# Obstetrics/Gynecology Professional Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Premier

☒ CareAdvantage Prime

The following payment policy applies to providers who render obstetrical and/or gynecological services to members of the CarePartners of Connecticut plans selected above.

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

## Policy

CarePartners of Connecticut covers medically necessary obstetrical and gynecological services, in accordance with the member's benefits.

## 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 portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

## Referral/ Authorization/Notification Requirements

Certain procedures, items and/or services may require 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. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

As per federal law, CarePartners of Connecticut 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 CarePartners of Connecticut inpatient notification requirements.

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, CarePartners of Connecticut 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.

Use of labs not participating in the member's applicable network(s) 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, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the non-participating lab that has been selected.

### 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.

### 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 contracted rates and applicable fee schedules.

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

CarePartners of Connecticut 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

CarePartners of Connecticut will not routinely compensate bacterial vaginosis testing (82120, 83986, 87210, 87510, 87660 or 87905) if billed and the only diagnosis is normal pregnancy.

### Cervical Cancer Screening

CarePartners of Connecticut 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 a member 21 years or 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

CarePartners of Connecticut 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

CarePartners of Connecticut 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.

CarePartners of Connecticut 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

CarePartners of Connecticut will not routinely compensate endometrial biopsy (58100, 58110) if the only diagnosis on the claim is infertility or infertility encounter.

### Non-obstetric Ultrasounds

CarePartners of Connecticut does not routinely compensate for a pelvic ultrasound (76856) if billed with a saline infusion sonohysterography (76831).

### Obstetrical Ultrasounds

CarePartners of Connecticut 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

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

CarePartners of Connecticut 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. CarePartners of Connecticut will deny claims when the gender and/or age of the member do not match the definition of the diagnosis.

CarePartners of Connecticut limits coverage of the following procedure codes:

- 76811 to once in a five-month period
- 76801-76802 to once within a 90-day period.

CarePartners of Connecticut 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.

CarePartners of Connecticut will not routinely compensate initial obstetric ultrasound services when codes 76805 or 76810-76812 have been billed in the past five months.

### Pap Smear Pathology

CarePartners of Connecticut 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 a two-year period (730 days).

### Planned Cesarean Delivery Less than 39 Weeks of Gestation

CarePartners of Connecticut does not routinely compensate for 59510, 59514 or 59515 (Cesarean delivery) when billed and a diagnosis of encounter for cesarean delivery without indication is present on the claim line and a diagnosis indicating a gestational age of less than 39 weeks is also present on the claim line.

### Screening Pelvic Examinations

CarePartners of Connecticut 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 two years from the first date of service.

## Additional Resources

- Evaluation and Management Payment Policy
- Family Planning Payment Policy
- Inpatient Hospital Admissions Payment Policy
- Surgery Professional Payment Policy

## Document History

- September 2023: Annual review; no changes
- September 2022: Annual policy review; administrative edits
- May 2021: Added edit for planned cesarean delivery less than 39 weeks of gestation effective for dates of service on or after July 1, 2021
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- June 2020: Document created

## Audit and Disclaimer Information

CarePartners of Connecticut 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 a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut 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 CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.