

## Obstetrics/Gynecology Professional Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)<sup>1</sup>
- Tufts Medicare Preferred HMO (a Medicare Advantage product)<sup>2</sup>
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)<sup>2</sup>

Applies to the following Tufts Health Public Plans products:

- Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- Tufts Health RITogether (a Rhode Island Medicaid Plan)
- Tufts Health Unify (OneCare Plan; a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracting providers who render obstetrical and/or gynecological services. For family planning services, including birth control counseling and contraceptive management and termination of pregnancy refer to the [Family Planning Professional Payment Policy](#).

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

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

### **POLICY**

Tufts Health Plan covers medically necessary obstetrical and gynecological services, in accordance with the member's benefit.

### **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 the secure Provider [website](#) or by contacting [Provider Services](#).

### **REFERRAL/AUTHORIZATION/NOTIFICATION REQUIREMENTS**

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

### **Commercial and Tufts Health Public Plans**

Providers should notify Tufts Health Plan of a member's pregnancy by completing the appropriate [Prenatal Registration Form](#) located in the Provider Resource Center and faxing it to the appropriate number listed on the form. For additional information refer to the Referrals, Authorizations and Notifications chapter of the [Commercial Provider Manual](#) or the Care Management chapter of the [Public Plans Provider Manual](#).

### **Inpatient Notification – Commercial, Tufts Medicare Preferred HMO and Tufts Health Public Plans Products**

As per federal law, Tufts Health Plan does not require prior authorization or inpatient notification for planned deliveries that fall within the timeframes (from time of delivery) of 48 hours for a vaginal delivery or 96 hours for a caesarian delivery. Obstetrical admissions that are not for a planned delivery are subject to Tufts Health Plan's inpatient notification requirements.

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<sup>1</sup> Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink<sup>SM</sup> when Tufts Health Plan is the primary administrator.

<sup>2</sup> Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

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**

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the [Professional Services and Facilities Payment Policy](#).

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

### **Certified Nurse Midwives Rendering Services to Tufts Health Freedom Plan Members**

Certified Nurse Midwives (CNMs) rendering services to Tufts Health Freedom Plan members must submit claims for maternity care rendered in the home<sup>3</sup> 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 procedure code.

### **Nonglobal Obstetrical Services**

Providers who do not provide global obstetrical services for various reasons, such as 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 procedure code(s).

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

### **Obstetrical Ultrasounds – Commercial Products**

Providers may bill obstetrical ultrasound services in accordance with their provider agreements. Refer to the Imaging Privileging Program chapter in the [Commercial Provider Manual](#) for specific codes.

### **Outcome of Delivery**

An outcome of delivery code should be included on every maternal record when a delivery has occurred.

### **COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the [Professional Services and Facilities Payment Policy](#).

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.

### **Antepartum and Postpartum Care**

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
- Antepartum services billed with a date of service up to one week following a delivery

### **Bacterial Vaginosis Screening**

Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate bacterial vaginosis testing (82120, 83986, 87210, 87510, 87660 or 87905) if billed and the only diagnosis is normal pregnancy.

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<sup>3</sup> Per N.H. RSA 415:18-q.

### **Cervical Cancer Screening**

Tufts Health Plan does not routinely compensate for cervical or vaginal screening services for a female member less than 21 years of age on the date of service when the only diagnosis is a screening diagnosis code or for a female member is 21 years of age and older under the following circumstances:

- When the only diagnosis is a screening diagnosis code and cervical or vaginal screening services have been reported in the previous 13 months, or
- When the only diagnosis is a screening diagnosis code and cervical or vaginal screening services have been reported in the previous three years

### **Delivery of Multiple Gestation Pregnancy**

Tufts Health Plan will not routinely compensate global package via vaginal delivery (59400) when billed with global package via cesarean delivery (59510) and the diagnosis is not multiple gestation.

### **Global Obstetrical Package**

Tufts Health Plan does not separately compensate E&M services that are included in the global obstetrical package for uncomplicated maternity cases billed on the same day as the delivery.

Tufts Health Plan does not routinely compensate E&M services or postpartum care billed within 42 days (6 weeks) by the same tax ID and specialty that performed a delivery that includes postpartum care.

### **Endometrial Biopsy for Infertility**

Tufts Health Plan will not routinely compensate endometrial biopsy (58100, 58110) if the only diagnosis on the claim is infertility or infertility encounter.

### **Non-obstetric Ultrasounds**

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

### **Obstetrical Ultrasounds**

Tufts Health Plan compensates for repeat obstetrical ultrasounds 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
- Suspected hydatidiform mole
- Size/date discrepancy
- Polyhydramnios
- Fetal growth restriction

Tufts Health Plan does not routinely compensate pregnant uterus ultrasound services (76801, 76802) if either code has been billed in the previous three months.

Tufts Health Plan compensates for ultrasound codes that involve multiple gestations when accompanied by one of the diagnoses for multiple gestations. Certain diagnoses, by definition or nature of the diagnoses, are limited to the treatment of one gender and/or age. Tufts Health Plan will deny claims when the gender and/or age of the member do not match the definition of the diagnosis.

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

Tufts Health Plan will not routinely compensate detailed fetal anatomic ultrasound (76811, 76812) when billed and the only diagnosis on the claim is supervision of normal pregnancy, routine screening for malformations using ultrasonics, fetal anatomic survey, or antenatal screening of mother.

Tufts Health Plan will not routinely compensate initial obstetric ultrasound services when codes 76805 or 76810-76812 has been billed in the past five months.

### **Pap Smear Pathology**

Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate screening pap smear pathology codes (P3000, G0123, G0143, G0144, G0145, G0147, or G0148) for low-risk diagnosis codes if billed by any provider more than once in 11 months for Commercial products or in a two-year period (730 days) for Senior Products and Tufts Health Public Plans.

## **Screening Pelvic Examinations**

Tufts Health Plan does not routinely compensate screening pelvic examinations (G0101) when billed by any provider under the following circumstances, except when a high-risk diagnosis is present:

- More than once within 334 days from the first date of service for **Commercial products**
- More than once within two years from the first date of service for **Senior Products and Tufts Health Public Plans.**

### **ADDITIONAL RESOURCES**

[Diagnosis-Related Group \(DRG\) Inpatient Facility Payment Policy](#) (Commercial Products)  
[Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#) (Tufts Health Public Plans Products)  
[Evaluation and Management Professional Payment Policy](#)  
[Family Planning Payment Policy](#)  
[Inpatient Facility Payment Policy](#) (Senior Products)  
[Non-Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#) (Commercial Products)  
[Non-Diagnosis Related Group \(DRG\) Inpatient Facility Payment Policy](#) (Tufts Health Public Plans)  
[Obstetric Anesthesia Service Payment Policy](#) (Tufts Health Public Plans Products)  
[Preventive Services Policy](#)  
[Surgery Professional Payment Policy](#) (Commercial Products)  
[Surgery Professional Payment Policy](#) (Senior Products)

### **DOCUMENT HISTORY**

- June 2020: Reviewed by committee; added Tufts Health Public Plans and Senior Products; removed member responsibility and preventive services sections and CPT/HCPCS codes
- October 2019: Updated link to Prenatal Registration form
- November 2018: Added claim edits for bacterial vaginosis screening; pap smear pathology codes, effective for dates of service on or after January 1, 2019
- September 2018: Corrected language for screening pelvic examinations
- August 2018: Added claim edits for cervical cancer screening and endometrial biopsy for infertility effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- February 2018: Added claim edits for delivery of multiple gestation pregnancies and screening pelvic examinations, effective for dates of service on or after April 1, 2018
- November 2017: Added edits for cervical cancer screening and obstetrical ultrasounds effective for dates of service on or after January 1, 2018.
- 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

### **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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's [audit policies](#), refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), 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 applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink<sup>SM</sup> 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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.