COLORADO Department of Health Care Policy & Financing

Special Provider Bulletin –
Obstetrics and Maternity Healthcare
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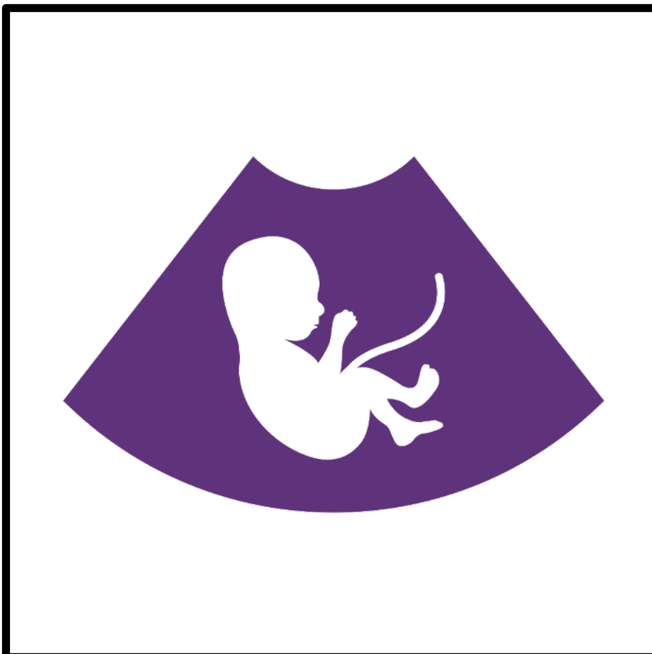


Obstetrics and Maternity Healthcare Providers

Revised Obstetrical Global Billing Requirements

The Centers for Medicare & Medicaid Services (CMS) requires Medicaid agencies to report quality measures (for example, prenatal and postpartum care) as a tool to monitor and help improve the quality of healthcare and health outcomes.

A new billing methodology has been developed to comply with CMS to capture information about care rendered throughout the maternity service timeframe (specifically identifying the timing and numbers of prenatal and postpartum visits). This new billing methodology will provide information needed to support high quality maternity care and enable providers to report provision of these critical services. Evaluating these maternity service components supports the understanding of quality maternal healthcare services for Health First Colorado (Colorado's Medicaid program) members during their pregnancies.

Billing globally covered obstetrics (OB)/maternity service codes will require coding inclusions to identify prenatal and postpartum care visits and the dates prenatal and postpartum services were provided, effective June 1, 2023.

This required OB billing change will be **enforced for Fee-for-Service (FFS) providers** submitting professional claims.

It is recommended that **Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers** also follow these new billing guidelines to identify prenatal care visits when billing for labor and delivery (L&D) services (outside the normal encounter rate billing methodology) to accurately capture provision of these healthcare services and quality healthcare metrics.

Providers are still required to bill the most appropriate global, bundled/partial or individual maternity/OB Common Procedural Terminology (CPT) codes (59400 – 59622) on claims. Using one of the CPT Category II codes to identify and document each prenatal and postpartum visit will be the required change in the obstetrical billing methodology. This should be done on the same claim as the global/partial maternity billing claim, ***or*** if only the prenatal or postpartum visits are provided (when billing the global/partial codes are not appropriate), then the CPT Category II prenatal and postpartum code(s) should also be included on that individual prenatal (antepartum) or postpartum claim. These added CPT Category II "F" codes (0500F, 0501F, 0502F or 0503F) are for reporting purposes only and will not affect the claim reimbursement.

Providers will also need to document on a separate line, below the identified maternity-related (global, partial or L&D) CPT code:

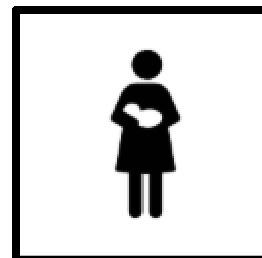
1. The date of service (DOS) for each of the prenatal visits and postpartum visits, ***and***
2. The appropriately described CPT Category II code documenting the prenatal or postpartum care visit.

These listed CPT Category II codes and associated DOS will be identified by the Colorado interChange as a "no-charge" line item.

The following CPT Category II "F" codes will be reported to identify and document the service provision for each prenatal and postpartum care visit:

Use either O500F *or* O501F as the descriptive code for the first (initial) prenatal visit:

- 0500F
- 0501F
- 0502F
- 0503F



The following are Obstetrical CPT codes and CPT Category II codes identifying the maternity service(s) included with each code. ***Code descriptions are not contained in this bulletin. The descriptions are copyrighted by the American Medical Association (AMA). Providers should reference the 2023 HCPCS and CPT coding manuals for procedure code descriptions. These coding manuals may be purchased through the AMA and publishers such as OptumInsight.***

Table 1:

Code	One per Gestation	Prenatal Care	Labor and Delivery	Postpartum Care
59400	X	X	X	X
59410	X		X	X
59409			X	
59610	X	X	X	X

Code	One per Gestation	Prenatal Care	Labor and Delivery	Postpartum Care
59614	X		X	X
59612			X	
59510	X	X	X	X
59515	X		X	X
59514			X	
59618	X	X	X	X
59622	X		X	X
59620			X	
59425	X	X		
59426	X	X		
59430				X
99201-205 / 99211-215				
0500F		X		
0501F		X		
0502F		X		
0503F				X

Detailed Examples: New Billing Requirements: Global, Partial, Labor and Delivery (L&D) Only and Billing Antepartum or Postpartum Only Codes

<u>**Section 1 – Billing Requirement for Codes Including L&D Services**</u>

Providers that render L&D service are required to bill the appropriate procedure code identifying whether the service was a vaginal delivery or cesarean section delivery.

- A provider that rendered the L&D care and also rendered antepartum (minimum of four visits) and postpartum care (at least one visit) must bill the appropriate Global obstetrics (OB) care code on the date of delivery as well as the antepartum and postpartum Common Procedural Terminology (CPT) Category II descriptive codes with the dates the antepartum and postpartum visits were rendered, all on the same claim.
    - The line with the Global OB care code will be paid a dollar amount associated with the most current Fee-For-Service (FFS) fee schedule.

    - The lines with the antepartum and postpartum visits will be identified as no charge lines (paid $0)

- A provider that rendered the L&D care and also rendered postpartum care (at least one visit) must bill the appropriate Partial OB care code on the date of delivery as well as the postpartum CPT Category II descriptive code and the dates of the postpartum visits on the same claim.
    - The line with the Partial OB care code will be paid a dollar amount associated with the most current online fee schedule.
    - An additional line(s) with the postpartum visit(s) CPT Category II code and date of service (DOS) must also be listed on the claim with this Category II code being identified as a no charge line.

- A provider that rendered the L&D care ***only*** and does not render any additional global OB services and no affiliated practitioners rendered antepartum or postpartum care must bill the appropriate L&D Only code on the date of delivery.
    - The line with the L&D Only OB care code will be paid a dollar amount associated with the most current FFS fee schedule.

- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers that bill for L&D services (as a carved-out service outside of normal encounter rate billing) should bill the appropriate L&D Only code on the date of delivery but also include the rendered CPT Category II antepartum care visits codes and associated dates of services (DOS) for identification of these prenatal visits on this same L&D claim.
    - The line with the L&D Only OB care code will be paid a dollar amount associated with the most current FFS fee schedule. The lines with the antepartum visits Category II codes will be used to identify prenatal/ antepartum care provision and are identified as no charge lines. Encounter rate payments for these prenatal services will not be impacted/changed when accurately reporting and identifying provision of these critical maternity care services on the L&D claims form.
    - Include the CPT Category II postpartum visit code (0503F) for postpartum visits on the regular encounter visit claim to capture and identify this postpartum care visit.

Table 2: Billing Examples for Global, Partial and L&D Only Services (and FQHC, RHC L&D billing)

Code		CPT Category II Codes must be associated with the days the services were rendered								
Line 1	Line 2	Line 3	Line 4	Line 5	Line 6	Line 7	Line 8	Line 9	Line 10	Addi-tional lines

Code	CPT Category II Codes must be associated with the days the services were rendered									
59400	0500F or 0501F	0502F	0502F	0502F	0502F*	0502F*	0502F*	0502F*	0503F	0503F*
59515	0503F	0503F*	0503F*							
59409	0500F or 0501F	0502F	0502F	0502F	0502F*	0502F*	0502F*	0502F*	0502F*	
*optional										

Example Specifics:

Claim with span DOS 1/1/22 – 11/11/22 for Global OB code, 8 antepartum visits and 2 postpartum visits

- Line 1: Procedure code 59400 on DOS 10/5/22 – Paid at the current FFS fee schedule
- Line 2: Procedure code 0500F or 0501F on DOS 3/15/22 – No charge line item
- Line 3: Procedure code 0502F on DOS 4/20/22 – No charge line item
- Line 4: Procedure code 0502F on DOS 5/25/22 – No charge line item
- Line 5: Procedure code 0502F on DOS 6/30/22 – No charge line item
- Line 6: Procedure code 0502F on DOS 7/20/22 – No charge line item
- Line 6: Procedure code 0502F on DOS 8/8/22 – No charge line item
- Line 6: Procedure code 0502F on DOS 8/26/22 – No charge line item
- Line 6: Procedure code 0502F on DOS 9/15/22 – No charge line item
- Line 7: Procedure code 0503F on DOS 11/4/22 – No charge line item
- Line 8: Procedure code 0503F on DOS 11/30/22 – No charge line item

Examples for new billing requirements for Antepartum/Prenatal Only codes:

Section 2 - Antepartum-Only Services

A provider that did not render and bill the L&D service but renders antepartum services must bill the appropriate antepartum-only care code and list the CPT Category II antepartum care visits codes and associated DOS for the individual prenatal visits on the same claim.

- Providers should bill the appropriate Evaluation and Management (E&M) codes (99201 – 99205 / 99211 – 99215) for up to three (3) antepartum visits.
- For four (4) or more antepartum visits:
  - Four (4) to six (6) antepartum visits: Providers must bill appropriate antepartum code (59425) that indicates 4-6 visits were rendered. This procedure code will pay at the most current FFS fee schedule. Then in the lines below, CPT Category II codes must be reported at a minimum of 4 visits and a maximum of 6 visits.
  - Seven (7) or more antepartum visits: Providers must bill the appropriate antepartum code (59426) that indicates 7 or more visits were rendered. This CPT

procedure code will pay at the most current FFS fee schedule. The Category II codes below must be listed a minimum of 7 times with no maximum.

- Providers must include on the same claims billed for 59425 or 59426:

  1. One of the Category II codes (0500F **or** 0501F) for the initial prenatal visit with a healthcare professional providing obstetrical care, indicating a pregnancy diagnosis ***or*** to report the prenatal flow sheet initial prenatal visit was provided. This code should be on the earliest date of the claim, never be billed twice on the same claim or billed twice by the same provider for the same pregnancy for the member. This descriptive CPT Category II code will be listed and identified as a no charge line on the claim.

     and

  2. Between three (3) and five (5) (0502F) CPT Category II codes should be listed on lines below 59425 ***or*** at least six (6) (0502F) CPT Category II codes should be listed on lines below 59426 to indicate subsequent prenatal visits. Identified 0502F codes must be dated after the 0500F or 0501F prenatal visit code dates on the claim. These descriptive codes will be identified as a no charge line.

- The claim will be identified as a split billed claim and denied for incorrect OB/ maternity code billing if the same provider attempts to bill four (4) or more antepartum visits on a separate claim from a claim with L&D ***and*** postpartum care, or vice versa.

Table 3: Billing Examples for Antepartum/Prenatal Only Claims

Code		CPT Category II Codes must be associated with the days the services were rendered								
Line 1	Line 2	Line 3	Line 4	Line 5	Line 6	Line 7	Line 8	Line 9	Line 10	Additional lines
59425	0500F or 0501F	0502F	0502F	0502F	0502F*					
59426	0500F or 0501F	0502F	0502F	0502F	0502F	0502F	0502F	0502F*	0502F*	
*optional										

Example:

Claim with DOS 1/1/22 – 5/30/22 for 5 antepartum visits

- Line 1: Procedure code 59425 on DOS 5/30/22 – Paid at the current FFS fee schedule (FQHC/RHC claims will pay at the encounter rate)
- Line 2: Procedure code 0500F or 0501F on DOS 1/4/22 – No charge line item
- Line 3: Procedure code 0502F on DOS 2/4/22 – No charge line item

- Line 4: Procedure code 0502F on DOS 3/4/22 – No charge line item
- Line 5: Procedure code 0502F on DOS 4/5/22 – No charge line item
- Line 6: Procedure code 0502F on DOS 5/10/22 – No charge line item

Examples for new billing requirements for Postpartum Only codes:

Section 3 - Postpartum-Only Services

A provider that did not render or bill an L&D service code but did render postpartum services must bill the appropriate postpartum care only code (59430) and include the associated CPT Category II postpartum visit code(s) (0503F) on the same claim and list the date(s) on which the postpartum care visit(s) were rendered. Providers must list at least one Category II postpartum visit code in addition to the postpartum care CPT code. Postpartum care codes will pay at the current FFS fee schedule. Descriptive CPT Category II postpartum visit code(s) will be identified as a no charge line item.

- FQHC and RHC providers who bill for postpartum visits must include the CPT Category II postpartum visit code (0503F) on the regular encounter visit claim form to capture and identify these important postpartum care visits.

Example:

Claim with DOS 10/1/22 - 11/30/22

- Line 1: Procedure code 59430 on DOS 10/1/22 - Paid at the current FFS fee schedule (FQHC/RHC claims will pay at the encounter rate)
- Line 2: Procedure code 0503F on DOS 10/15/22 - No charge line item
- Line 3: Procedure code 0503F on DOS 11/15/22 - No charge line item
- Line 4: Procedure code 0503F on DOS 11/30/22 - No charge line item

The Obstetrical Care Billing Manual will be updated with this information.

Contact the Provider Services Call Center with questions regarding billing. Contact Melanie Reece at Melanie.Reece@state.co.us with questions regarding the policy.

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