The services for obstetrics and nursery are usually contained within three revenue departments:

- 1. Labor and Delivery Outpatient services, and labor resources
- 2. Post Partum Inpatient Services, daily hospital service, routine care
- 3. Nursery Inpatient services, daily hospital services, limited procedures

To provide the "best" possible understanding of the charges, codes and reimbursement, Medicare HCPCS terminology is utilized within this paper, due to a number of Medicaid plans adopting the HCPCS data set.

If your Hospital has payer specific questions, please contact PARA for assistance.

Labor and Delivery

There are several components to these services:

- 1. Outpatient ante partum check
- 2. Outpatient infusion services and procedures
- 3. Labor charges

The outpatient ante partum check is one of the most common processes performed; an expectant mother may experience a number of issues or trauma which requires the status of the mother and baby to be evaluated. It is usually the case that if a 2nd or 3rd trimester mother presents in the ED the mother is immediately transported to the OB outpatient department for an evaluation.

The charges for the evaluation are based the length of time the mother resides in the clinic, this is usually 2-4 hours.

The codes are based on a "new" or "established" patient visit.

99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Q3 - Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Q3 - Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

Labor and Delivery - outpatient ante partum care (continued)

It is recommended that the charge structure be set as follows, with different rates based on the time in the department:

- 1. New Patient 2 Hours (99205)
- 2. New Patient 2 4 hours (99205)
- 3. Established Patient 2 Hours (99215)
- 4. Established Patient 2 4 hours (99215)

If the labor check lasts longer than four hours it is recommended that the patient be "admitted" to medical observation care, observation is charged hourly and should not last longer than 48 hours.

99218 - Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.	B - Not paid under OPPS.
99219 - Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.	B - Not paid under OPPS.
99220 - Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.	B - Not paid under OPPS.
G0378 - HOSPITAL OBSERVATION SERVICE, PER HOUR	N - Payment is packaged into payment for other services.
G0379 - DIRECT ADMISSION OF PATIENT FOR HOSPITAL OBSERVATION CARE	Q3 - Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

Labor and Delivery - outpatient ante partum care (continued)

There are several services which are commonly utilized by a Patient during these "labor checks". The most common is the non-stress test; the majority of payers will not reimburse for fetal monitoring.

59000 - Amniocentesis; diagnostic	T - Paid Under OPPS; Separate APC.
59001 - Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	T - Paid Under OPPS; Separate APC.
59012 - Cordocentesis (intrauterine), any method	T - Paid Under OPPS; Separate APC.
59015 - Chorionic villus sampling, any method	T - Paid Under OPPS; Separate APC.
59020 - Fetal contraction stress test	T - Paid Under OPPS; Separate APC.
59025 - Fetal non-stress test	T - Paid Under OPPS; Separate APC.
59030 - Fetal scalp blood sampling	T - Paid Under OPPS; Separate APC.
59050 - Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	M - Not paid under OPPS.
59070 - Transabdominal amnioinfusion, including ultrasound guidance	T - Paid Under OPPS; Separate APC.
36430 - Transfusion, blood or blood components	S - Paid Under OPPS; Separate APC.
51798 - Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	X - Paid Under OPPS; Separate APC.
51701 - Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)	X - Paid Under OPPS; Separate APC.
51702 - Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	X - Paid Under OPPS; Separate APC.
51703 - Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	T - Paid Under OPPS; Separate APC.

Labor and Delivery - outpatient ante partum care (continued)

There are a number of infusion, hydration and injection procedures.

96360 - Intravenous infusion, hydration; initial, 31 minutes to 1 hour	S - Paid Under OPPS; Separate APC.
96361 - Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	S - Paid Under OPPS; Separate APC.
96366 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
96367 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
96368 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)	N - Payment is packaged into payment for other services.
96369 - Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	S - Paid Under OPPS; Separate APC.
96370 - Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
96371 - Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
96372 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	S - Paid Under OPPS; Separate APC.
96373 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial	S - Paid Under OPPS; Separate APC.
96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	S - Paid Under OPPS; Separate APC.
96375 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
96376 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N - Payment is packaged into payment for other services.
96379 - Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	S - Paid Under OPPS; Separate APC.

Labor and Delivery - outpatient ante partum care (continued)

There are several radiology procedures which the Patient may utilize.

76801 - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation	S - Paid Under OPPS; Separate APC.
76802 - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
76805 - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation	S - Paid Under OPPS; Separate APC.
76810 - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
76811 - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	S - Paid Under OPPS; Separate APC.
76812 - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
76813 - Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	S - Paid Under OPPS; Separate APC.
76814 - Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)	S - Paid Under OPPS; Separate APC.
76815 - Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	S - Paid Under OPPS; Separate APC.
76816 - Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	S - Paid Under OPPS; Separate APC.
76817 - Ultrasound, pregnant uterus, real time with image documentation, transvaginal	S - Paid Under OPPS; Separate APC.
76818 - Fetal biophysical profile; with non-stress testing	S - Paid Under OPPS; Separate APC.
76819 - Fetal biophysical profile; without non-stress testing	S - Paid Under OPPS; Separate APC.

Labor and Delivery - outpatient ante partum care (continued)

There are several additional services which may be performed within the department.

59072 - Fetal umbilical cord occlusion, including ultrasound guidance	T - Paid Under OPPS; Separate APC.
59074 - Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	T - Paid Under OPPS; Separate APC.
59076 - Fetal shunt placement, including ultrasound guidance	T - Paid Under OPPS; Separate APC.
59160 - Curettage, postpartum	T - Paid Under OPPS; Separate APC.
59200 - Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)	T - Paid Under OPPS; Separate APC.
59300 - Episiotomy or vaginal repair, by other than attending physician	T - Paid Under OPPS; Separate APC.
59320 - Cerclage of cervix, during pregnancy; vaginal	T - Paid Under OPPS; Separate APC.
59412 - External cephalic version, with or without tocolysis	T - Paid Under OPPS; Separate APC.
59414 - Delivery of placenta (separate procedure)	T - Paid Under OPPS; Separate APC.

Labor charges

The majority of hospitals will charge an incremental nursing procedure for the active labor hours. This charge is hourly and is usually a two level charge, each with a 0720 revenue code.

- 1. Labor charge hourly Active labor
- 2. Labor charge hourly Hi risk labor

The Pricing on the charge is based on the additional Nursing time required by the Patient, fully loaded with benefits (1.4 x hourly rate) times a mark-up multiplier (3-5 times fully loaded cost).

Labor and Delivery - outpatient ante partum care (continued)

When there is a delivery, there is the delivery charge to consider.

59409 - Vaginal delivery only (with or without episiotomy and/or forceps);	T - Paid Under OPPS; Separate APC.
59514 - Cesarean delivery only;	C - Not Paid under OPPS. Admit Patient; Bill as Inpatient.
59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	T - Paid Under OPPS; Separate APC.
59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	C - Not Paid under OPPS. Admit Patient; Bill as Inpatient.

C-Section Operating Charges

- 1. Anesthesia
- 2. Room time
- 3. Recovery

Post Partum - Inpatient Services, daily hospital service, post partum care

There are very few additional services which can be charged to allocate resources; the majority of these services will not be reimbursed.

- 1. Lactation services
- 2. Private duty Nurses
- 3. Diabetic education

Nursery – Inpatient services, daily hospital services and procedures

In addition to the daily charge for the Nursery there are several procedures performed in the Nursery.

40806 - Incision of labial frenum (frenotomy)	T - Paid Under OPPS; Separate APC.
40819 - Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	T - Paid Under OPPS; Separate APC.
41010 - Incision of lingual frenum (frenotomy)	T - Paid Under OPPS; Separate APC.
41115 - Excision of lingual frenum (frenectomy)	T - Paid Under OPPS; Separate APC.
41520 - Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	T - Paid Under OPPS; Separate APC.
54150 - Circumcision, using clamp or other device with regional dorsal penile or ring block	T - Paid Under OPPS; Separate APC.
54160 - Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)	T - Paid Under OPPS; Separate APC.
54161 - Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age	T - Paid Under OPPS; Separate APC.

Additional Nursery charges

There are several additional charges which can be used to allocate costs and resources:

- 1. Bilirubin light therapy
- 2. Growing feeder babies
- 3. Respiratory therapy services
- 4. Hearing screen

These babies may require care after the Mother has discharged, the level of care be may shifted to a higher level due to the additional Nursing time expended.

A listing of the daily hospital service revenue codes is listed on the following pages with nursing hours per patient day.

Obstetric and Nursery daily Hospital service revenue codes

Code	Description
0112	Room & Board - Private (Medical or General) - OB
0122	Room & Board - Semiprivate Two-Bed (Medical or General) - OB
0170	Nursery - General Classification
0171	Nursery - Newborn - Level I
0172	Nursery - Newborn - Level II
0173	Nursery - Newborn - Level III
0174	Nursery - Newborn - Level IV
0179	Nursery - Other

017X # Days Nursery

This code indicates routine service charges for nursing care provided to newborn and premature infants in nursery accommodations. Subcategory codes 1–4 are used by facilities with nursery services designed around distinct areas and/or levels of care. Levels of care defined under state regulations or other statutes supersede the guidelines contained here. For example, some states have fewer than four levels of care or have multiple levels within a category (e.g., intensive care).

This revenue code usually applies to inpatient claims only.

The total number of accommodation days in the units field (FL 46) must equal the sum total of covered days from admission through the discharge period shown by the from and through dates in the statement covers period (FL 6).

The accommodation rate is required in FL 44 whenever a room and board revenue code is reported.

Per UB manual instructions, the level of care correlates to the intensity of medical care provided to an infant and **not** to the NICU facility certification level. The level of care should be clinically evaluated on a daily basis, typically based on the resources provided to the infant.

- The assigned revenue code should correspond to the level of care determined during the daily evaluation.
- Levels of care and resulting revenue codes will most likely fluctuate during the infant's stay in the facility.

0170 General

0171 Newborn—Level I - This level reflects routine care of apparently normal full-term or preterm neonates (considered to be newborn nursery).

0172 Newborn—Level II - This level reflects low birth-weight neonates who are not sick but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (considered to be continuing care).

0173 Newborn–Level III - This level reflects sick neonates who do not require intensive care, but require six to 12 hours of nursing each day (considered to be intermediate care).

0174 Newborn—**Level IV** - This level reflects newborns who need constant nursing and continuous cardiopulmonary and other support for severely ill infants (considered to be intensive care).