CHAPTER 1
SECTION 18

PROFESSIONAL SERVICES: OBSTETRICAL CARE

ISSUE DATE: August 26, 1985
AUTHORITY: 32 CFR 199.4(c)(2)(xii)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. POLICY

A. Obstetrical services are reimbursed as an all-inclusive global maternity professional fee which includes all professional services normally provided for routine antepartum care, vaginal delivery (with or without episiotomy, or forceps or breech delivery) and postpartum care.

B. The price for total (all-inclusive; global) obstetric care includes all attending physician or attending certified nurse-midwife services required during the course of the maternity episode. Incidental activity (observation, preparation, coordination, administration) rendered by office staff in support of the obstetrical professional's delivery of services are included in the price.

III. EXCEPTIONS

A. Hospital-employed provider. Line item charges for covered obstetrical services of a physician or certified nurse-midwife employed by (1) a DRG-exempt hospital is reimbursed on a billed-charge basis; by (2) a DRG hospital is reimbursed subject to the TRICARE/ CHAMPUS-determined maximum allowable charge.

B. Partial care rendered. Separate billings for antepartum care or delivery or postpartum care may be reimbursed subject to the aggregate amount limitations for a given segment of care prescribed in paragraph V.B. (LIMITATIONS) below.

C. Tests.

1. Technical component of tests. A separate allowance in addition to the global fee, subject to the appropriate area prevailing profile, may be made for the technical component of medically necessary tests provided during the period of maternity care.

2. Test-related professional charges. A legitimate consultation for the examination, analysis, interpretation, or application of diagnostic or laboratory test results by a professional other than the attending obstetrician or attending certified nurse midwife shall not be considered as included in the obstetric global fee.

D. Pregnancy testing. A separate allowance in addition to the global fee may be made for diagnostic tests for determination of a pregnate condition. The test may be cost-shared regardless of the outcome of the test.

E. Extraordinary professional services.

1. A separate allowance in addition to the global fee, subject to the appropriate area prevailing profile, may be made for professional services in excess of the quantity usually associated with a normal pregnancy and delivery when the extraordinary services are not otherwise excluded by the contractor's medical review. The rationale for reimbursement of these cases must be fully documented by the contractor.

2. Medically necessary antepartum office visits in excess of a total number of antepartum visits equal to twelve (12) visits plus one (1) weekly visit from the 37th week of gestation through delivery, may be considered for an additional allowance only when the contractor's medical review confirms documented maternal or fetal risk factors which required special management, or complications of pregnancy.

3. Medically necessary postpartum office visits in excess of two (2) may be considered for an additional allowance only for the management of a complication of pregnancy.

IV. POLICY CONSIDERATIONS

A. CPT[1] procedure codes 59400 or 59510 (total care; all-inclusive care; global care)

1. CPT[1] procedure codes 59400 or 59510 may be allowed only if the billing individual professional provider, or an alternate supervised by that provider, provided all segments of maternity care (antepartum care, delivery and postpartum care).

2. Natural childbirth classes and training may be allowed only when included in the charge for CPT[1] procedure code 59400 (all-inclusive care).

3. Charges for global care with and without natural childbirth classes and training should be included in the prevailing charge database for CPT[1] procedure code 59400.

B. Billing. Charges for the technical and professional components of tests must be separately identified on the maternity care bill and the number of antepartum and postpartum office visits must be indicated.

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C. Birthing center professional services. Reimbursement for professional services for maternity care and childbirth furnished by a TRICARE-authorized birthing center is included in the birthing center all-inclusive rate.

NOTE: The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services discussed in Chapter 1, Section 1, Chapter 5, Section 1, and Chapter 5, Section 3 does not apply to birthing center claims. The reimbursement guidelines as discussed in the TRICARE Policy Manual, Chapter 11, Section 3.1 are to be used by the contractors.

D. Discontinue use of CPT[2] procedure code 59421. CPT[2] procedure code 59421 should not be used to report any maternity care rendered after March 31, 1989. CPT[2] procedure code 59420 shall be used to report individual antepartum services rendered March 31, 1989 through December 31, 1992. CPT[2] procedure code 59420 was deleted effective with Current Procedural Terminology 1993. There is no code for the entire antepartum episode after March 31, 1989.

E. The LIMITATION that interim billings from a single individual professional provider or separate billings from different individual professional providers were subject to an aggregate maximum amount determined as a percentage of the price for CPT[2] procedure code 59400 was removed effective with Revision number 7.

V. LIMITATIONS

A. The billing of separate maternity care procedures is subject to rebundling to CPT[2] procedure codes 59400 or 59510 when all-inclusive maternity care was provided by the same professional provider. See also: Chapter 1, Section 3, Rebundling Of Procedure Codes.

B. Office-based childbirth services. The allowable charge for all-inclusive maternity care and childbirth in a physician's office or in a certified nurse-midwife's office is limited to the established allowable-charge for professional services for all-inclusive maternity care plus the allowable-charges for supplies usually associated with an in-home delivery.

VI. EXCLUSIONS

A. The following procedures[2] are excluded when billed separately:

99071 PATIENT EDUCATION MATERIALS
99078 GROUP HEALTH EDUCATION

B. No technical component of a diagnostic or laboratory test is included in the total obstetric care price.

C. Test-related charges by the attending professional. With the exception of medically necessary ultrasounds, no separate allowance may be made for the examination, analysis, interpretation, or application of diagnostic or laboratory test results by the attending

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obstetrician or attending certified nurse-midwife. These activities are considered to be the responsibility of the attending professional and included in the global fee of the attending obstetrical care professional. For maternity related ultrasounds, see the TRICARE Policy Manual, Chapter 5, Section 2.1.

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