICD-10 Billing Guide

Providers who bill obstetrical services on a global basis will use the FROM date of service to determine the ICD code set used when billing. Claims with a FROM date of service prior to October 1, 2015, must use ICD-9-CM diagnosis codes. Claims with a FROM date of service on or after October 1, 2015, must use ICD-10-CM diagnosis codes.

Transfer of Care

Providers who accept a Medi-Cal transfer patient must bill each antepartum visit separately. Providers who accept a transfer-of-care patient are restricted to the number of visits reimbursed (up to one initial visit [HCPCS code Z1032] and a total of 13 antepartum visits [HCPCS code Z1034]) in nine months by all primary obstetrical providers.

Global Obstetrical Codes and Assistant Surgeons

The following global obstetrical codes are no longer reimbursable to assistant surgeons.

- 59400 (global antepartum care, vaginal delivery and postpartum care)
- 59510 (global antepartum care, cesarean delivery and postpartum care)
- 59610 (routine OB care vaginal delivery w/without episiotomy and/or forceps and postpartum care after previous cesarean delivery)
- 59618 (routine OB care cesarean delivery and postpartum care following attempted vaginal delivery after cesarean delivery)

Brainteasers: Global OB

1. The initial pregnancy-related visit HCPCS code Z1032 is included in the global fee and cannot be billed separately.
True False
2. If fewer than 13 visits are rendered, providers must bill services on a per-visit basis.
True False
3. Global OB claims must be billed on the _____ claim form using the _____ – _____ billing format.
4. If a provider plans to bill globally but does not perform the delivery, each antepartum visit (HCPCS code Z1034) must be billed separately. For any visits that exceed the six-month billing limit, providers should enter code _____ in the _____ field (Box _____) and state in the *Additional Claim Information* field (Box 19) the _____ the patient left their care.
5. To be reimbursed for global claims, providers must verify the recipient's eligibility for services during the _____.
6. Global claims are subject to the six-month billing limit, based on the delivery date.
True False

Answer Key: 1) False; 2) True; 3) CMS-1500, from, through; 4) "1"; EMG, 24C, date; 5) month of delivery; 6) True

CMS-1500 Global Billing Example

Documentation Requirements

- Date of Last Menstrual Period (LMP)
- Hospitalization dates
- Documentation of at least 13 antepartum visits in the *Additional Claim Information* field (Box 19)
- Pregnancy diagnosis
- "From-Through" billing format
- Global delivery procedure code
- Name, address of where the delivery took place and NPI # in Fields 32 and 32a

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 05 08 15				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 02 12 16 TO 02 14 16				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 110215, 111615, 113015, 121415, 122815, 011116, 012516, 020116, 020816				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. D1D1D1D B. C. D. E. F. G. H. I. J. K. L.				22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT7/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPCSOT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 07 03 15		02 12 16		21		59400 AG		120000		1		NPI					
2												NPI					
3												NPI					
4												NPI					
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 120000		29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <i>Jane Doe</i> DATE 03/30/16				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN, CA 958765555 a. 0123456789 b.				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555 a. 0123456789 b.									

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Example: Partial CMS-1500 Claim Form

CMS-1500 Global Billing Example: Vaginal Delivery with Tubal Ligation – Same Date of Service

Documentation Requirements

- Date of LMP
- Hospitalization dates
- Documentation of at least 13 antepartum visits in the *Additional Claim Information* field (Box 19)
- Documentation of start/stop times for both procedures in the *Additional Claim Information* field (Box 19) or on an attachment
- Diagnosis codes to support pregnancy and tubal ligation services
- “From-Through” billing format
- Global delivery and tubal ligation procedure codes with appropriate modifiers
- Submission of the PM 330 sterilization *Consent Form*
- Name, address of where the delivery took place and NPI # in Fields 32 and 32a

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 05 08 15				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 02 12 16 TO 02 14 16				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 070315, 080415, 090615, 100315 110215, 111615, 113015, 121415, 122815, 011116, 012516, 020116, 020816				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0				22. RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0				23. PRIOR AUTHORIZATION NUMBER				24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
A. D1D1D1D B. D2D2D2D C. _____ D. _____				E. _____ F. _____ G. _____ H. _____				I. _____ J. _____			
1				07 03 15 02 12 16 21 59400 AG				120000 1 NPI			
2				02 12 16 02 12 16 21 58605 AG				40000 1 NPI			
3								NPI			
4								NPI			
5								NPI			
6								NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			
28. TOTAL CHARGE \$ 160000				29. AMOUNT PAID \$				30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Jane Doe</i> SIGNED Jane Doe DATE 03/30/16				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN, CA 958765555				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555			
a. 0123456789				b. _____				a. 0123456789 b. _____			

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Example: Partial CMS-1500 Claim Form

CMS-1500 Global Billing Example: Cesarean Section with Tubal Ligation – Same Date of Service

Documentation Requirements

- Date of LMP
- Hospitalization dates
- Documentation of at least 13 antepartum visits in the *Additional Claim Information* field (Box 19)
- Diagnosis codes to support pregnancy and tubal ligation services
- “From-Through” billing format
- Global delivery and tubal ligation procedure codes with appropriate modifiers
- Submission of the PM 330 sterilization *Consent Form*
- Name, address of where the delivery took place and NPI # in Fields 32 and 32a

NOTE

See Part 2 – *Surgery: Billing with Modifiers* (surg bil mod): This illustrates the policy that allows code 58611 with modifier 51 to be reimbursed at 100 percent on the same date as the primary surgery with modifier AG.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 05 08 15				15. OTHER DATE QUAL: MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 02 12 16 TO 02 14 16				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 110215, 111615, 113015, 121415, 122815, 011116, 012516, 020116, 020816				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <u>D1D1D1D</u> B. <u>D2D2D2D</u> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 07 03 15 02 12 16 21				59510 AG				120000		1				NPI			
2 02 12 16 02 12 16 21				58611 51				40000		1				NPI			
3														NPI			
4														NPI			
5														NPI			
6														NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 160000		29. AMOUNT PAID \$		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Jane Doe</i> SIGNED DATE 03/30/16				32. SERVICE FACILITY LOCATION INFORMATION COMMUNITY HOSPITAL 1234 HEALTHCARE STREET ANYTOWN, CA 958765555 a. 0123456789 b. _____				33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555 a. 0123456789 b. _____									

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Example: Partial CMS-1500 Claim Form

Unique Billing Condition

Assistant Surgeon Billing for Delivery and Tubal Ligation – Same Date of Service

Assistant surgeons must bill CPT-4 code 59514 (cesarean delivery only) with modifier 80 and CPT-4 code 58611 with modifier 99. The *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form must indicate that modifier 99 was used to signify modifier 80 and modifier 51.

NOTE

Delivery services performed in an inpatient setting must be billed on a *CMS-1500* claim form using the physician's National Provider Identifier (NPI). The NPI is entered in Box 33a.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										
Line 2: 99 = 80 + 51										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind. 0
A. D1D1D1D			B. D2D2D2D			C. _____		D. _____		
E. _____			F. _____			G. _____		H. _____		
I. _____			J. _____			K. _____		L. _____		
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										
MM DD YY MM DD YY SERVICE EMG CPT/HCPCS MODIFIER										
1	10	02	15			21		59514	80	
2	10	02	15			21		58611	99	
3										

Common Billing Practice for Ultrasound During Pregnancy

Policy

An ultrasound performed for routine screening during pregnancy is considered an integral part of the patient's care during pregnancy and its reimbursement is included in the obstetrical fee. Ultrasound during pregnancy is separately reimbursable only when used for the diagnosis or treatment of specific medical conditions.

Diagnosis, Frequency and Documentation Guidelines

Ultrasound services are reimbursable as defined below:

- Diagnosis on the claim must be appropriate for the CPT-4 code being billed.
- Frequency must meet the restrictions listed.
- Some claims must have documentation in the *Remarks* field (Box 80) of the *UB-04* claim form and the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form.

NOTE

See the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for the most current list of codes, frequency limits and documentation.

Diagnosis, Frequency and Documentation Guidelines

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76801, 76805, 76811	<p>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</p> <p>O03.0 – O03.9 Spontaneous abortion</p> <p>O04.5 – O04.89 Complications following (induced) termination of pregnancy</p> <p>O09.511 – O09.513 Elderly primigravida</p> <p>O09.521 – O09.523 Elderly multigravida</p> <p>O10.011 – O16.9 Edema, proteinuria and hypertensive disorders</p> <p>O20.0 – O29.93 Other maternal disorders</p> <p>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</p> <p>O60.00 – O60.03 Preterm labor without delivery</p> <p>O98.011 – O98.919 Maternal infectious and parasitic diseases</p> <p>O99.011 – O99.89 Other maternal disease classifiable elsewhere</p> <p>O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</p> <p>Z33.2 Encounter for elective termination of pregnancy</p> <p>Z36 Encounter for antenatal screening of mother</p>	<p>Once in 180 days, same provider.</p> <p>Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity, unless documentation states that another pregnancy had occurred.</p>

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76802, 76810, 76812	O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Four in 180 days, same provider. Additional claims are cut back to the rate for code 76816 even if billed with documentation to justify medical necessity, unless documentation states that another pregnancy had occurred. Four per day maximum when billing for a pregnancy with multiple gestation. Provider must document the number of fetuses in the <i>Remarks</i> field (Box 80/ <i>Additional Claim Information</i> field (Box 19) of the claim.
76813	Z36 Encounter for antenatal screening of mother	One per day. Requires documentation with the claim that states: The physician performing or supervising the ultrasound is credentialed by either the Nuchal Translucency Quality Review program or the Fetal Medicine Foundation. *

* The responsible party, the physician, is required to be certified, regardless of whether performing or merely supervising the ultrasound for nuchal translucency measurement.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76814	Z36 Encounter for antenatal screening of mother	<p>Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/<i>Additional Claim Information</i> field (Box 19) of the claim.</p> <p>Requires documentation with the claim that states: The physician performing or supervising the ultrasound is credentialed by either the Nuchal Translucency Quality Review program or the Fetal Medicine Foundation. *</p>
76815	<p>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</p> <p>O03.0 – O03.9 Spontaneous abortion</p> <p>O04.5 – O04.89 Complications following (induced) termination of pregnancy</p> <p>O09.511 – O09.513 Elderly primigravida</p> <p>O09.521 – O09.523 Elderly multigravida</p> <p>O10.011 – O16.9 Edema, proteinuria and hypertensive disorders</p> <p>O20.0 – O29.93 Other maternal disorders</p> <p>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</p> <p>O60.00 – O60.03 Preterm labor without delivery</p> <p>O98.011 – O98.919 Maternal infectious and parasitic diseases</p> <p>O99.011 – O99.89 Other maternal disease classifiable elsewhere</p> <p>O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</p> <p>Z33.2 Encounter for elective termination of pregnancy</p> <p>Z36 Encounter for antenatal screening of mother</p>	<p>Once in 180 days, same provider.</p> <p>Additional claims may be reimbursed if documentation justifies medical necessity.</p>

* The responsible party, the physician, is required to be certified, regardless of whether performing or merely supervising the ultrasound for nuchal translucency measurement.

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76816	<p>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</p> <p>O03.0 – O03.9 Spontaneous abortion</p> <p>O04.5 – O04.89 Complications following (induced) termination of pregnancy</p> <p>O09.511 – O09.513 Elderly primigravida</p> <p>O09.521 – O09.523 Elderly multigravida</p> <p>O10.011 – O16.9 Edema, proteinuria and hypertensive disorders</p> <p>O20.0 – O29.93 Other maternal disorders</p> <p>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</p> <p>O60.00 – O60.03 Preterm labor without delivery</p> <p>O98.011 – O98.919 Maternal infectious and parasitic diseases</p> <p>O99.011 – O99.89 Other maternal disease classifiable elsewhere</p> <p>O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</p> <p>Z33.2 Encounter for elective termination of pregnancy</p> <p>Z36 Encounter for antenatal screening of mother</p>	<p>Once in 180 days (when billed without modifier 59), same provider.</p> <p>Additional claims may be reimbursed if documentation justifies medical necessity. Multiple gestation does not justify second and subsequent claims; use modifier 59.</p> <p>Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/<i>Additional Claim Information</i> field (Box 19) of claim.</p>

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76817	O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception O03.0 – O03.9 Spontaneous abortion O04.5 – O04.89 Complications following (induced) termination of pregnancy O09.511 – O09.513 Elderly primigravida O09.521 – O09.523 Elderly multigravida O10.011 – O16.9 Edema, proteinuria and hypertensive disorders O20.0 – O29.93 Other maternal disorders O30.001 – O48.1 Maternal care related to fetus and amniotic cavity O60.00 – O60.03 Preterm labor without delivery O98.011 – O98.919 Maternal infectious and parasitic diseases O99.011 – O99.89 Other maternal disease classifiable elsewhere O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse Z33.2 Encounter for elective termination of pregnancy Z36 Encounter for antenatal screening of mother	Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity.
76820	O36.5110 – O36.5999 Maternal care for known or suspected poor fetal growth O41.00X0 – O41.03X9 Oligohydramnios O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome	Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).

CPT-4 Code	Diagnosis Restriction	Frequency Restrictions/ Documentation Requirements
76821	O36.0110 – O36.0999 Maternal care for rhesus isoimmunization O36.1110 – O36.1999 Care for other isoimmunization O36.20X0 – O36.23X9 Maternal care for hydrops fetalis O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome O98.511 – O98.519 Other viral diseases complicating pregnancy	Once in 180 days. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).
76825, 76827	O24.011 – O24.919 Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days, same provider. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).
76826, 76828	O24.011 – O24.919 Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage	Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19).

Common Billing Denial

Remittance Advice Details (RAD) code 9109: This service is not payable for the diagnosis billed.

Billing Tip: Verify the diagnosis code is valid for the procedure being billed.

Ultrasound Billing Example: UB-04 Claim Form

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3a PAT. CNTL. # 3b MED. REC. #		4 TYPE OF BILL 731	
8 PATIENT NAME b DOE, JANE				9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR	
17 STATE		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACCT STATE		30		31 OCCURRENCE CODE		32 OCCURRENCE DATE	
33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH	
37		38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	
101		102		103		104	
105		106		107		108	
109		110		111		112	
113		114		115		116	
117		118		119		120	
121		122		123		124	
125		126		127		128	
129		130		131		132	
133		134		135		136	
137		138		139		140	
141		142		143		144	
145		146		147		148	
149		150		151		152	
153		154		155		156	
157		158		159		160	
161		162		163		164	
165		166		167		168	
169		170		171		172	
173		174		175		176	
177		178		179		180	
181		182		183		184	
185		186		187		188	
189		190		191		192	
193		194		195		196	
197		198		199		200	
201		202		203		204	
205		206		207		208	
209		210		211		212	
213		214		215		216	
217		218		219		220	
221		222		223		224	
225		226		227		228	
229		230		231		232	
233		234		235		236	
237		238		239		240	
241		242		243		244	
245		246		247		248	
249		250		251		252	
253		254		255		256	
257		258		259		260	
261		262		263		264	
265		266		267		268	
269		270		271		272	
273		274		275		276	
277		278		279		280	
281		282		283		284	
285		286		287		288	
289		290		291		292	
293		294		295		296	
297		298		299		300	
301		302		303		304	
305		306		307		308	
309		310		311		312	
313		314		315		316	
317		318		319		320	
321		322		323		324	
325		326		327		328	
329		330		331		332	
333		334		335		336	
337		338		339		340	
341		342		343		344	
345		346		347		348	
349		350		351		352	
353		354		355		356	
357		358		359		360	
361		362		363		364	
365		366		367		368	
369		370		371		372	
373		374		375		376	
377		378		379		380	
381		382		383		384	
385		386		387		388	
389		390		391		392	
393		394		395		396	
397		398		399		400	
401		402		403		404	
405		406		407		408	
409		410		411		412	
413		414		415		416	
417		418		419		420	
421		422		423		424	
425		426		427		428	
429		430		431		432	
433		434		435		436	
437		438		439		440	
441		442		443		444	
445		446		447		448	
449		450		451		452	
453		454		455		456	
457		458		459		460	
461		462		463		464	
465		466		467		468	
469		470		471		472	
473		474		475		476	
477		478		479		480	
481		482		483		484	
485		486		487		488	
489		490		491		492	
493		494		495		496	
497		498		499		500	
501		502		503		504	
505		506		507		508	
509		510		511		512	
513		514		515		516	
517		518		519		520	
521		522		523		524	
525		526		527		528	
529		530		531		532	
533		534		535		536	
537		538		539		540	
541		542		543		544	
545		546		547		548	
549		550		551		552	
553		554		555		556	
557		558		559		560	
561		562		563		564	
565		566		567		568	
569		570		571		572	
573		574		575		576	
577		578		579		580	
581		582		583		584	
585		586		587		588	
589		590		591		592	
593		594		595		596	
597		598		599		600	
601		602		603		604	
605		606		607		608	
609		610		611		612	
613		614		615		616	
617		618		619		620	
621		622		623		624	
625		626		627		628	
629		630		631		632	
633		634		635		636	
637		638		639		640	
641		642		643		644	
645		646		647		648	
649		650		651		652	
653		654		655		656	
657		658		659		660	
661		662		663		664	
665		666		667		668	
669		670		671		672	
673		674		675		676	
677		678		679		680	
681		682		683		684	
685		686		687		688	
689		690		691		692	
693		694		695		696	
697		698		699		700	
701		702		703		704	
705		706		707		708	
709		710		711		712	
713		714		715		716	
717		718		719		720	
721		722		723		724	
725		726		727		728	
729		730		731		732	
733		734		735		736	
737		738		739		740	
741		742		743		744	
745		746		747		748	
749		750		751		752	
753		754		755		756	
757		758		759		760	
761		762		763		764	
765		766		767		768	
769		770		771		772	
773		774		775		776	
777		778		779		780	
781		782		783		784	
785		786		787		788	
789		790		791		792	
793		794		795		796	
797		798		799		800	
801		802		803		804	
805		806		807		808	
809		810		811		812	
813		814		815		816	
817		818		819		820	
821		822		823		824	
825		826		827		828	
829		830		831		832	
833		834		835		836	
837		838		839		840	
841		842		843		844	
845		846		847		848	
849		850		851		852	
853		854		855		856	
857		858		859		860	
861		862		863		864	
865		866		867		868	
869		870		871		872	
873		874		875		876	
877		878		879		880	
881		882		883		884	
885		886		887		888	
889		890		891			

Obstetrical Ancillary Services

1. Reimbursement for individual antepartum visits and global OB service _____ routine urinalysis. Claims for routine urinalysis with a diagnosis related to pregnancy will be denied.

NOTE

Claims for urinalysis, when billed with an ICD-10-CM diagnosis code for pregnancy, may be reimbursed if billed in conjunction with another diagnosis code other than Z00.00, Z00.8, Z01.00, Z01.01, Z01.10, Z01.110, Z01.118, Z01.89, Z02.1 or Z02.89. A pregnancy diagnosis code must be present on the claim form for reimbursement for recipients whose eligibility is restricted to pregnancy-only Medi-Cal.

2. Office visits for conditions not related to pregnancy must be billed using the appropriate office visit code (CPT-4 codes 99201 – 99215) and a _____-_____ related diagnosis.
3. Fetal stress and non-stress testing (CPT-4 code 59020 and 59025) is limited to _____-_____ pregnancies.

NOTE

CPT-4 code 59025 (fetal non-stress test) may be billed more than 10 times in nine months with any of the following ICD-10-CM diagnosis codes: O09.212 – O09.293, O09.892, O09.893, O24.011 – O24.919, O36.5120 – O36.5939, O36.8920 – O36.8999, O42.112, O42.113.

4. Supplies used during fetal stress or non-stress testing _____ separately reimbursable.
5. CPT-4 codes 59020 and 59025 may be split billed with modifier ____ or _____. When billing for both the professional and technical components, a modifier is not required nor allowed.

Answer Key: 1) include; 2) non-pregnancy; 3) high-risk; 4) are not; 5) 26, TC

Pregnancy Share of Cost (SOC)

Refer to the *Pregnancy: Share of Cost* section (preg share) in the appropriate Part 2 provider manual.

Global Billing

- Providers who bill on a global basis for OB services must make arrangements to collect or obligate the SOC for the month of delivery only.
- Arrangements must be made to collect or obligate the SOC for HCPCS code Z1032 (initial antepartum visit and any non-global OB services [e.g., sonogram or amniocentesis]).
- If the intent to bill globally is prevented because the patient moves or leaves care, providers must bill on a fee-for-services basis and collect SOC for each month of service.

Per-Visit Billing

Providers are reminded that, if they bill on a fee-for-service basis for obstetrical care, they must collect the SOC for each month in which services were rendered.

Common Billing Denial

Remittance Advice Details (RAD) code 0314: Recipient is not eligible for the month of service billed.

Billing Tip: Verify the recipient has a Share of Cost (SOC) and is eligible for the month of service.

Early Care and Diagnostic Services

Fetal Fibronectin Testing

Fetal fibronectin assay tests identify a subgroup of pregnant women who may require aggressive treatment with tocolytics, antibiotics, corticosteroids and other treatment measures to prevent pre-term delivery or to minimize complications during delivery. These tests are only recommended once every two weeks between 24 and 35 weeks gestation.

Fetal fibronectin testing is reimbursable when billed with the following:

- CPT-4 code 82731 (fetal fibronectin, cervicovaginal secretions, semi-quantitative)
- ICD-10-CM diagnosis codes O60.02 and O60.03 (premature labor after 22 weeks, but before 37 completed weeks of gestation without delivery)

Preventing Preterm Births: Hydroxyprogesterone Caproate – HCPCS Code J1725

HCPCS code J1725 (injection, hydroxyprogesterone caproate 1 mg) is reimbursable with a gender restriction of female only in conjunction with ICD-10-CM diagnosis codes O09.211 – O09.219 (supervision of pregnancy with history of pre-term labor).

Injections are administered to prolong pregnancy for women with documented histories of spontaneous preterm births (less than 37 weeks gestation) and a current singleton pregnancy. Recommended dosage is one 250 mg injection every seven days between 16 and 36 weeks of gestation. Refer to the *Pregnancy: Early Care and Diagnostic Services* (preg early) section of the Part 2 provider manual for more information.

Obstetric Panel – CPT-4 Code 80055

The obstetric panel is restricted to once in nine months for the same provider. The provider may be reimbursed for second or subsequent obstetric panel within the nine-month period if there is documentation to justify medical necessity or documentation of a different pregnancy.

Noninvasive Prenatal Testing: Fetal Aneuploidy – CPT-4 Codes 81420, 81479 and 81507

The noninvasive prenatal test for fetal aneuploidy is reimbursable with CPT-4 codes 81420, 81479 or 81507. A *Treatment Authorization Request* (TAR) is required. Please refer to the *Pathology: Molecular Pathology* (path molec) section of the Part 2 provider manual for documentation requirements.

Internal Fetal Monitoring (IFM) During Labor

CPT-4 code 59050 (fetal monitoring during labor by consulting physician (that is, non-attending physician) with written report; supervision and interpretation) and 59051 (...interpretation only) are reimbursable only when the following billing requirements are met:

- The IFM is performed by a consultant (not the attending/delivering physician).
- The facility type must be inpatient hospital code “11” or “12” on the *UB-04* claim form or Place of Service code “21” on the *CMS-1500* claim form.
- Procedure is limited to use during labor within 48 hours before delivery in conjunction with diagnosis codes O35.0XX0 – O42.92, O61.0 – O63.9, O75.0 – O75.3, O76 – O77.9.
- Codes are reimbursable only once per pregnancy.
- The date of delivery is specified in the *Additional Claim Information* field (Box 19) or the *Remarks* field (Box 80) of the claim.

Tobacco Cessation Counseling for Pregnant and Postpartum Women

Under Medi-Cal, providers must offer one face-to-face smoking/tobacco cessation counseling session and a referral to tobacco cessation quit-line to pregnant and postpartum recipients. Counseling and referral services must be offered without cost sharing. Services are required during the prenatal and postpartum period (the end of the month in which the 60-day period following termination of the pregnancy ends).

Modifiers Commonly Used by OB Providers

Modifier	Description
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52 *	Reduced services
59	Distinct procedural service (use only with CPT-4 code 76816, transabdominal ultrasound)
80	Assistant surgeon
99	Multiple modifiers
AG	Primary surgeon
FP	Family planning services
SA	Nurse practitioner with physician service
SB	Certified nurse midwife service (when not billing as an independent provider)
TC	Technical component
TH *	Obstetrical treatment/services, prenatal or postpartum
U7	Physician assistant service For multiple modifiers billed for PA services, use modifier 99. Document on the claim form what is being used; e.g. 99 = U7 +ZL.

* As they become available, effective dates for these modifiers will appear in the Medi-Cal provider bulletins.

Special Appendix

HIPAA-Compliant Maternal Care Services Billing Code Conversions

The Department of Health Care Services (DHCS) will discontinue use of current Medi-Cal interim codes for maternal care services. These interim codes will be replaced by HIPAA-compliant CPT-4 codes and HCPCS code modifiers to comply with the provisions of HIPAA of 1996, Public Law 104-191, *Code of Federal Regulations*, Title 45, Part 162.1000.

Providers should monitor their monthly *Medi-Cal Update* bulletins for news about the specifics of these changes.

