Obstetrics

Reimbursement Policy ID: RPC.0068.5400

Recent review date: 05/2025

Next review date: 01/2026

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes the reimbursement guidelines for submitting claims for obstetrical services, including antepartum, delivery and postpartum services.

Exceptions

N/A

Reimbursement Guidelines

A Primary Care Provider (PCP) can serve as the member's personal practitioner and is responsible for coordinating and managing the medical needs of AmeriHealth Caritas District of Columbia members. Advanced nurse practitioners, nurse midwives, and licensed physicians in the following specialties may serve as Plan PCPs:

- General Practice
- Pediatrics
- Internal Medicine
- Geriatrics
- Obstetrics/gynecology (OB/GYN)
- Family Practice

OB/GYN practitioner as PCP
Participating Obstetricians are responsible for medical services during the course of the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care may include:

- Treatment of minor colds, sore throat, or asthma
- Treatment of minor injuries
- Preventative health screenings and maintenance
- Routine gynecological care

Initial prenatal visit
For purposes of billing and reimbursement, each new pregnancy (270 days) is considered a new patient whether or not the patient has been seen previously by the provider/practice.

Prenatal visits
AmeriHealth Caritas District of Columbia requires the provider to submit the appropriate level evaluation and management (E/M) CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The reimbursement for these services shall include, but is not limited to:

- The obstetrical (OB) examination.
- Routine fetal monitoring (excluding fetal non-stress testing)
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy
- Routine dipstick urinalysis

Delivery
Delivery procedure codes 59410, 59515, 59614, and 59622 include immediate postpartum services within the delivery hospitalization. Deliveries of less than 20 full weeks gestation are billed using procedure codes 59820 and 59821, not a delivery procedure code. When there is a vaginal delivery followed by a cesarean section, the provider must bill both the procedure code for the vaginal delivery and the procedure code for the cesarean section with a modifier 22 on the same claim form.

Definitions

Antepartum
The period of time between conception and the onset of labor.

Postpartum
The period of time after the delivery of the baby.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI)
V. American Congress of Obstetricians and Gynecologists (ACOG).
VI. Applicable District of Columbia Fee schedule

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
12/2024	Annual review • No major updates
07/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section