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

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.

Note: Interim codes Z1032, Z1034 and Z1038 will be 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, ICD-10-CM and HCPCS codes used to bill for services for providers who render obstetrical care.

Confirmation of Pregnancy

Evaluation and Management Codes

When a patient’s pregnancy has not yet been confirmed, an appropriate Evaluation and Management (E&M) code (CPT codes 99201 thru 99215) should be billed with ICD-10-CM diagnosis code N91.0 thru N91.2 (amenorrhea, unspecified) to reflect the actual reason the patient was seen to _____________ pregnancy.

E&M office visit codes 99201 thru 99215 _____________ reimbursable with a pregnancy-related diagnosis. Claims submitted with E&M codes and a pregnancy diagnosis code may cause claims to deny.

Providing Verification of Pregnancy

County welfare departments will accept as verification of pregnancy, either self-attestation of pregnancy or 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. The statement must give the estimated date of confinement and provide _____________ information to substantiate the diagnosis. Pregnant patients applying for Medi-Cal must either self-attest to pregnancy or submit the written statement as part of their application.

See the Appendix for the Answer Key.
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 (Z1032)**

Initial pregnancy-related office visit HCPCS code (Z1032) is considered to be the ____________ prenatal visit and is billed after the pregnancy has been confirmed. When billing with Z1032, providers ____________ use one of the following pregnancy associated diagnosis codes: O09.00 thru O26.93, O29.011 thru O48.1, O98.011 thru O9A.519, Z34.00 thru Z34.93.

For pregnancy related office visit code (_________), providers must:

- Bill separately in conjunction with per-visit or global care.
- Limit 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.
- 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 (Z1032)**

Consultants who co-manage a pregnancy without complete transfer of care ____________ ____________ bill with HCPCS code Z1032. Instead, E&M consultation codes 99241 thru 99245 should be used.

See the Appendix for the [Answer Key](#).
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 _________ pregnancy or who render fewer than ______ antepartum visits must bill each visit or procedure separately. The initial pregnancy-related office visit (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 Office Visit (Z1034)

For HCPCS code Z1034 (antepartum office visit):

- 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 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.

Referral for Specialty Care or Medically Necessary Care

When referring a pregnant or postpartum woman for specialty or other medically necessary care, providers must include a _________ _________ code on the claim form to ensure reimbursement.

- Claims should be billed with either CPT E&M consultation codes 99241 thru 99245 or the most appropriate billing code for the service provided.
- Antepartum office visit code Z1034 or E&M procedure codes 99201 thru 99215 must not be billed with the consultation codes 99241 thru 99245 or the claim may be denied.

See the Appendix for the Answer Key.
Postpartum Care Office Visit (Z1038)

When billing any medically necessary service during the postpartum period, providers are reminded to include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied. For HCPCS code Z1038 (postpartum office visit):

- 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.

Providers may render and be reimbursed for ________ than one postpartum visit 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.

Policy Update for Postpartum Office Visits

On or after September 1, 2019, any additional postpartum visits billed with Z1038 are required to include documentation of a medical or mental health postpartum risk factor or complication. Documentation should appear either in the Remarks field (Box 80) Additional Claim Information field (Box 19) of the claim, or an attachment for reimbursement.

Refer to the following sections of the Part 2 provider manual for more information: Pregnancy: Early Care and Diagnostic Services (preg early), Pregnancy: Global Billing (preg glo), Pregnancy: Per-Visit Billing (preg per) and Pregnancy: Postpartum and Newborn Referral Services (preg post).

See the Appendix for the Answer Key.
Maternal Depression Screening

Medi-Cal reimburses screening for depression as an outpatient service only. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment options including referral to mental health specialists and appropriate follow-up.

Providers who render prenatal care and postpartum care can submit claims twice a year per pregnant or postpartum recipient, once when the recipient is pregnant and once when she is postpartum.

Billing Codes

For dates of service on or after July 1, 2020, the following chart lists procedure codes/modifiers that can be used when billing for depression screening:

<table>
<thead>
<tr>
<th>Recipient Category</th>
<th>Positive Depression Screen</th>
<th>Negative Depression Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant or postpartum</td>
<td>G8431 with modifier HD</td>
<td>G8510 with modifier HD</td>
</tr>
</tbody>
</table>

For more information regarding Evaluation and Management codes for maternal mental health, providers may refer to the following website: [www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Maternal-Mental-Health.aspx](http://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Maternal-Mental-Health.aspx)
## Per-Visit Obstetrical Codes

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Definition</th>
<th>Frequency Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z1032</td>
<td>Initial comprehensive pregnancy-related office visit</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>Z1034</td>
<td>Antepartum office visit</td>
<td>13 in 9 months</td>
</tr>
<tr>
<td>Z1038</td>
<td>Postpartum office visit</td>
<td>1 in 6 months: <strong>Note:</strong> More than 1 in 6 months if documentation of complication is indicated in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim.</td>
</tr>
<tr>
<td>59409</td>
<td>Vaginal delivery only</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean delivery only</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>59525</td>
<td>Subtotal or total hysterectomy after cesarean delivery</td>
<td>1 in 6 months (subtotal) or once in a lifetime (total)</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous cesarean with/without episiotomy, and/or forceps</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery</td>
<td>1 in 6 months</td>
</tr>
</tbody>
</table>
Knowledge Review 1

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

2. More than 13 antepartum visits are allowed in nine months if there is documentation of a second pregnancy.
   True [ ]  False [ ]

3. If providers bill one antepartum (HCPCS code Z1034), they __________ bill globally.
   a) must    b) cannot

4. If a provider bills per-visit CPT code 59409, 59612 (vaginal delivery only), 59514 or 59620 (cesarean delivery only), the provider must bill all antepartum visits separately.
   True [ ]  False [ ]

5. Postpartum visits (HCPCS code Z1038) can be billed by the primary maternity care provider or the provider who saw the patient for only the postpartum office visit.
   True [ ]  False [ ]

See the Appendix for the Answer Key.
Per-Visit Billing Vaginal Delivery and Antepartum Office Visit

Sample: Per-Visit Billing – CMS 1500 claim form. Adapt to your billing situation.

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 Initial OB visit and Antepartum Office Visit

**Sample**: Per-Visit Billing – *UB-04* claim form. Adapt to your billing situation.
Global Billing for Pregnancy

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

**Policy**

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.

**Global Billing Requires 13 OB Visits**

As of January 1, 2016, the requirement for global obstetrical (OB) billing changed from a minimum of eight to 13 antepartum visits.

A provider who bills for global obstetrical care must render at least 13 antepartum OB visits (HCPCS code Z1034). The initial comprehensive pregnancy-related office visit may ________ 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.

**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

See the Appendix for the **Answer Key**.
# Global Obstetrical Codes

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<th>Definition</th>
<th>Frequency Limit</th>
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</thead>
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<tr>
<td>59400</td>
<td>Global antepartum care, vaginal delivery and postpartum care.</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>59510</td>
<td>Global antepartum care, cesarean delivery and postpartum care.</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>59525</td>
<td>Subtotal or total hysterectomy after cesarean delivery.</td>
<td>1 in 6 months (subtotal) or once in a lifetime (total)</td>
</tr>
<tr>
<td>59610</td>
<td>Routine OB care vaginal delivery w/without episiotomy and/or forceps and postpartum care after previous cesarean delivery.</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td>59618</td>
<td>Routine OB care cesarean delivery and postpartum care following attempted vaginal delivery after cesarean delivery.</td>
<td>1 in 6 months</td>
</tr>
</tbody>
</table>

**Note:** Refer to the CPT code book for complete procedure descriptions.
Transfer of Care

Providers who accept a Medi-Cal transfer patient must bill each antepartum visit separately, regardless of the number of times the provider sees the patient prior to delivery.

Providers who accept Medi-Cal transfer patients are not restricted to the number of visits for which they may be reimbursed (up to the Medi-Cal limit of one initial comprehensive and 13 antepartum visits for all primary obstetrical providers within nine months).

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)

Multiple Surgical Procedure Exceptions

The following medical policies have been established for specific, multiple surgeries when billed for a recipient, by the same provider, for the same date of service.

A vaginal delivery (CPT codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a ______ – one child delivered vaginally and one by cesarean section.

See the Appendix for the Answer Key
Global Billing Example: Vaginal Delivery

Documentation Requirements

- Date of Last Menstrual Period (LMP)
- Hospitalization dates (From – To)
- 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 with appropriate modifier

**Note:** Delivery services performed in an inpatient setting must be billed on a CMS-1500 claim form. The physician’s billing information is entered in the Billing Provider Information & PH# field (Box 33). Physician’s NPI is entered in Box 33a.

**Sample:** Partial CMS-1500 claim form. Adapt to your billing situation.
Global Billing Example: Vaginal Delivery with Tubal Ligation – Same Date of Service

Documentation Requirements

- Date of LMP
- Hospitalization dates (From – To)
- 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 Sterilization Consent Form (PM 330)

Note: Delivery services performed in an inpatient setting must be billed on a CMS-1500 claim form. The physician’s billing information is entered in the Billing Provider Information & PH# field (Box 33). Physician’s NPI is entered in Box 33a.

Sample: Partial CMS-1500 claim form. Adapt to your billing situation.
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 Sterilization Consent Form (PM 330)

Note: Delivery services performed in an inpatient setting must be billed on a CMS-1500 claim form. The physician’s billing information is entered in the Billing Provider Information & PH# field (Box 33). Physician’s NPI is entered in Box 33a.

Sample: Partial CMS-1500 claim form. Adapt to your billing situation.
CNMs “Assistant at Surgery” Cesarean Deliveries

Certified nurse midwives (CNMs) may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by a licensed physician and surgeon.

CNM Reimbursement Requirements

- Only non-global CPT codes 59514 or 59620 are reimbursable when submitted with an appropriate assistant surgeon modifier (80).
- A licensed physician and surgeon performing the cesarean section must state on the operative report that the CNM performed the function of an “assistant at surgery.”
- A CNM will not be permitted to be reimbursed by both the surgeon performing the cesarean section and Medi-Cal.
- A patient undergoing the cesarean section must be currently enrolled in Medi-Cal at the time of surgery.

Sample: Partial CMS-1500 claim form. Adapt to your billing situation
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 code being billed
- Frequency must meet the restrictions listed
- Some claims must have documentation in the Remarks field (Box 80)/Additional Claim Information field (Box 19) on the claim to justify medical necessity.

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.
Reimbursable Ultrasound Codes

**Diagnosis, Frequency and Documentation Guidelines**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Restriction</th>
<th>Frequency Restrictions/Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>76801, 76805, 76811</td>
<td>O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception</td>
<td>Once 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.</td>
</tr>
<tr>
<td></td>
<td>O03.0 thru O03.9: Spontaneous abortion</td>
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<td></td>
<td>O09.511 thru O09.513: Elderly primigravida</td>
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<td></td>
<td>O09.521 thru O09.523: Elderly multigravida</td>
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<td></td>
<td>O10.011 thru O16.9: Edema, proteinuria and hypertensive disorders</td>
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<td>O20.0 thru O21.9 and O23.00 thru O29.93: Other maternal disorders</td>
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<td></td>
<td>O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity</td>
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<td>O60.00 thru O60.03: Preterm labor without delivery</td>
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<td>O98.011 thru O98.919: Maternal infectious and parasitic diseases</td>
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<td></td>
<td>O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere</td>
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<td>O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse</td>
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<td>Z33.2: Encounter for elective termination of pregnancy</td>
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<td></td>
<td>Z36.0 thru Z36.9: Encounter for antenatal screening of mother</td>
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## Diagnosis, Frequency and Documentation Guidelines (continued)

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| 76802, 76810, 76812 | O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception  
O03.0 thru O03.9: Spontaneous abortion  
O04.5 thru O04.89: Complications following (induced) termination of pregnancy  
O09.511 thru O09.513: Elderly primigravida  
O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity  
O60.00 thru O60.03: Preterm labor without delivery  
O98.011 thru O98.919: Maternal infectious and parasitic diseases  
O99.011 thru O99.419 and O99.511 thru O99.89: Other maternal disease classifiable elsewhere  
O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse  
Z33.2: Encounter for elective termination of pregnancy  
Z36.0 thru Z36.9: 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 Remarks field (Box 80/Additional Claim Information field (Box 19) of the claim. |
### Diagnosis, Frequency and Documentation Guidelines (continued)

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<tr>
<td>76813</td>
<td>Z36.82 Encounter for antenatal screening for nuchal translucency</td>
<td>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. Error! Reference source not found.</td>
</tr>
<tr>
<td>76814</td>
<td>Z36.82 Encounter for antenatal screening for nuchal translucency</td>
<td>Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of the claim. 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. Error! Reference source not found.</td>
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<tr>
<td>76815</td>
<td>O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception</td>
<td>Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.</td>
</tr>
<tr>
<td></td>
<td>O03.0 thru O03.9: Spontaneous abortion</td>
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<td>O04.5 thru O04.89: Complications following (induced) termination of pregnancy</td>
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<tr>
<td>76816</td>
<td>O00.0 thru O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</td>
<td>Once in 180 days (when billed without modifier 59), same provider. Additional claims may be reimbursed if documentation justifies medical necessity. For multiple gestations, bill procedure code 76816 in conjunction with modifier 59 (any modifier position 1-4). Code 76816 thru 59 is payable for multiple gestations, even when a claim has been paid in history on the same date of service. Four per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the Remarks field (Box 80)/Additional Claim Information field (Box 19) of claim.</td>
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<tr>
<td></td>
<td>O9A.111 thru O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Z33.2 Encounter for elective termination of pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Z36.0 thru Z36.9 Encounter for antenatal screening of mother</td>
<td></td>
</tr>
</tbody>
</table>
### Diagnosis, Frequency and Documentation Guidelines (continued)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Restriction</th>
<th>Frequency Restrictions/Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>76817</td>
<td>O00.0 thru O02.9: Ectopic, hydatidiform mole and other abnormal products of conception</td>
<td>Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.</td>
</tr>
<tr>
<td></td>
<td>O03.0 thru O03.9: Spontaneous abortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O04.5 thru O04.89: Complications following (induced) termination of pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O09.511 thru O09.513: Elderly primigravida</td>
<td></td>
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<tr>
<td></td>
<td>O09.521 thru O09.523: Elderly multigravida</td>
<td></td>
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<tr>
<td></td>
<td>O10.011 thru O16.9: Edema, proteinuria and hypertensive disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O20.0 thru O21.9 and O23.00 thru O29.93: Other maternal disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O30.001 thru O48.1: Maternal care related to fetus and amniotic cavity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O60.00 thru O60.03: Preterm labor without delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O98.011 thru O98.919: Maternal infectious and parasitic diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O99.011 thru O99.419 and O99.511 thru O99.89 : Other maternal disease classifiable elsewhere</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O9A.111 thru O9A.519: Maternal malignant neoplasms, traumatic injuries and abuse</td>
<td></td>
</tr>
<tr>
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<td>Z33.2: Encounter for elective termination of pregnancy</td>
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<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Restriction</th>
<th>Frequency Restrictions/Documentation Requirements</th>
</tr>
</thead>
</table>
| 76820    | O36.5110 thru O36.5999: Maternal care for known or suspected poor fetal growth  
O41.00X0 thru O41.03X9: Oligohydramnios  
O43.021 thru O43.029: Fetus-to-fetus placental transfusion syndrome | Once in 180 days, same provider.  
Additional claims may be reimbursed if documentation justifies medical necessity.  
Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the Remarks field (Box 80)/Additional Claim Information field (Box 19). |
| 76821    | O36.0110 thru O36.0999: Maternal care for rhesus isoimmunization  
O36.1110 thru O36.1999: Care for other isoimmunization  
O36.20X0 thru O36.23X9: Maternal care for hydrops fetalis  
O43.021 thru O43.029: Fetus-to-fetus placental transfusion syndrome  
O98.511 thru 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 Remarks field (Box 80)/Additional Claim Information field (Box 19). |
| 76825,  
O35.0XX0 thru O35.9XX9: Maternal care for known or suspected fetal abnormality and damage  
O36.8310 thru O36.8399: Maternal care for abnormalities of the fetal heart rate or rhythm | 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 Remarks field (Box 80)/Additional Claim Information field (Box 19). |
Diagnosis, Frequency and Documentation Guidelines (continued)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Restriction</th>
<th>Frequency Restrictions/Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>76826, 76828</td>
<td>O24.011 thru O24.02, O24.111 thru O24.12, O24.311 thru O24.32, O24.410 thru O24.429, O24.811 thru O24.82, O24.911 thru O24.919: Pre-existing diabetes mellitus and gestational diabetes O35.0XX0 thru O35.9XX9: Maternal care for known or suspected fetal abnormality and damage O36.8310 thru O36.8399: Maternal care for abnormalities of the fetal heart rate or rhythm</td>
<td>Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity. Five per day maximum when billing for a pregnancy with multiple gestation. Providers must document the number of fetuses in the Remarks field (Box 80)/Additional Claim Information field (Box 19).</td>
</tr>
</tbody>
</table>

Ultrasound 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.

**Note:** See the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit)* section of the Part 1 provider manual. Select the link at the bottom of the page for the RAD codes, messages, and Electronic correlations.
Per-Visit Billing Antepartum Office Visit and Ultrasound

Sample: Partial CMS-1500 claim form. Services were rendered by a Nurse Midwife (SB) Adapt to your billing situation.

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**Per-Visit Billing Antepartum Office Visit, Ultrasound and Amniocentesis**

**Sample: UB-04** claim form. Billing without a modifier indicates that both technical and professional components of the ultrasound were performed.
Obstetrical Ancillary Services

Urinalysis

Reimbursement for individual antepartum visits and global OB service includes 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.

Office Visits

Office visits for conditions not related to pregnancy must be billed using the appropriate office visit code (CPT codes 99201 thru 99215) and a non-pregnancy-related diagnosis.
Fetal Stress, Non-Stress Testing

Fetal Non-Stress Testing Benefit Guidelines

When billing for CPT code 76819 (fetal biophysical profile; without non-stress testing) or CPT code 59025 (fetal non-stress test) services, they are reimbursable Medi-Cal benefits limited to high-risk pregnancies. Providers are required to use an appropriate antepartum high-risk ICD-10CM diagnosis code within the range of O09.211 thru O9A.513.

Reimbursement for CPT code 76819 is limited to once per week, but may be billed more than five times in nine months, and CPT code 59025 may be billed more than 10 times in nine months, when billed in conjunction with one of the ICD-10 diagnosis codes in the following table:

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O09.212 – O09.293</td>
<td>Pregnancy with other poor reproductive history</td>
</tr>
<tr>
<td>O09.892, O09.893</td>
<td>Supervision of other high-risk pregnancy</td>
</tr>
<tr>
<td>O24.011 – O24.919</td>
<td>Diabetes melitus of pregnancy</td>
</tr>
<tr>
<td>O36.5120 – O36.5939</td>
<td>Maternal care known or suspected poor fetal growth</td>
</tr>
<tr>
<td>O036.8920 – O36.8999</td>
<td>Maternal care for other specified fetal problems</td>
</tr>
<tr>
<td>O42.112, O42.113</td>
<td>Preterm premature rupture of membranes</td>
</tr>
</tbody>
</table>

Note: Supplies used during fetal stress or non-stress testing are not separately reimbursable.

CPT codes 59020, 59025 and 76819 may be split billed with modifier 26 or TC. When billing for both the professional and technical components, a modifier is not required nor allowed. These codes may not be billed with modifier 51 (multiple procedures).
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 obstetrical services must make arrangements with the patient to collect or obligate the SOC for the month of delivery only.
- However, arrangements must also be made to collect or obligate the SOC for the initial antepartum office visit (HCPCS code Z1032) and for non-global OB services (for example, sonogram or amniocentesis).
- When 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 who bill on a fee-for-service basis for obstetrical care, must collect the SOC for each month in which services were rendered.

SOC 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 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 injections (HCPCS code J1726 and J1729) are administered to prolong pregnancy for pregnant patients with documented histories of spontaneous preterm births (less than 37 weeks gestation) and a current singleton pregnancy. Both HCPCS codes J1726 10 mg and J1729 250 mg injections are limited to one injection every seven days between 16 and 36 weeks gestation.

Claims must include ICD-10 diagnosis code from the range of O09.211 thru O09.219 (supervision of pregnancy with history of pre-term labor). Modifiers SA and UD are allowed. Modifier UD is used by Section 340B providers to denote drugs purchased under this program.

Refer to the Pregnancy: Early Care and Diagnostic Services (preg early) section of the Part 2 provider manual for more information.

Obstetric Panel Frequency Restriction

CPT codes 80055 (obstetric panel) and 80081 (obstetrical panel [includes HIV testing]) are restricted to once in nine months for the same provider.

Providers may only be reimbursed for either code 80055 or 80081 in a nine-month period. 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

The noninvasive prenatal test for fetal aneuploidy is reimbursable with CPT 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.

Notes:
Knowledge Review 2

1. The postpartum office visit (HCPCS code Z1038) is restricted to once in six months. 
   __________
   1. True ☐ False ☐

2. Providers who accept Medi-Cal transfer-of-care patients are restricted to the one initial visit (HCPCS code Z1032) and a total of 13 antepartum visits (HCPCS code Z1034) in nine months by all primary obstetrics providers. __________
   2. True ☐ False ☐

3. Which claim form allows providers to choose to bill per-visit or bill globally? __________
   a) UB-04
   b) CMS-1500

4. Can the initial pregnancy office visit (HCPCS code Z1032) count as one of the 13 visits when billing globally? __________
   a) Yes
   b) No

See the Appendix for the Answer Key.
Internal Fetal Monitoring (IFM) During Labor

CPT code 59050 (fetal monitoring during labor by consulting physician [i.e., 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 O00.201 thru O002.219, O35.0XX0 thru O42.92, O61.0 thru O63.9, O75.0 thru O75.3, O76 thru 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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Professional component</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedures</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service (use only with CPT-4 code 76816, transabdominal ultrasound)</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>99</td>
<td>Multiple modifiers</td>
</tr>
<tr>
<td>AG</td>
<td>Primary surgeon</td>
</tr>
<tr>
<td>AS</td>
<td>Certified nurse midwives may be reimbursed as an “assistant at surgery” during cesarean section deliveries performed by licensed physician or surgeon.</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning services</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner with physician service</td>
</tr>
<tr>
<td>SB</td>
<td>Certified nurse midwife service (when not billing as an independent provider)</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
</tr>
<tr>
<td>TH</td>
<td>Obstetrical treatment/services, prenatal or postpartum</td>
</tr>
<tr>
<td>U7</td>
<td>Physician assistant service</td>
</tr>
</tbody>
</table>

For multiple modifiers billed for PA services, use modifier 99. Document on the claim form what is being used; e.g. 99 = U7 +ZL.

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

HIPAA-Compliant Maternal Care ServicesBilling 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 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.
Resource Information

References

Provider Manual References

Part 1
Remittance Advice Details (RAD) Codes and Messages: 300 – 399 (remit cd300)
Link at the bottom of the page Remittance Advice Details (RAD) Codes and Messages: 001-9999 (remit cd9000)

Part 2
Modifiers: Approved List (modif app)
Pregnancy Determination (preg determ)
Pregnancy: Early Care and Diagnostic Services (preg early)
Pregnancy Examples: CMS-1500 (preg ex cms)
Pregnancy Examples: UB-04 (preg ex ub)
Pregnancy: Fetal Monitoring, Labor and Delivery Services (preg fetal)
Pregnancy: Global Billing (preg glo)
Pregnancy: Per-Visit Billing (preg per)
Pregnancy: Postpartum and Newborn Referral Services (preg post)
Pregnancy: Share of Cost (preg share)
Remittance Advice Details (RAD) (remit adv)
Module B Answer Key

Page 2 Answer Key 1
Page 2 fill in:
Answer: confirm, are not, sufficient

Page 3 Answer Key 1
Page 3 fill in:
Answer: first, must, Z1032, should not

Page 4 Answer Key 1
Page 4 fill in:
Answer: entire, 13, pregnancy diagnosis

Page 5 Answer Key 1
Page 5 fill in:
Answer: more

Page 11 Answer Key 1
Page 11 fill in:
Answer: not

Page 13 Answer Key 1
Page 13 fill in:
Answer: multiple pregnancy
Knowledge Review 1

Question 1: Reimbursement for antepartum visit (HCPCS code Z1034) is limited to _________ visits in a nine-month period.
Answer 1: B thirteen

Question 2: More than 13 antepartum visits are allowed in nine months if there is documentation of a second pregnancy.
Answer 2: True

Question 3: If providers bill one antepartum (HCPCS code Z1034), they _________ bill globally.
Answer 3: B cannot

Knowledge Review 2

Question 1: The postpartum office visit (HCPCS code Z1038) is restricted to once in six months. True or False.
Answer 1: False

Question 2: Providers who accept Medi-Cal transfer-of-care patients are restricted to the one initial visit (HCPCS code Z1032) and a total of 13 antepartum visits (HCPCS code Z1034) in nine months by all primary obstetrics providers.
Answer 2: False

Question 3: Which claim form allows providers to choose to bill per-visit or bill globally.
Answer 3: B

Question 4: Can the initial pregnancy office visit (HCPCS code Z1032) count as one of the 13 visits when billing globally.