Pregnancy: Fetal Monitoring, Labor and Delivery Services

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This section contains information for billing labor and delivery services, including fetal monitoring and assistant surgeon services

Note: For assistance in completing claims for pregnancy services, refer to the *Pregnancy Examples* section in this manual. ‹‹For information about inpatient delivery services, outpatient providers refer to “OB Admissions” in the *Designated Public Hospital Inpatient Services* section.››

External/Internal Fetal Monitoring During Labor

Fetal heart rate and uterine activity may need to be monitored during labor by either external (indirect) or internal (direct) methods. External Fetal Monitoring (EFM) provides less information but is non-invasive and has wider clinical application. Internal Fetal Monitoring (IFM) requires that the membranes be ruptured, and the cervix be sufficiently dilated to insert an intrauterine catheter and apply a fetal scalp electrode. IFM may be required for monitoring uterine activity while inducing or augmenting labor (for example, when the mother is obese or agitated). It may also be required for monitoring fetal heart rate (for example, fetal bradycardia/tachycardia, beat-to-beat variability).

External Fetal Monitoring

EFM services are considered part of routine labor management. The equipment used is part of the cost of conducting these services; therefore, use of EFM equipment is not separately reimbursable.

Internal Fetal Monitoring

CPT® code 59050 (fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; supervision and interpretation) and 59051 (...interpretation only) are reimbursable only when the following billing requirements are met:

- The IFM is performed by a consultant (not the attending/ delivering physician).
- The facility type must be inpatient hospital code “11” or “12” on the *UB-04* claim form and Place of Service code “21” on the *CMS-1500* claim form.
- This procedure is limited to use during labor within 48 hours before delivery in conjunction with diagnosis codes O00.201 thru O00.219, O35.0XX0 thru O42.92, O61.0 thru O63.9, O75.0 thru O75.3, O76 thru O77.9.
- Codes 59050 and 59051 are reimbursable only once per pregnancy (once in a 180-day period)

- The date of delivery is specified in the Remarks field (Box 80) or *Additional Claim Information* field (Box 19) of the claim

Note: Codes 59050 and 59051 are reimbursable at 100 percent even when billed with modifier 51. Refer to "Surgeries Paid at 100% Even When Performed as a Multiple Surgery" in the *Surgery: Billing with Modifiers* section of this manual.

Use of internal fetal monitoring equipment is not separately reimbursable.

If the consultant is billing for CPT code 59050 or 59051, and the attending physician from the same medical group is not billing for OB services for the same date of service, same recipient, then a separate claim is submitted by the consultant to reflect the IFM services rendered. The applicable diagnosis must be identified in the Box 67 on the *UB-04* claim form and in the *Diagnosis/Nature of Illness or Injury* field (Box 21) on the *CMS-1500* claim form.

If the consultant is billing for CPT code 59050 or 59051 and the attending obstetrician from the same medical group is billing for OB services for the same date of service, same recipient, both physicians must bill their services on the same claim.

- On the *UB-04* claim form, the group provider number is entered in the *NPI* field (Box 56) and the rendering provider numbers of on the *UB-04* claim form and both the consultant and the attending obstetrician must be entered in the *Remarks* field (Box 80) to identify who performed the services.
- On the *CMS-1500* claim form, the group provider number is entered in the billing provider's NPI field (Box 33A). The rendering provider numbers of both the consultant and the attending obstetrician must be entered in *Rendering Provider ID* field (Box 24J) to identify who performed the services.

Note: Medical Services Providers – Refer to *Figure 6* in *Pregnancy Examples: CMS-1500* for a sample claim showing how to bill internal fetal monitoring services.

Physician On-Call for C-Section or Complicated Delivery

To facilitate reimbursement for services billed under CPT code 99360 when performed for either on-call for C-section or complicated delivery, providers only need to indicate the procedure involved (for example, “On call for C-section” or “Complicated Delivery”) and the duration of the standby time in the *Remarks* field (Box 80) or *Additional Claim Information* field (Box 19) of the claim. The medical necessity and the nature of the tasks performed in these cases will be understood.

Assistant Surgeon Services

Medical justification requirements for assistant surgeons performing vaginal and cesarean deliveries are as follows:

Vaginal Delivery

Assistant surgeons billing Medi-Cal for services performed in conjunction with a vaginal delivery (CPT codes 59400, 59409, 59610 or 59612; modifier 80) must include medical justification for the assistant surgeon services. The justification must include the reason an assistant surgeon was required for the delivery and may be written in the *Remarks* field (Box 80) or *Additional Claim Information* field (Box 19) or on an 8½ x 11-inch sheet of paper attached to the claim

Cesarean Section Delivery

Medical justification is not required when billing for assistant surgeon services performed in conjunction with a cesarean section delivery (CPT code 59514 or 59620).

Spontaneous Abortion

When a patient is seen for treatment of spontaneous abortion (diagnosis codes O03.0 thru O03.9), providers must bill using the appropriate CPT code.

‹‹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.