PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEDI-CAL PROVIDER MANUAL
CLAIMS DEPARTMENT

X.L. Obstetrical Services

Those codes indicated as CPSP codes (Table #1), can be used by CPSP certified providers. CPSP or non- CPSP providers can use the OB billing codes listed on Table #2 below.

Note: Initial assessment codes Z6202, Z6300, Z6402 must be provided and billed prior to billing for intervention services. The two exceptions to this are codes Z6400 (client orientation) and Z6412 (group health education). Both of these services may be provided and reimbursed prior to the time the patient received initial assessment services.

TABLE #1 CPSP CERTIFIED PROVIDERS ONLY CPSP CODES - ONLY			
Comprehensive Psychosocial Services	**Comprehensive Health Education Services**	**Comprehensive Nutritional Services**	**Other**
Z6300	Z6400	Z6200	Z6500
Z6302	Z6402	Z6202	Z1032/ZL
Z6304	Z6404	Z6204	Z1036
Z6306	Z6406	Z6206	
Z6308	Z6408	Z6208	
	Z6410	Z6210	
	Z6412		
	Z6414		

TABLE #2 CPSP OR NON-CPSP PROVIDERS OB AND CPSP CODES		
Office Visits	**Delivery**	**Global**
Z1032	59409*	59400#
Z1034**	59412*	59510#
Z1038	59414*	59610#
	59514*	59618#
	59525*	59525#
	59612*	
	59620*	

* These codes must be billed with an outcome of delivery as one of the diagnosis. Outcome of delivery codes 650. or V27.0 – V27.7 must be one of the diagnosis billed.

\# These codes must be billed with:

1. An outcome of delivery as one of the diagnosis billed.

2. In the "from-through" billing format (called "from-to" on the CMS 1500 claim form) with modifier AG. The "from" DOS is the first date the member was seen for this pregnancy, and the "through" or "to" date of service is the date of the delivery.

3. A minimum of four prenatal visits listed in the *Remarks* area/*Reserved for Local Use* field (Box 19) or on an attachment. (The member must be eligible for at least a minimum of four visits.)

** <u>New PHC Policy on Prenatal Visits</u>

Partnership HealthPlan recognizes that some pregnant patients need more than 10 prenatal visits, for medical reasons. See the State MediCal Manual for documentation requirements for standard prenatal visits (codes used for first visit, tenth visit, second through 9th visit, post-partum visit). This explains documentation requirements and standards for submitting claims for more than 10 prenatal visits. It does not apply to office visits for non-obstetrical problems that occur during pregnancy.

Effective for dates of service on or after August 1, 2012:

1. <u>Additional visits with no TAR requirements:</u> Patients requiring 11-15 prenatal visits (using Z1034) for medically necessary reasons, may have those claims paid *without* submission of a TAR.A provider may not use both a global OB billing code and bill for individual prenatal visits. Since the initial OB visit and the tenth OB visit use different codes, this means that Z1034 may be billed up to 13 times without a TAR form.

2. <u>Examples of Medical Necessity</u>: Medical Necessity includes early onset of prenatal care, threatened miscarriage, pre-term labor, hyperemesis, pre-eclampsia, diabetes during pregnancy or other complications of pregnancy requiring more frequent visits. The diagnosis code for the reason for Medical Necessity must be included in claims submitted. Early entry into prenatal care has no exact ICD9 code; V22.2 may be used with a notation in the comments field "early entry into prenatal care, initial visit date: ______"

3. <u>TAR requirements</u>: A TAR is required for prenatal visits beyond 15. The TAR form and instructions for completing the TAR can be found on the Partnership HealthPlan website: www.partnershiphp.org

4. Subject to Audit: We hope and expect that our obstetrical providers will bill for these services appropriately, but to help assure medical necessity, Partnership will audit in two ways. Practices with a high percentage of patients with extra visits will have a random selection of charts audited to confirm Medical Necessity. IN addition, Partnership will audit prenatal visit volume on a 6 month frequency. If lack of Medical Necessity is found in the chart audit, the provider will be subject to further action, including but not limited to retroactive denial of claims found to lack medical necessity and lose the ability to bill for prenatal visits 11-15 without prior authorization.