Obstetrics/Gynecology Professional Payment Policy

The following payment policy applies to Tufts Health Plan contracting providers who render obstetrical and/or gynecological services. This policy applies to Commercial\(^1\) products (including Tufts Health Freedom Plan).

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

**Note:** Audit and disclaimer information is located at the end of this document.

**POLICY**
Tufts Health Plan covers medically necessary obstetrical and gynecological services as described below.

**GENERAL BENEFIT INFORMATION**
Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our secure Provider website or by contacting Provider Services.

**Nuchal Translucency Testing**
Tufts Health Plan provides coverage for nuchal translucency tests based upon the member's medical risk factor and medical necessity as determined by the obstetrician/gynecologist. This test does not require prior authorization.

Nuchal translucency testing is done via ultrasound. In combination with the testing of maternal blood for free beta human chorionic gonadotrophin and pregnancy-associated plasma protein A, a determination of the risk of Down syndrome can be made. This testing is also known as early risk assessment (ERA), Ultrascreen, Firstlook or first trimester screening.

**Gynecology**
Members are covered for one routine gynecology visit per calendar year, any medically necessary gynecological follow-up care identified at the examination, and any additional medically necessary gynecological conditions. Family planning services, including birth control counseling and contraceptive management, genetic counseling and termination of pregnancy are not part of the standard gynecology benefit. Refer to the Family Planning Professional Payment Policy for additional information.

**PREVENTIVE SERVICES**
Due to the Patient Protection and Affordable Care Act (commonly referred to as federal health care reform), with the exception of groups maintaining “grandfathered” status, all Tufts Health Plan plans are required to provide 100% coverage for preventive care services. Grandfathered groups are not subject to this requirement, but many of these groups have opted to cover preventive services with no cost sharing.

This means that most members will have no cost-sharing responsibility when preventive services are rendered by an in-network provider. Members may still be required to pay a copayment, deductible or coinsurance for preventive services received from out-of-network providers (PPO and POS plans), or for nonpreventive services received in conjunction with a preventive services visit. Refer to the Preventive Services list for a complete list of services that have been deemed preventive in nature.

**MEMBER RESPONSIBILITY**

**Outpatient Maternity Services**
All outpatient routine prenatal and postpartum office visits are covered in full for new groups and upon plan renewal date for existing members of all fully and self-insured nongrandfathered plans. Any

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^\text{SM}\) when Tufts Health Plan is the primary administrator.
outpatient maternity services not considered routine, or those related to complications or risks with a
pregnancy, may be subject to cost sharing based on the member’s plan. Some examples of services
not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and
obstetrical ultrasounds.

**AUTHORIZATION REQUIREMENTS**

Obstetrical admissions that result in the planned delivery of a newborn do not require inpatient
notification. Admissions that fall outside of the mandated 48 hours for a vaginal delivery or 96 hours
for a caesarian delivery require inpatient notification. Obstetrical admissions that are not for a planned
delivery are subject to Tufts Health Plan’s notification requirements.

Providers should complete the [Massachusetts Health Quality Partners (MHQP) Obstetrical Risk
Assessment Form](#) between 12 and 14 weeks gestation and fax it to the Health Programs Department
at 617.972.9417 prior to services being rendered.

Obstetrical care management services are available to assist high-risk members and manage
antepartum care during their pregnancy. When the member’s obstetrician completes the [MHQP
Obstetrical Risk Assessment Form](#), a Tufts Health Plan care manager may enroll the member in the
obstetrical care management program, if applicable.

In the event that the birth mother and/or the newborn(s) must stay longer due to illness, an inpatient
notification is required.

**BILLING INSTRUCTIONS**

**Outcome of Delivery**

Providers should follow the official ICD-CM guidelines for coding and reporting when submitting claims
for an outcome of delivery. An outcome of delivery code should be included on every maternal record
when a delivery has occurred.

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z37.0</td>
<td>Single live birth</td>
</tr>
<tr>
<td>Z37.1</td>
<td>Single stillbirth</td>
</tr>
<tr>
<td>Z37.2</td>
<td>Twins, both liveborn</td>
</tr>
<tr>
<td>Z37.3</td>
<td>Twins, one liveborn and one stillborn</td>
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<tr>
<td>Z37.4</td>
<td>Twins, both stillborn</td>
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<td>Z37.50</td>
<td>Multiple births, unspecified, all liveborn</td>
</tr>
<tr>
<td>Z37.51</td>
<td>Triplets, all liveborn</td>
</tr>
<tr>
<td>Z37.52</td>
<td>Quadruplets, all liveborn</td>
</tr>
<tr>
<td>Z37.53</td>
<td>Quintuplets, all liveborn</td>
</tr>
<tr>
<td>Z37.54</td>
<td>Sextuplets, all liveborn</td>
</tr>
<tr>
<td>Z37.59</td>
<td>Other multiple births, all liveborn</td>
</tr>
<tr>
<td>Z37.60</td>
<td>Multiple births, unspecified, some liveborn</td>
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<tr>
<td>Z37.61</td>
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<tr>
<td>Z37.62</td>
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<tr>
<td>Z37.63</td>
<td>Quintuplets, some liveborn</td>
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<td>Other multiple births, all stillborn</td>
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<tr>
<td>Z37.9</td>
<td>Outcome of delivery, unspecified</td>
</tr>
</tbody>
</table>

**Collaborating Practitioners Submitting Claims for Certified Nurse Midwives (Massachusetts only)**

Submit claims using the collaborating practitioner’s name and provider identification number for
appropriately rendered services. Claims billed without the collaborating practitioner’s name and
provider identification number will deny.
It is the responsibility of the collaborating practitioner to educate the certified nurse midwives (CNMs) on all Tufts Health Plan policies, procedures and guidelines. The collaborating practitioner is responsible for maintaining appropriate state licensing information for CNMs.

**CNMs Rendering Services to Tufts Health Freedom Plan Members:**
Submit claims for maternity care rendered in the home² with place of service 12 or 25.

**Global Obstetrical Services**
Do not submit individual claims for antepartum care when billing for global delivery, as they will deny as included in the global delivery. Submit only one claim following delivery for global services with the appropriate CPT procedure code:
- 59400 (vaginal delivery)
- 59510 (cesarean delivery)
- 59610 (vaginal delivery after a previous cesarean delivery)
- 59618 (cesarean delivery after vaginal delivery attempt after a previous cesarean delivery)

**Nonglobal Obstetrical Services**
Providers who do not provide global obstetrical services for various reasons, including the member moving to another practitioner not associated with the practice, moving away prior to delivery, losing the pregnancy, or changing insurance plans, should submit claims for nonglobal services with the appropriate CPT procedure codes:
- 59425-59426 (antepartum visits)
- 59409, 59514, 59612, or 59620 (delivery only)
- 59410, 59515 or 59614 (the delivery and postpartum care only)
- 59430 (postpartum care only)

**Note:** When billing 1-3 antepartum visits, submit the most appropriate evaluation and management (E&M) CPT procedure code.

**COMPENSATION/REIMBURSEMENT INFORMATION**
Obstetricians receive one global case payment for total obstetrical care including antepartum visits, delivery and postpartum visits. Included in the global case payment are the routine urine lab tests and other related tests performed at each antepartum visit. Tufts Health Plan will deduct one copayment equal to the total number of office copayments from the global delivery payment based on the benefit plan document at the time of delivery.

**Antepartum and Postpartum Care**
When an obstetrician performs either antepartum or postpartum services only, Tufts Health Plan compensates for individual visits or visit ranges when reported according to the billing guidelines.

If a member transfers to an obstetrician late in her pregnancy, Tufts Health Plan compensates for the antepartum visits, the delivery and postpartum care, when reported according to the billing guidelines.

Tufts Health Plan does not routinely compensate for the following:
- Antepartum care-only codes when either antepartum code has been previously billed
- The global delivery code if the provider has billed antepartum care in the last eight months

**E&M Services Provided Within the Global Period**
Surgical procedures are assigned a global day period of 0, 10 or 90 day(s) by CMS based on the complexity of the procedure. Services rendered within the assigned specified numbers of global days, including E&M services, are considered inclusive to the primary procedure and are not eligible for separate compensation. Refer to the **Evaluation and Management Professional Payment Policy** for additional information.

**Obstetrical Ultrasounds**
Tufts Health Plan compensates for obstetrical ultrasounds once during the second and third trimester when billed with a high-risk ICD-CM code, which includes but is not limited to:
- Threatened abortion
- Missed abortion
- Suspected ectopic

² Per N.H. RSA 415:18-q.
• Suspected hydatidiform mole
• Size/date discrepancy
• Polyhydramnios
• Fetal growth restriction

Claims for obstetrical ultrasounds billed more than once without a high-risk ICD-CM code will deny.

Tufts Health Plan does not routinely compensate for a pelvic ultrasound (76856) when billed with a saline infusion sonohysterography (76831).

Obstetrical Ultrasounds
Tufts Health Plan limits coverage of the following procedure codes:
• 76811 to once in a five-month period
• 76801-76802 to once within a 90-day period.

DOCUMENT HISTORY
• April 2017: Policy reviewed; removed AIUM certification language for obstetrical ultrasounds
• January 2017: Template updates
• January 2016: Added information for Tufts Health Freedom Plan members
• September 2015: Template conversion, template updates
• July 2015: Added obstetrical ultrasounds policies effective for dates of service on or after October 1, 2015, template updates
• April 2015: Revised obstetrical ultrasounds policy, effective for dates of service on or after April 1, 2014, template updates
• December 2014: Added information regarding collaborating physicians submitting claims for certified nurse midwives
• November 2014: Added policies regarding antepartum care-only codes and the global delivery code billed with antepartum care, effective for dates of service on or after January 1, 2015, template updates.
• July 2014: Updated ICD-10 implementation language, template updates
• May 2014: Updated information regarding obstetrical admissions, template updates
• January 2014: Added information about changes in cost share for all outpatient routine prenatal and postpartum office visits, beginning January 1, 2014
• November 2013: Updated information regarding obstetrical ultrasounds, template updates.
• September 2013: Template conversion
• July 2013: Added ICD-10 diagnosis codes for outcome of delivery, template updates
• November 2012: Added change in preregistration requirements, effective for dates of admission on or after January 1, 2013
• March 2012: Updated CareLink disclaimer language
• February 2012: Policy reviewed, no content changes
• October 2011: Template updates, no content changes
• September 2010: Added information regarding Preventive Services
• July 2010: Revised member responsibility and reimbursement information to clarify copayment language
• February 2008: Revised general benefit information with self-service channels information
• December 2002: Policy originated.

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.
This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink when Cigna is the primary administrator for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.