Obstetrics

Reimbursement Policy ID: RPC.0068.0100

Recent review date: 05/2025

Next review date: 01/2026

Keystone First 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. Keystone First 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

Consistent with Pennsylvania state mandates and HEDIS requirements, AmeriHealth Caritas Pennsylvania requires the provider to complete the Obstetrical Needs Assessment Form (ONAF) on every pregnant member, which is located https://obcare.optum.com/ This form is used to document prenatal, antenatal, and postpartum care and must completed thoroughly and accurately for the claim not be rejected. Requirements for the ONAF must include the following:

- Submission time: Form should be completed in Optum within seven days of the initial prenatal visit, after delivery, and after postpartum visit.
- Demographics: The demographics section should be completed in full for each submission
- Clinical section: The clinical section should be completed in full and accurately for each submission. This includes checking the trimester in which a risk of medical condition was identified.
- Dates: The dates of all visits, including the postpartum visit, should be included.
- Effective 1/1/2023 reimbursement for thorough and correct completion of the ONAF forms is through the Maternity Quality Enhancement Program (MQEP) and not through the claim payment system for qualified providers (providers with equal to or greater than 50 deliveries per year) though the claim with procedure code T1001U9 and 99429 must be submitted and match (i.e., member, DOS, etc.) the ONAF form completed in Optum.

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 Pennsylvania 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:

- 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
Providers should bill the appropriate CPT code that describes the type of delivery (example: vaginal, cesarean section).

CPT Code	Description
59409	Vaginal delivery only (with or without episiotomy and/or forceps
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59514	Cesarean delivery only * Assistant Surgeon permitted
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean * Assistant Surgeon permitted

Postpartum
A postpartum visit rendered within 7 to 84 days after delivery should be reported with CPT code 59430 and an appropriate postpartum diagnosis code. This procedure code will be reimbursed once per pregnancy.

AmeriHealth Caritas Pennsylvania does not reimburse for the global obstetric submissions.

Anesthesia
Administration of obstetrical anesthesia using CPT codes is reimbursable for

- Neuraxial analgesia for vaginal delivery (includes repeated subarachnoid needle placement, drug injection, and necessary epidural catheter replacement during labor); or
- Anesthesia for cesarean delivery.

The anesthesia codes below pay an additional 4 base units. Anesthesia codes 01967-01969 are excluded from multiple surgery reduction when billed together.

CPT Code	Description
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01962	Anesthesia for emergency hysterectomy following delivery
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
+01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia

Definitions

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

Neuraxial Anesthesia
Neuraxial anesthesia and analgesia techniques include spinal, epidural, and combined spinal-epidural.

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-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI)
V. American Congress of Obstetricians and Gynecologists (ACOG)
VI. Centers for Medicare and Medicaid Services (CMS).
VII. Corresponding Keystone First Clinical Policies.
VIII. Applicable Keystone First manual reference.
IX. Commonwealth of Pennsylvania Medicaid Program guidance.
X. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0038.0000 Obstetric Ultrasound

Policy History

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
01/2025	Annual Review • No major changes
08/2024	Reimbursement Policy Committee Approval
08/2024	Updated to include anesthesia guidelines
04/2024	Revised preamble
08/2023	Removal of policy implemented by Keystone First 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