Obstetrics

Reimbursement Policy ID: RPC.0068.2100

Recent review date: 01/2025

Next review date: 01/2026

AmeriHealth Caritas Louisiana 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 Louisiana 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

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Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas Louisiana follows guidelines stated in the AmeriHealth Caritas Louisiana providers manual for submission of claims for antepartum, delivery, and postpartum.

AmeriHealth Caritas Louisiana covers two initial prenatal visits per pregnancy (270 days). These two visits may not be performed by the same attending provider.

AmeriHealth Caritas Louisiana considers the enrollee a 'new patient' for each pregnancy whether the enrollee is a new or established patient to the provider/practice. The appropriate level E&M CPT procedure code is required to be billed for the initial prenatal visit with the TH modifier. A pregnancy-related diagnosis code must also be used on the claim for as either the primary or secondary diagnosis.

AmeriHealth Caritas Louisiana requires the provider to submit the appropriate level E&M CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The E&M CPT code for each of these visits must be modified with the TH modifier.

The TH modifier is not required for observation, inpatient hospital physician services or post-partum tobacco cessation counseling.

Reimbursement for the initial prenatal visit, which must be modified with the TH, shall include, but is not limited to, the following:

- Estimation of gestational age by ultrasound or firm last menstrual period. (If the ultrasound is performed during the initial visit, it may be billed separately. Also, see the ultrasound policy below.)
- Identification of patient at risk for complications including those with prior preterm birth
- Health and nutrition counseling; and
- Routine dipstick urinalysis.

AmeriHealth Caritas Louisiana requires notification by the provider of obstetrical care at the time of the first visit of the pregnancy. The reimbursement for this service 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

Please refer to the provider manual for additional Non-Invasive Prenatal Testing (NIPT).
https://www.amerihealthcaritasla.com/pdf/provider/resources/manual/handbook.pdf

AmeriHealth Caritas Louisiana covers the Obstetric panel as defined by CPT once per pregnancy. A complete urinalysis is covered only once per pregnancy (270 days) per billing provider, or more when medically necessary, for example, to diagnosis a disease or infection of the genitourinary tract.

If the pregnancy is not verified, or if the pregnancy test is negative, the service may only be submitted with the appropriate level E&M without the TH modifier.

AmeriHealth Caritas Louisiana requires notification by the provider of obstetrical care at the time of the first visit of the pregnancy.

Delivery
Providers should bill the most appropriate CPT code that describes the type of delivery (ex., vagina, cesarean section) along with the required modifier to indicate the gestational period the delivery occurs. Claims submitted without the associated modifier will not be reimbursed. When submitting claims, physicians must append a modifier to the delivery services.

Modifier GB
- Delivery is 39 weeks or greater

Modifier AT
- Delivery is less than 39 weeks and medically indicated/spontaneous

Modifier GZ
- Delivery is less than 39 weeks and NOT medically indicated

None
- Claim denies Z93- “Correct modifier needed”

Global delivery maternity procedure codes which include antepartum and/or postpartum care should only be billed when the member has primary coverage that includes maternity benefits and still requires one of the applicable maternity modifiers listed above. If the primary payer is major medical without maternity benefits, then a global delivery procedure code should not be billed.

The postpartum care CPT code (which is not modified with the TH) shall be reimbursed for the postpartum care visit when performed. Reimbursement is allowed for one postpartum visit per 270 days.

The reimbursement for the postpartum care visit included, but is not limited to:
- Physical examination
- Body mass index (BMI) assessment and blood pressure check
- Routine dipstick urinalysis
- Follow up plan for women with gestational diabetes.
- Family planning counseling
- Breast feeding support including referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), if needed
- Screening for postpartum depression and intimate partner violence; and
- Other counseling and or services associated with releasing a patient from obstetrical care.

In cases of multiple births (twins, triplets, etc.), the diagnosis code must indicate a multiple birth.

Modifier 22 (in addition to the applicable maternity modifier from the list above) for unusual circumstances should be used with the most appropriate CPT code for a vaginal or C-Section delivery when the method of delivery is the same for all births.

If the multiple gestation results in a cesarean section delivery and a vaginal delivery, the provider must use the most appropriate “delivery only” CPT code for the cesarean section delivery and also bill the most appropriate vaginal “delivery only” procedure code with modifier -51 appended. Both delivery codes must also include the applicable maternity modifier from the list above.

When sterilizations are performed with a delivery and no valid sterilization form was obtained, the procedure code for the sterilization and the diagnosis code associated with the sterilization must not be reported on the claim form, and charges related to the sterilization process must not be included on the claim form.

When a long-acting reversible contraceptive (LARC) is inserted immediately postpartum and prior to discharge, the LARC device should be billed separate from the inpatient stay, on a CMS 1500 claim form to receive reimbursement.

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) in Medicaid.
V. American Congress of Obstetricians and Gynecologists (ACOG).
VI. Claims Filing Instructions, https://www.amerihealthcaritasla.com/pdf/provider/billing/claim-filing-instructions.pdf
VII. Provider manual, https://www.amerihealthcaritasla.com/pdf/provider/resources/manual/handbook.pdf

Attachments

N/A

Associated Policies

RPC.0038.2100 Obstetric Ultrasound

Policy History

04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval
12/2024	Annual review

	• No major updates
09/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Louisiana 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
	Precedes Act 319