

# AvMed OB/GYN Guidelines

These guidelines are for AvMed's Obstetrician's, Gynecologists, Midwives and their staff. They should answer most questions regarding procedures for AvMed members.

## OBSTETRICAL GUIDELINES

As an obstetrician, you become the member's primary care physician for the duration of the pregnancy. As such, members whose plan requires PCP assignment must be assigned to your panel of members. On or about the 1st of each month, you will receive a monthly eligibility listing. You can also obtain a current eligibility list on our web site at [www.avmed.org](http://www.avmed.org). Please check this listing when AvMed members present for services. If a member whose plan requires PCP assignment is not on your panel, please have the member contact Member Services for re-assignment to your panel for the duration of her pregnancy. Fetal non-stress tests and OB ultrasounds performed in the office do not require authorization. **Please notify AvMed if the delivery does not occur in the hospital.**

## OBSTETRICAL REIMBURSEMENT

AvMed's global payment is inclusive of the delivery, antepartum and postpartum care, as well as all hospital and office services provided throughout the member's pregnancy. The initial OB visit will be reimbursed when billed with the appropriate industry standard CPT code. An additional reimbursement will be made when postpartum care is provided 21-56 days following delivery and accompanied with the appropriate postpartum CPT code. The initial OB visit and post partum fee's are deducted from the global delivery fee and is contingent upon care being provided throughout the pregnancy (antepartum, delivery and postpartum). In order to receive your full contract rate for complete OB care, you must bill the initial OB visit and the postpartum visits as indicated above.

Contact Member Services to verify the member's responsibility for co-payment/co-insurance and/or deductible for maternity office visits and delivery.

## NON MATERNITY RELATED

Non-maternity related admissions are reimbursed on a fee for service basis with authorization from AvMed' Pre- Authorization Department. Non-maternity office visits submitted with a non-maternity diagnosis code is also payable fee for service.

## CIRCUMCISIONS

Circumcisions performed in the hospital setting are

reimbursable under the authorization number (obtained from the facility) for the delivery. Circumcisions performed in office are covered up to 12 months after birth and authorization is not required; however contact Member Services for verification of the member benefits.

## TRANSITION OF CARE

In the event care is transferred or terminated during the maternity care period, AvMed will pay antepartum care using industry standard CPT codes. Billing guidelines for antepartum care are as follows:

- 1-3 visits – bill appropriate Evaluation & Management CPT codes (contact Member Services to verify member's co-payment/co-insurance and/or deductible)
- 4-6 visits – bill using CPT code 59425 (contact Member Services to verify member's co- payment/co-insurance and/or deductible)
- 7 or more visits – bill using CPT code 59426 (contact Member Services to verify member's co- payment/co-insurance and/or deductible)

## HIGH-RISK GUIDELINES

AvMed Health Plans will continue to reimburse additionally for pregnancies that are confirmed high risk by the AvMed Medical Department. Once the provider has received authorization approval for the high-risk pregnancy, the provider will only bill for the appropriate global delivery code, vaginal or C-section. When the claim is submitted and processed, the system will reimburse based on the authorization in the system. If two OB/GYN physicians from separate practices are involved in the care of the member during an identified high-risk pregnancy, the additional payment will be divided between the two physicians.

## MIDWIVES ARE NOT ELIGIBLE FOR REIMBURSEMENT OF HIGH-RISK PREGNANCIES.

When submitting an authorization request for a pregnancy that is considered high-risk, please indicate it in the additional information section of the authorization form. "Requesting High Risk Payment". This will flag the Medical Department to review for consideration. Be sure to enter the diagnosis code for High-Risk OB and attach all necessary clinical documentation.

## GENERAL MEDICAL CRITERIA FOR HIGH RISK PREGNANCY

- Multiple Gestation

Continued on other side

- Gestational diabetes or pre-gestational IDDM
- Chronic hypertension on anti-hypertensive medication or PIH prior to 37 weeks
- Intrauterine growth retardation (IUGR) confirmed by ultrasound
- Preterm labor requiring tocolytic agents prior to 37 weeks
- Incompetent cervix
- Uterine Fibroids (symptomatic during pregnancy)
- Overweight when BMI equal to or > 30, Underweight when BMI is equal to or < 19
- Hemoglobinopathies including sickle cell disease, excludes sickle cell trait
- NYHA Class II, III and IV or cardiac history (excludes MVP)
- Chronic Renal Disease
- Lupus
- HIV
- Miscellaneous high-risk patients (refer to Medical Director)

### GYNECOLOGY GUIDELINES

AvMed members may self refer to one annual gynecological (well woman) exam per calendar year. Use industry standard CPT codes with Dx. V72.31 when billing for this service. Reminder, all lab specimens must be sent to the AvMed contracted lab. Authorization is not required when medically necessary care is needed during the annual gynecological exam or follow-up care afterwards. In office gynecological surgeries are subject to verification of the Members Benefit. Gynecological surgeries performed in an Out Patient facility require an authorization. Please do not schedule the surgery until you have received written confirmation the procedure has been authorized.

### FAMILY PLANNING

Family Planning is an AvMed covered benefit. Diaphragm fitting with instructions and insertion of an IUD are payable depending on the Members Benefit; contact Members Services for benefit verification.

Sterilization is a covered service and subject to Members co-payment/co-insurance and/or deductible. Contact Member Services to verify the Members Benefit. If sterilization is planned through tubal ligation, authorization is not required. If sterilization is planned through hysterectomy, authorization is required.

Contraception for birth control is a covered benefit for members with the group RX benefit that includes contraceptives. Please contact Member Services

to confirm whether a member has an RX plan that includes contraceptives.

Depo Provera, when used as a contraceptive, is a covered service if the member has the contraceptive rider on their policy. No authorization is required for this service. When used as a contraceptive, the member will have a co-payment/co-insurance and/or deductible. Depo Provera, as a contraceptive, can be administered two ways:

- You may write a prescription for the drug. The pharmacy would collect the applicable co-payment/co-insurance and/or deductible, when the member picks up the Depo. If the member returns to your office for the injection and you bill for an office visit, please collect applicable co-payment/co-insurance and/or deductible. Any applicable co-payment/co-insurance and/or deductible can be verified with our Member Services department.
- The office can supply the drug and collect the co-payment/co-insurance and/or deductible. If you are billing an office visit in addition to the Depo injection, an office visit co-payment/co-insurance and/or deductible should be collected in addition to the drug co-payment. Any applicable co-payment/co-insurance and/or deductible can be verified with our Member Services department.

If Depo Provera is to be administered for medically necessary reasons other than birth control, no authorization is required. Co-payments/co-insurance and/or deductible are applicable for medically necessary injectable contraceptives.

### TERMINATION OF PREGNANCY

Termination of pregnancy procedures requires authorization. Please contact Member Services for benefit verification.

### INFERTILITY

Infertility diagnosis and treatment, artificial insemination and reversal of sterilization are not a covered benefit for the majority of AvMed members.