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 – 99215) should be billed with ICD-10-CM diagnosis code N91.0 – N91.2 (amenorrhea, unspecified) to reflect the actual reason the patient was seen to ________________ pregnancy.

E&M office visit codes 99201 – 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.

Answer Key: 1) confirm; 2) are not; 3) sufficient:
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 – O26.93, O29.011 – O48.1, O98.011 – O9A.519, Z34.00 – 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 – 99245 should be used.

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**NOTES**

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**Answer Key:** 1) first; 2) must; 3) Z1032; 4) should not
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.

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

Answer Key: 1) entire; 2) 13; 3) pregnancy diagnosis
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 more 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.

Updated Policy for Postpartum Office Visits

Effective for dates of service 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).

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

The following chart lists procedure codes/modifiers that must 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).

Answer Key: 1) more
## 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</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE</strong></td>
<td></td>
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<tr>
<td></td>
<td>More than 1 in 6 months if documentation of complication is indicated in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the Remarks field (Box 80)/Additional Claim Information field (Box 19)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of the claim.</td>
<td></td>
</tr>
<tr>
<td>59409; 59514</td>
<td>Vaginal delivery only; 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,</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td></td>
<td>and/or forceps</td>
<td></td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean delivery only, following attempted vaginal delivery after</td>
<td>1 in 6 months</td>
</tr>
<tr>
<td></td>
<td>previous cesarean delivery</td>
<td></td>
</tr>
</tbody>
</table>
Knowledge Review

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) may be billed by the primary maternity care provider or provider who saw the patient for only the postpartum office visit.
   True □  False □

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>RBR</th>
<th>HRT</th>
<th>Tailoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/01</td>
<td>99301</td>
<td>Initial OB Visit</td>
<td>1001</td>
<td>1001</td>
<td>Initial OB</td>
</tr>
<tr>
<td>10/02/01</td>
<td>99305</td>
<td>Antepartum Office Vis</td>
<td>1001</td>
<td>1001</td>
<td>Antepartum</td>
</tr>
</tbody>
</table>

**Sample:** Per-Visit Billing – Initial OB and Antepartum Office Visits
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

On 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

Answer Key: 1) not
# Global Obstetrical Codes

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<tr>
<th>HCPCS/CPT Code</th>
<th>Definition</th>
<th>Frequency Limit</th>
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</thead>
<tbody>
<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>

* Refer to the CPT codebook 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 __________ a multiple pregnancy – one child delivered vaginally and one by cesarean section.
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
- 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.

Example: Partial CMS-1500 Claim Form
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 the PM 330 sterilization Consent Form
- 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.

Example: Partial CMS-1500 Claim Form
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
- 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.

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.

Example: Partial CMS-1500 Claim Form
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.

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) 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.
## 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>
</table>
| 76801, 76805, 76811 | 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 – O21.9 and O23.00 – 029.93 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  
O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse  
Z33.2 Encounter for elective termination of pregnancy  
Z36.0 – Z36.9 Encounter for antenatal screening of mother | 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. |
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Restriction</th>
<th>Frequency Restrictions/Documentation Requirements</th>
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</thead>
</table>
| 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  
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O60.00 – O60.03 Preterm labor without delivery  
O98.011 – O98.919 Maternal infectious and parasitic diseases  
O9A.111 – O9A.519 Maternal malignant neoplasms, traumatic injuries and abuse  
Z33.2 Encounter for elective termination of pregnancy  
Z36.0 – 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. |
| 76813 | Z36.82 Encounter for antenatal screening for nuchal translucency | 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.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Diagnosis Restriction</th>
<th>Frequency Restrictions/Documentation Requirements</th>
</tr>
</thead>
<tbody>
<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. *</td>
</tr>
<tr>
<td>76815</td>
<td>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 – O21.9 and O23.00 – 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 – O99.419 and O99.511 – 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 Z36.0 – Z36.9 Encounter for antenatal screening of mother</td>
<td>Once in 180 days, same provider. Additional claims may be reimbursed if documentation justifies medical necessity.</td>
</tr>
</tbody>
</table>

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<tr>
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</thead>
<tbody>
<tr>
<td>76816</td>
<td>O00.0 – 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 – 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>
</tr>
<tr>
<td></td>
<td>O03.0 – O03.9 Spontaneous abortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O04.5 – O04.89 Complications following (induced) termination of pregnancy</td>
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</tr>
<tr>
<td>76817</td>
<td>O00.0 – O02.9 Ectopic, hydatidiform mole and other abnormal products of conception</td>
<td>Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity.</td>
</tr>
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<td></td>
<td>O03.0 – O03.9 Spontaneous abortion</td>
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<td></td>
<td>O30.001 – O48.1 Maternal care related to fetus and amniotic cavity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O60.00 – O60.03 Preterm labor without delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O98.011 – O98.919 Maternal infectious and parasitic diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O9A.111 – 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 – Z36.9 Encounter for antenatal screening of mother</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>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>
<tr>
<td>76820</td>
<td>O36.5110 – O36.5999 Maternal care for known or suspected poor fetal growth</td>
<td>Once in 180 days, same provider. Additional claims may be reimbursed with documentation justifying medical necessity.</td>
</tr>
<tr>
<td></td>
<td>O41.00X0 – O41.03X9 Oligohydramnios</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Diagnosis Restriction</td>
<td>Frequency Restrictions/Documentation Requirements</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>76821</td>
<td>O36.0110 – O36.0999 Maternal care for rhesus isoimmunization</td>
<td>Once in 180 days.</td>
</tr>
<tr>
<td></td>
<td>O36.1110 – O36.1999 Care for other isoimmunization</td>
<td>Additional claims may be reimbursed with documentation justifying medical necessity.</td>
</tr>
<tr>
<td></td>
<td>O36.20X0 – O36.23X9 Maternal care for hydrops fetalis</td>
<td>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>
<tr>
<td></td>
<td>O43.021 – O43.029 Fetus-to-fetus placental transfusion syndrome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O98.511 – O98.519 Other viral diseases complicating pregnancy</td>
<td></td>
</tr>
<tr>
<td>76827</td>
<td>O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O36.8310 – O36.8399 Maternal care for abnormalities of the fetal heart rate or rhythm</td>
<td></td>
</tr>
<tr>
<td>76828</td>
<td>O35.0XX0 – O35.9XX9 Maternal care for known or suspected fetal abnormality and damage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O36.8310 – O36.8399 Maternal care for abnormalities of the fetal heart rate or rhythm</td>
<td></td>
</tr>
</tbody>
</table>

**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.
Per-Visit Billing Antepartum Office Visit and Ultrasound

<table>
<thead>
<tr>
<th>Line</th>
<th>Date/Time</th>
<th>Service Code</th>
<th>Provider</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10 01 18</td>
<td>Z1034</td>
<td>SB</td>
<td>10000</td>
</tr>
<tr>
<td>2</td>
<td>10 04 18</td>
<td>76805</td>
<td>SB</td>
<td>20000</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>NPI</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>NPI</td>
</tr>
</tbody>
</table>

CMS-1500 claim example: Services were rendered by a Nurse Midwife (SB)

NOTES

December 2018 23
UB-04 claim example: 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 – 99215) and a non-pregnancy-related diagnosis.

NOTES
Fetal Stress, Non-Stress Testing

New Fetal Non-Stress Testing Benefit Guidelines

Effective for dates of service on or after October 1, 2018, CPT code 76819 (fetal biophysical profile; without non-stress testing) is reimbursable Medi-Cal benefit limited to high-risk pregnancies. When billing for CPT code 76819 or CPT code 59025 (fetal non-stress test), providers are required to use an appropriate antepartum high-risk ICD-10CM diagnosis code within the range of O09.211 – O9A.513.

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

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Code Range</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>O09.211 – O09.30</td>
<td>O43.191 – O43.210</td>
<td>O98.411 – O98.419</td>
</tr>
<tr>
<td>O09.32</td>
<td>O43.810 – O60.03</td>
<td>O98.511 – O98.519</td>
</tr>
<tr>
<td>O09.33</td>
<td>O67.0 – O68</td>
<td>O98.611 – O98.619</td>
</tr>
<tr>
<td>O09.511 – O09.90</td>
<td>O77.0 – O77.9</td>
<td>O98.711 – O98.719</td>
</tr>
<tr>
<td>O09.92 – O16.9</td>
<td>O88.011 – O88.019</td>
<td>O98.811 – O98.819</td>
</tr>
<tr>
<td>O23.00 – O26.62</td>
<td>O88.311 – O88.319</td>
<td>O99.280 – O99.333</td>
</tr>
<tr>
<td>O28.0 – O31.8X0</td>
<td>O98.111 – O98.119</td>
<td>O99.511 – O99.830</td>
</tr>
<tr>
<td>O32.0XX0 – O41.1499</td>
<td>O98.211 – O98.219</td>
<td>O99.840 – O99.843</td>
</tr>
<tr>
<td>O42.00 – O43.119</td>
<td>O98.311 – O98.319</td>
<td>O9A.111 – O9A.53</td>
</tr>
</tbody>
</table>

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 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 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

Hydroxprogesterone 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. Injection is 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 – O09.219. 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.
Knowledge Review

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

Answer Key: 1) False; 2) False; 3) b; 4) No:
Internal Fetal Monitoring (IFM) During Labor

CPT 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 O00.201 – O002.219, 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

<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>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.

* 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 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)
Remittance Advice Details (RAD) Codes and Messages: 9000 – 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)