Obstetrics: Revenue Codes and Billing Policy for Designated Public Hospitals

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This section contains information to help Designated Public Hospitals (DPHs), i.e., those hospitals reimbursed through certified public expenditures (CPEs) for acute inpatient care, accurately bill for acute inpatient obstetrical (OB) delivery and newborn accommodation services. The charts in this section are designed to help hospitals determine whether to submit a joint or separate claim for a mother and her newborn. In addition, policies outlined in this section should help DPHs bill OB and/or newborn inpatient days for disproportionate share purposes.

Notice: Effective for admissions on or after July 1, 2013, reimbursement for inpatient general acute care hospitals (which do not participate in certified public expenditure reimbursement) is based on a diagnosis-related groups (DRG) reimbursement methodology. Due to DRG, the instructions in this manual section may not pertain to your facility. If your facility is reimbursed according to the DRG model, refer to corresponding DRG instructions in the appropriate Part 2 provider manual.

The revenue codes that a hospital bills are based on a per diem basis for OB.

CPE Per Diem Hospitals

Refer to the *Designated Public Hospital Inpatient Services* section of this manual for a description of CPE per diem hospitals.

OB/Newborn Revenue Chart

The following policies apply to DPHs reimbursed via a CPE per diem.

OB Authorization-Free Days

For information about OB authorization-free days, refer to the *Designated Public Hospital Inpatient Services* section of this manual.

Using the OB/Newborn Revenue Chart

The information below is common when more than one hospital is referenced in the heading. The information is unique when only one hospital is referenced in the heading.

"Procedure code" refers to ICD 10-CM Volume III procedure codes.

Policy for Revenue Codes 112, 122, 132 and 152

Table of Descriptions for Revenue Codes 112, 122, 132 and 152

Revenue Code	Description
112	Room & Board: Private – OB
122	Room & Board: Semi-Private 2 Beds – OB
132	Room & Board: Semi-Private; 3 and 4 Beds – OB
152	Room & Board Ward – OB

- DPHs reimbursed under CPE per diem
  - With Delivery:
    - ❖ Used to bill OB-related room and board services for the mother.
    - ❖ Must be billed with one of the following procedure codes:
      - 0Q820ZZ thru 0Q834ZZ, 0U7C7ZZ, 0W8NXZZ, 10907ZA, 10908ZA, 10900ZC, 10903ZC, 10904ZC, 10907ZC, 10908ZC, 10A00ZZ thru 10A04ZZ, 10D00Z0 thru 10D00Z2, 10D07Z3 thru 10D07Z8, 10E0XZZ, 10S07ZZ, 10S0XZZ, 10T20ZZ thru 10T24ZZ
    - ❖ Must bill revenue code 112, 122, 132 or 152 for the mother and revenue code 171 for the baby on the same claim.
    - ❖ Post-reimbursement review is possible if the delivery occurs beyond the first two hospital days for all days prior to and including the delivery day. Claims require a delivery-related procedure code. Electronically submitted 16-1 claims also must include admit type "3" or "6." *
    - ❖ If delivery occurs within the OB authorization-free period but hospitalization continues, post-reimbursement review is possible for all days beyond the post-delivery, OB authorization-free period. The post-delivery, OB authorization free period is two days for vaginal delivery and four days for cesarean section.
    - ❖ May be used to bill for post-delivery inpatient care of a well-newborn who remains in the hospital during the mother's unused OB authorization-free period after the mother is discharged or expires.

- Without Delivery:
  - ❖ Claims require a procedure code other than a delivery procedure code – if a procedure code is applicable – in the *Principal/Other Procedure* fields (Boxes **74** and **74A**). Electronically submitted 16-1 claims also require an admit type other than "3" or "6".*

Policy for Revenue Codes 119, 129, 139 and 159

Table of Descriptions for Revenue Codes 119, 129, 139 and 159

Revenue Code	Description
119	Room & Board: Private; Other
129	Room & Board: Semi-private – 2 Beds; Other
139	Room & Board: Semi-Private – 3 to 4 Beds
159	Room & Board: Ward

- DPHs reimbursed under CPE per diem
  - Used to bill OB-related room and board services for the mother and newborn when vaginal delivery occurs outside the hospital.
  - The post-delivery, OB authorization-free period is two days beginning at midnight at the end of the day the mother delivers vaginally.
  - Any admission or stay past the two days following vaginal delivery requires a TAR.
  - Any admission or stay past the two days following vaginal delivery is subject to post reimbursement review for medical necessity.
  - The actual time and day of delivery will be established from a combination of the mother's statement, records of auxiliary personnel involved in the care and transport of the mother and the attending physician's assessment.
  - Bill revenue codes 119, 129, 139 or 159 in conjunction with admit type code "4" (newborn) in the *Type of Admission* field (Box 14), admission source code "4" (extramural birth) in the *Source of Admission* field (Box 15) in conjunction with ICD-10-PCS code 10D07Z8 (extraction of products of conception, other via natural or artificial opening).
  - May be used to bill for post-delivery inpatient care of a well-newborn who remains in the hospital during the mother's unused OB authorization-free period after the mother is discharged or expires.

Policy for Revenue Code 170

Revenue code 170 (Description: Nursery, General Classification)

- DPHs reimbursed under CPE per diem
  - Used to bill nursery care for well or sick newborns (other than babies in the NICU) delivered by a mother who is ineligible for Medi-Cal. The ineligible mother either has no other medical insurance coverage **or** has medical coverage that does not provide coverage for the baby. No claims may be submitted to Medi-Cal for services provided to the ineligible mother.
  - Each reimbursed day for the baby is subject to post reimbursement review.
  - Claim for the baby requires a procedure code other than a delivery procedure code – if a procedure code is appropriate – in the Principal/Other Procedure fields (Boxes 74 and 74A). Electronically submitted 16-1 claims also require an admit type other than "3" or "6." *
  - Used to bill for care for the baby when both the baby and the ineligible mother are in the hospital. If the ineligible mother no longer remains in the hospital, but the baby remains in the hospital, providers should bill outstanding hospital days for the baby using revenue code 172, 173 or 174, as appropriate.

Policy for Revenue Code 171

Revenue code 171 (Description: Nursery, Newborn; Level I)

- DPHs reimbursed under CPE per diem
  - If the admission resulted in a delivery, revenue code 171 should be billed with revenue code 112, 122, 132 or 152, as appropriate, and a delivery-related procedure code.
  - Must bill revenue code 171 with appropriate inpatient accommodation code for mother on the same claim.
  - If admission was a result of a delivery outside the hospital, bill code 171 together with 119, 129, 139 or 159 in conjunction with admit type code "4" (newborn) in the *Type of Admission* field (Box 14), admission source code "4" (extramural birth) in the *Source of Admission* field (Box 15) and procedure code 73.99. *
  - Not separately reimbursable. Used for disproportionate share reimbursement adjustments.

Policy for Revenue Code 172

Important: Revenue code 172 has multiple purposes. Providers are cautioned to bill appropriately.

Revenue code 172 (Description: Nursery, Newborn; Level II [sick newborn with associated delivery])

- DPHs reimbursed under CPE per diem
  - With Associated Delivery:
    - ❖ Used to bill care rendered to a sick newborn (non-NICU) during the same hospital admission associated with the delivery.
    - ❖ Must be billed with one of the following procedure codes:
      - 0Q820ZZ thru 0Q834ZZ, 0U7C7ZZ, 0W8NXZZ, 10907ZA, 10908ZA, 10900ZC, 10903ZC, 10904ZC, 10907ZC, 10908ZC, 10A00ZZ thru 10A04ZZ, 10D00Z0 thru 10D00Z2, 10D07Z3 thru 10D07Z8, 10E0XZZ, 10S07ZZ, 10S0XZZ, 10T20ZZ thru 10T24ZZ.
    - ❖ Must be billed separately from services rendered to the mother.
    - ❖ Services are reimbursable beginning with the day of the mother's discharge.
      - Enter date of mother's discharge in the *Remarks* field (Box 80) of the claim.

        Tip #1: Submit the mother's claim first, then the claim for the baby.

Revenue code 172 (Description: Nursery, Newborn; Level II [sick newborn not associated with delivery])

- DPHs reimbursed under CPE per diem
  - Without Associated Delivery:
    - ❖ Used to bill care (non-NICU) rendered to a sick newborn whose hospitalization is not associated with a delivery.
    - ❖ Claim requires other than a delivery procedure code – if a procedure code is appropriate – in the *Principal/Other Procedure* fields (Boxes 74 and 74A). Electronically submitted 16-1 claims also require an admit type other than "3" or "6." *

Revenue code 172 (Description: Nursery, Newborn; Level II [Disproportionate share])

- DPHs reimbursed under CPE per diem
  - Used to bill sick-baby days, other than NICU days, for disproportionate share purposes. This code is not otherwise reimbursable.
  - Must bill revenue code 172 with revenue codes 112, 122, 132 or 152, as appropriate, on the same claim.

    Tip #1: All contract hospitals should bill revenue code 172, when appropriate, for disproportionate share eligibility calculation purposes. Only hospitals qualified for disproportionate share status are eligible to be paid disproportionate share adjustments.

    Tip #2: Revenue code 172 should always be billed on the mother's claim, regardless of the mother's health status.
  - Used to bill for sick newborn days prior to the mother's discharge.

Policy for Revenue Code 173

Revenue code 173 (Description: Nursery, Newborn; Level III)

- DPHs reimbursed under CPE per diem
  - Must be associated with a delivery.
  - Used to bill sick newborn services for the newborn when staffing ratio is 1 staff to 3 or more recipients and the mother is still an inpatient.
  - Must be billed separately from mother's claim.

Policy for Revenue Code 174

Revenue code 174 (Description: Nursery, Newborn; Level IV)

- DPHs reimbursed under CPE per diem
  - Used to bill medically necessary Neonatal Intensive Care (NICU) services for the newborn, whether or not the hospitalization is associated with a delivery.
  - Requires separate TAR approval for newborn commencing with onset of illness and admission to NICU.
  - Must be billed separately from mother's claim.
  - Claims require a procedure code other than a delivery procedure code – if a procedure code is applicable – in the *Principal/Other Procedure* fields (Boxes 74 and 74A). Electronically submitted 16-1 claims also require an admit type other than "3" or "6." *
  - Reimbursable only to hospitals with licensed neonatal intensive care beds.
  - Do not submit a separate claim for the newborn while the mother and newborn are both inpatients unless medically necessary NICU services are rendered.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Refer to *UB-04 Completion: Inpatient Services,* for “admit type” instructions for the *UB-04* claim.