FEE-FOR-SERVICE PREGNANCY AND NEWBORN CARE BILLING TUTORIAL

LABOUR AND BIRTH FEES

1. DELIVERY FEES AND FP OBSTETRIC DELIVERY INCENTIVES:

DELIVERY FEE	FP OBSTETRIC DELIVERY INCENTIVE FEE
14104 Vaginal Delivery and post-natal hospital care	14004
14105 Management of labour and transfer to an alternate facility for delivery	14005
14108* Post-natal hospital care after elective C-section	14008
14109* Primary Management of Labour and attendance at Emergency C-section	14009

An FP Obstetric Delivery Incentive is billable on any vaginal or cesarean section delivery attended by a family physician, to a maximum of 25 delivery incentives of any combination per physician per calendar year.

All delivery fees include in-hospital postpartum care related to the admission for delivery. If readmission occurs subsequently to manage any complications, all care is billable as a new hospital admission. See 8. Antenatal Admission to hospital below. Post-partum care visits in the clinic are billed separately under 14094 in the 6 weeks postpartum for all types of deliveries, regardless of who attended the delivery.

For multiple births, **04092** (Multiple births, each additional child – natural birth) can also be billed by delivering physician.

2. PROLONGED SECOND STAGE:

The prolonged 2nd stage management fee **14199** is billable any time of day and any day of the week when the 2nd stage exceeds 2 hours. 14199 is billable per ½ hour or major portion thereof after 2 hours. This means if the 2nd stage is at least 2 hours and 16 minutes long, 14199 is applicable.

- This fee must be accompanied by a claim note record stating "2nd stage prolonged" with the times the patient was fully dilated as well as delivered.
- 2nd stage begins with full dilation, whether or not the patient begins to push immediately.
- Start time (fully dilated) and end time (delivery time) must be entered in fee submitted.

3. CONTINUING CARE SURCHARGES FOR PROLONGED 2nd & 3rd STAGES OUT OF OFFICE HOURS:

Call in fees and out of office hours surcharges are also applicable to all forms of delivery except elective c-sections.

Surcharges **01205, 01206, and 01207** are billable when the 2nd & 3rd stages exceed 30 minutes during "out of office hours" (1800 – 0759 weekdays or any time Sat/Sun/Stat).

- Continuing care surcharges are billable per ½ hour or major portion thereof after 30 minutes.
- The fee submission must be accompanied by a claim note record stating "2nd & 3rd stage prolonged", with the times the patient was fully dilated, time of delivery and time of conclusion of 3rd stage.
- Fee submission must include start time (fully dilated) and end time (end of 3rd stage.) Usually, the number of units billable starts at 30 minutes after full dilation.
- The number of units billable will depend on how much of the required 30 minute wait time is covered in this circumstance prior to full dilation. For example, if called in to see the patient and assessed to be at 9 cm but continued attendance is required until fully dilated 45 minutes later, then the timing of the billable units starts with full dilation.

However, if the attending physician has been providing continuous care, either by constant attendance to the laboring patient prior to full dilation (or from seeing a previous patient and then attending directly to the laboring patient), this is considered "Continuing Care from Previous Patient (CCFPP)."

- In this circumstance, the time spent prior to full dilation counts toward the required 30-minute wait time.
- Ensure that the claim note record states "CCFPP and prolonged 2nd and 3rd stage of labour" with times of full dilation, delivery, and end of 3rd stage (placenta delivery).
- Fee submission must include start time (fully dilated) and end time (end of 3rd stage)
- The number units billable starts after the required 30 minute wait time.

4. CALL OUT FEES:

Multiple call backs are not usually paid. MSP will pay only one call out fee on any calendar day.

- Extra visits are considered included in the delivery fee.
- When submitting for an emergency call back, such as abnormal fetal heart tracing/fetal distress, there must be a fulsome claim note record to justify the claim. Use submission code "D" to indicate a duplicate visit.

When called from outside the hospital, bill **00112, 01200, 01201, or 01202,** depending on time and day.

- If no delivery occurs on that calendar day, then an out-of-office visit fee **(13200)** should be billed in addition to the call in fee.
- The exception to this is **00112** which includes the assessment.

When called to assess a patient from another location inside the hospital (e.g. ER or postpartum ward) during out of office hours for a reason other than delivery, the appropriate fee codes are **00113, 00123, or 00105**.

- An additional out-of-office visit fee is not payable with 00113, 00123, or 00105 as these fees include the patient assessment.

5. INDUCTION AND AUGMENTATION OF LABOUR:

Outpatient induction with insertion of Prostaglandin gel or Cervidil is billable as **13200** (out-of-office visit fee). An inpatient induction with insertion of Prostaglandin gel or Cervidil is billable as a **13008** (hospital visit fee).

A call out charge may be billed in addition, if appropriate (e.g. part of call in for SROM.) No call out fee is billable if the induction is pre-booked, and you are called when pt arrives.

- Visit fee submission must include a claim note record stating time of visit and "prostaglandin gel/cervidil inserted."
- If the pt. delivers on same calendar day (with at least 2 hrs between induction and delivery) use submission code "D" (for duplicate) with the delivery fee. Write a claim note record that includes the delivery time and the reason for billing two different services on the same day.

Induction or augmentation of labour with Oxytocin may be billed when attendance by the physician is readily available (i.e. On site but not necessarily in the room all the time.) This is a time-based fee, with the first hour billed under **04118,** and subsequent hours, to a maximum of 10 hours, billed per hour under **04119**.

6. SURGICAL ASSIST AND SURGICAL SURCHARGE FEES:

when assisting at a C-Section and providing intrapartum/postpartum care in hospital, the following fees may be billable**:**

- The FP may bill the relevant delivery and postnatal care fee (**14109/14108**)
- For an elective C/S, a surgical assist fee of **00196** is to be billed.
- For an Emergency C/S, or an elective C/S where there is an additional service (e.g.salpingectomy, complication, 00197 is usually billed. (Check with the obstetrician/surgeon to confirm how much was billed).
- First Surgical Assist of the Day (**13194**) is billable in addition to the surgical assist fee for the first surgical assist on any calendar day, including c-section assists.
- Body Mass Index Surgical Assist Surcharge **(13003)** is payable at 25% of the surgical assist code (00195, 00196 and 00197) when the patient has a BMI greater than or equal to 35. This must be documented in the patient chart.

When a C/S is performed outside of normal weekday hours, the appropriate surgical surcharge is billable in addition to the basic surgical assist fee **(01210, 01211, or 01212.)**

- When called in for an emergency c-section, submit a separate time for the call out and the surgical start time for the surgical assist fee.
- This will avoid rejection of the 00112 weekday daytime call out fee.
- In some circumstances, you may be assisting at a c-section when an OB or midwife is providing the intra-partum/post-partum in-hospital care. In this case, only the surgical assist fee and any applicable surcharges are billable.

7. COMPLICATIONS OF DELIVERIES:

When complications of a vaginal delivery arise and are managed by the delivering FP, then the appropriate fee below may be billed at 50% in addition to the **14104.** This includes:

- **04000** - complicated vaginal delivery (e.g. shoulder dystocia, pre-term <37 weeks or baby <2500g)
- **04022** – repair of 3rd degree tear
- **04023** – repair of extensive vaginal/cervical laceration (e.g. vaginal tear with multiple extensions)
- **04024** – repair of 4th degree tear
- **04026** – manual removal of retained placenta

8. ANTENATAL ADMISSION TO HOSPITAL:

If the patient is admitted to the hospital for antenatal complications, hospital visit fees are billable for care provided by the FP.

- If the FP is MRP, then daily visits **13008** for the first 30 days may be billed.
- If providing supportive care for a patient under the MRP care of an obstetrician, then **13028** is payable daily for the first 10 days and then once weekly.

If the FP providing supportive care must see the patient to manage an unrelated medical condition (e.g. acute asthma), then the MRP fee (13008) may be billed with a different diagnostic code and a claim note record indicating the medical need for this care.

In addition to the **13008** or **13028**, the FP first facility visit of the day fee **13338** is also billable.

9. UNASSIGNED INPATIENT CARE

The term “Unassigned Inpatient” is used in this context to denote those patients who do not have a family physician (or alternate) with admitting privileges to provide the care needed in the acute care facility to which the patient has been admitted.

- If a patient has been under the care of a midwife or FP who provides OB care, but at a different hospital, then she is considered “unassigned”.
- Pregnant patients who have been referred to another family physician/primary care obstetric clinic group for their maternity care and delivery are considered assigned to the FP(s) providing this care.

The FPSC Unassigned In-patient fee **(14088)** is billable in addition to the hospital visit or delivery fee when an unassigned patient is admitted under the MRP care of a Maternity Network participating FP.

- If the MRP care is assumed by an obstetrician (e.g. Emergency C-Section at 28 weeks) and the FP only provides surgical assistance (OB does post-partum/post-op care), then the 14088 is not billable.

10. MISCELLANEOUS FEE:

For unusual circumstances, requiring constant attendance by the FP, such as post-partum hemorrhage, or fetal compromise prior to the beginning of second stage, a **miscellaneous fee 00199** may be billed.

- Calculate the value of the 00199 based on one of the non-operative continuing care surcharges (**01205/01206/01207**) or the Emergency care fees (**00081/00082**) depending on the intensity and complexity of the extraordinary condition managed (e.g. Pre-term admission requiring stabilization and transfer to higher level of care).
- To decrease rejection of this fee, it is recommended to bill this fee with a very detailed claim note record outlining the circumstances requiring physician attendance, including the start and end time.

11. NST INTERPRETATION:

Bill **00790** for interpretation and signs off on NST done unrelated to labor. This fee is not billable for the interpretation of fetal heart rate performed during labor.

Quick reference ICD-9 Codes:

650 Normal delivery	657 Polyhydramnios	641 Antepartum Hemorrhage
645 Prolonged pregnancy	658 PROM	642 P.I.H.
646 Complicated Delivery	662 Prolonged labour	643 Hyper-emesis
651 Multiple Gestation	656 Fetal distress	667 Retained Placenta
652 Malposition/presentation	660 Obstructed labour	664 Perineal Trauma

NEWBORN CARE FEES

1. NEWBORN CARE IN HOSPITAL:

Routine care of the Newborn in hospital is billed under **00119.**

- It is billed once for the full course in hospital, regardless of the number of days spent in hospital or how many FPs may be involved in the care.
- Physicians who share postpartum care duties in hospital must determine who bills between themselves.

Complicated Newborn care in hospital:

- If the newborn experiences **any complications during hospital stay** (e.g. jaundice, excessive weight loss, fever, pre-term gestational age), daily care hospital visit, and bonus fees are billable **(13008 +/- 13338.)**
- If in NICU, daily visits are payable to the FP ***(13008 +/-13888)*** and the consultant specialist (using their appropriate fees.)
- If the newborn is admitted under a pediatrician as the MRP, FP supportive care hospital visit fees are applicable.
- Note: if billing daily or supportive care visits, "Normal Newborn Care" **00119** is not billable in addition.

In addition, an "out of office" complete examination can be billed (**12201**), when the initial examination of the newborn is not routine (e.g. congenital anomalies) and a pediatrician is not in attendance at the time of delivery.

2. CARE OF NEWBORN AT C-SECTION

When a FP is requested by the physician performing the c-section to attend to provide care of the newborn then **00118** is billable if a pediatrician is not in attendance.

Quick reference ICD-9 Codes:

08A Normal Newborn Care	765 Prematurity/low birth weight	769 RDS
763.4 C/S delivery	766 Long gestation/high birth weight	774 Jaundice
763.3 Vacuum	768 Hypoxia	779 Other perinatal problems