Connecticut Medical Assistance Program

PB 2012-48
Policy Transmittal 2012-14
October 2012

Roderick L. Bremby, Commissioner

Effective Date: October 1, 2012
Contact: Nina Holmes @ (860) 424-5486

TO: Physicians, Advanced Practice Registered Nurses (APRN), Certified Nurse Midwives (CNMs)
RE: Physician Fee Schedule – Reimbursement Updates for Obstetrical Delivery Procedures Codes

The purpose of this policy transmittal is to inform providers of a change to the obstetrical (OBS) reimbursement for vaginal and cesarean delivery procedure codes. Effective for dates of service October 1, 2012 and forward the Department has updated the reimbursement for the following procedure codes:

- 59400 - Routine obstetric care including antepartum care, vaginal delivery and postpartum care
- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59410 - including postpartum care
- 59510 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- 59514 - Cesarean delivery only
- 59515 - including postpartum care
- 59610 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59612 – Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59614 - including postpartum care
- 59618 – Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery
- 59620 – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- 59622 –including postpartum care

This change applies to services rendered to all individuals enrolled under the HUSKY A, B, C, D and Charter Oak programs. As a reminder to providers in order for a service to qualify for the OBS reimbursement all of the following criteria must be met:

- The billing provider has a specialty in family practice or obstetrics and gynecology, and has met enrollment requirements.
- The OBS ICD-9 Diagnosis code must be the primary diagnosis code.
- The procedure codes have an OBS rate type on the Physician Fee Schedule.
- The client is a female and the claim indicates a pregnancy-related ICD-9-CM diagnosis code (630-634.92, 640-676.92, V22-V25.9, V26.3, and V28-V28.9).

Accessing the Fee Schedule:
The updated fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download", click "I Accept", and then select the "Physician Surgical" fee schedule. Click on the CSV link. If you are unable to open the file, press the control key while clicking the CSV link, then select "Open".

For questions about billing or if further assistance is needed to access the fee schedule on the Connecticut Medical Assistance Program Web site, please contact the HP Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Posting Instructions: Holders of the Connecticut Medical Assistance Program Provider Manual should replace their existing fee schedule with the new schedule. Policy transmittals can also be downloaded from the Connecticut Medical Assistance Program Web site at www.ctdssmap.com

Distribution: This policy transmittal is being distributed to holders of the Connecticut Medical Assistance Program Provider Manual by HP Enterprise Services.

Responsible Unit: DSS, Medical Care Administration, Medical Policy Section; Nina Holmes, Policy Consultant, (860) 424-5486.

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