Module 10: Maternity Care

10.1 Prenatal Visits

The usual maximum number of prenatal visits that can be billed for a maternity patient is fee item 14090 x1 and fee item 14091 x 14, per patient, per pregnancy, for routine, uncomplicated prenatal care.

If the patient experiences pregnancy-related complications necessitating additional visits, continue to bill under fee item 14091. Indicate the condition requiring additional visits by using the appropriate diagnostic code and/or providing the information in a note record. Examples of such conditions are:

- diabetes
- post-maturity
- hypertension
- toxaemia
- pre-eclampsia
- previous intra-uterine death
- polyhydramnios
- premature labour
- HELLP Syndrome

When a patient transfers her prenatal care to another physician, the new physician may bill the complete examination (fee item 14090) for the first visit and further visits under fee item 14091. However, the limit of 14 visits for the patient under fee item 14091 still applies. Indicate that the patient's maternity care has been transferred in a note record. (Temporary substitution for vacation should not be considered a patient transfer.)

Patient visits unrelated to the pregnancy have no impact on the limit. These should be billed under the appropriate visit fee (*e.g.*, fee item 00100) using the appropriate diagnostic code, and will not be included in the prenatal limit.

Pre-natal visit - complete examination (fee item 14090)

Fee item 14090 is normally billed only once during a patient's pregnancy.

When a patient transfers her pre-natal care to another physician, the new physician can also bill fee item 14090, but a note record is required that indicates transfer of care. Temporary substitution by other physicians for vacation or other leave of absence should not be considered a patient transfer.

Fee item 14560 (Routine pelvic examination including Papanicolaou [Pap] smear) is considered included in fee item 14090 and cannot be billed in addition to fee item 14090.

Pap test during the pre-natal period:

If a Pap smear is specifically requested by the BC Cancer Agency (BCCA), fee item 14560 may be billed during the pre-natal period. If the specially requested Pap smear (fee item 14560) is done at the same time as a pre-natal visit, the Pap smear should be billed at 50%, in accordance with Preamble B.12.d. A note record is required, indicating that the test was requested by the BCCA.

TIP: For billing information regarding other minor procedures performed during the course of a pre-natal visit, refer to Preamble B.12 of the *MSC Payment Schedule***.**

10.2 Fee Item 14199

Fee item 14199 (management of prolonged second stage of labour, per 30 minutes or major portion therof) is intended to compensate a physician who is in constant attendance with a patient for over two hours during prolonged second stage of labour. When billing this fee item, both a start time and an end time is required on the claim submission. The start time should indicate the time the doctor started continuous attendance with the patient in second stage of labour, and the end time should indicate the time that the doctor was able to leave the patient, or the end time of second stage.

Note: Although time for payment of this listing does not begin until after the first two hours spent with the patient, total time spent must be indicated in the start and finish times. Payment will be made at a rate of 1 x 14199 for each 30 minutes (or major portion) spent with the patient after the first two hours of continuous care.

This fee item is not billable with complicated delivery fees.

Example #1

Doctor attends patient in second stage of labour from 13:00 to end time 16:00.
Third Stage ends at 16:05

Bill 14199 x 2 – start time 1300, end time 1600 (1st two hours – payment included in the delivery fee, last hour bill fee item 14199 for each 30 minutes).

Example #2

Doctor attends patient in second stage of labour from 13:00 to end time 15:10.

No claim should be made under fee item 14199 as time after two hours was less than the major portion of 30 minutes.

10.3 Emergency Visits

00112 Emergency visit (call placed between 0800 hrs. and 1800 hrs.)
Notes:

i) This item to be charged only when one must immediately leave home, office, or hospital to render immediate care. Call to hospital emergency department while at hospital, bill under appropriate on-call hospital visit listings or procedure.
ii) Claim must state time service rendered.

The following are examples of situations explaining when it would and would not be appropriate to bill under fee item 00112:

Example 1:
Physician is called by patient with non-urgent condition. Physician agrees to meet the patient later in the day at the hospital.

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

Example 2:
Physician is called to assess a patient at the hospital. Due to the urgent nature of the patient's condition, the physician must leave his/her office immediately.

Fee item 00112 is applicable, as all the criteria are met.

Example 3:
Physician is visiting patients at the hospital during the daytime. She/he is called to attend a patient in the emergency ward. Due to the urgent nature of the patient's condition, the physician must attend the patient immediately.

Fee item 00112 is not applicable, as the physician remained at the same site.

Example 4:
The physician is called at home regarding a patient. She/he asks the patient to meet him/her at the office later in the day for assessment.

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

10.4 Emergency Visits with Delivery

One emergency visit (such as fee item 00112 or 04005) or the appropriate visit fee plus a call-out charge (for services performed in the evening or on weekends) may be billed in addition to the delivery fee, provided that the criteria for the fee item(s) billed are met.

Expected follow-ups are not normally paid because these services are considered to be included in the fee established for the delivery.

If a serious complication, such as foetal distress, necessitates the physician's immediate attendance, the appropriate visit(s) and/or call-out charge(s) may be billed. Claims for more than one visit or call-out charge (fee items 01200, 01201, 01202) in conjunction with delivery should be supported by details in a note record.

10.5 Complicated Obstetrical Surgery

If a specialist must perform a complicated obstetrical surgery following a vaginal delivery, both the surgery and the delivery (fee item 14104) may be paid in full (100%), with the following exceptions; fee item 04023 and 04026 are paid at 50% with fee item 14104.

The fee items for complicated obstetrical surgery are:

04022	Repair of complete separation of external sphincter (operation only). Not paid in addition to 04024.
04023	Repair of extensive cervical and/or vaginal lacerations (operation only). Not paid in addition to 04022 and 04024.
04024	Repair of 4th degree laceration (operation only).
04026	Manual removal of retained placenta. Paid at 50% with 14104

10.6 Stages of Labour

The first stage is from the onset of true labour to complete dilation of the cervix.

The second stage is from complete dilation (complete cervical dilation is 10cm) of the cervix to the birth of the baby.

The third stage is from the birth of the baby to delivery of the placenta.

10.7 Induction or Stimulation of Labour

For situations involving the induction or stimulation of labour by oxytocin intravenous drip, the limit of 10 hours per pregnancy for fee items 04118 and 04119 applies, regardless of the number of physicians involved.

These fee items apply only when the physician must be in **constant attendance**. Fee item 04118 may be billed more than once per pregnancy if the services are rendered on different days with a break in continuous care. However, no more than a total of 10 hours per pregnancy can be billed.

10.8 Billing Services for Unregistered Newborn

If the newborn has not yet been registered with MSP, services can be billed under the mother's PHN using dependent number 66.

The maximum period during which MSP will cover an unregistered baby under the mother's PHN is the month of birth plus the following two months.

10.9 Billing Tips for Emergency Services Provided with Delivery

- The non-operative continuing care surcharge applies to the actual delivery only, not to standby time or the first stage of labour. State the continuous time spent with the patient during second or third stages of labour only.

The first line of the note record must state SECOND STAGE, THIRD STAGE, or FULLY DILATED to enable the Claims Processing System to process the claim correctly.

- The non-operative continuing care surcharge fees may also be billed in addition to fee item 14199 (management of prolonged second stage of labour, per 30 minutes or major portion thereof) when applicable.

Note that the timing of fee item 14199 begins after the first two hours of continuous care for the second stage of labour, while the timing for fee items 01205 – 01207 begins after the first 30 minutes of continuous care for the second stage of labour, unless CCFPP or if the practitioner was in attendance for more than 30 minutes prior to the onset of second stage.

- Only one emergency visit fee (*e.g.*, 00112) or service charge (01200, 01201, 01202) is routinely payable with delivery. Additional call-backs prior to delivery are not normally paid for routine, expected follow-ups because these services are considered included in the fee established for the delivery.

If there are serious complications that require the physician's attendance (such as foetal distress) the appropriate visit(s) and/or service charge(s) may be billed.

Claims for more than one visit or service charge in conjunction with delivery should be supported by providing details of the circumstances in your note record.

Example 1*:*

Physician is called to attend patient in second stage of labour at 1830 hours. Delivery occurs at 1930 hours, third stage ends at 1935

What to bill:	**Fee Item**	**Start Time**	**End Time**	**Note**
	14104			
	01200	1830		
	01205	1900	1930	second stage

Example 2:
Physician is called to attend patient in second stage of labour at 1830 hours. Delivery occurs at 2300 hours, third stage ends at 2305

What to bill:	**Fee Item**	**Start Time**	**End Time**	**Note**
	14104			
	14199 x 5	1830	2300	
	01200	1830		
	01205 x 8	1900	2305	second stage

Explanation: When the physician is in constant attendance during the second and third stage of labour, the appropriate non-operative continuing care surcharge fee is applicable for each 30-minute period (or major portion thereof) after the initial 30 minutes spent with the patient.

Fee item 14199 is applicable as well, but only after the first two hours. Total time spent with the patient in the second stage of labour must be stated on the claim.

More Billing Tips

- Fee item 14109 is billable to the attending physician who refers a patient to another physician for an emergency C-section.
- Fee item 14109 can be paid to the physician who performs a C-section only in unusual circumstances, as when there is only one physician available and the physician is fully expecting to perform a vaginal delivery.
- Fee item 04107 is meant for supervision of vaginal delivery by a physician other than the physician doing the delivery. This item is not a surcharge to the delivery fee.
- Fee item 04116 may be billed for bleeding within the 6-week post-natal period. Dilation and curettage for delayed bleeding should be billed under fee item 04500.
- Fee item 04410 is billable following surgical procedures only. Although complicated delivery items are now considered "surgical" items, 04410 does not apply to deliveries. A post-partum haemorrhage after delivery (either vaginally or by C-section) that requires curettage is paid under fee item 04116.
- Insertion of prostaglandin gel to assist in dilation of the cervix is billable as a visit fee only.

- Fee item 14104 includes Mitivac delivery, so no extra payment is made for this service.

- Failed mid-forceps deliveries: If an emergency C-section is required immediately after a failed mid-forceps (note record must be provided), the C-section should be billed as fee item 04052 at 100% and the midforceps as fee item 04000 at 50%.

  - Delivery of stillborn may be billed as follows:
  - Delivery at 25 weeks gestation or more is billable under fee item 14104.
  - Delivery between 18 and 25 weeks gestation is billable under fee item 04999 in equity with fee item 04114.
  - Delivery under 18 weeks gestation is billable as fee item 04500 if curettage is performed.

  For more information on billing maternity care fee items:
  Claims Billing Support:
  Vancouver: 604 456-6950
  Toll Free: 1 866 456-6950

10.10 Maternity Care FAQ

Q: What to bill for manual removal of placenta?

A: Bill fee item 04026. Fee item 04026 is paid at 50% with fee item 14104.

Q: How are multiple call backs prior to delivery billed and paid?

A: Call backs prior to delivery are not normally paid more than once for routine/expected follow-ups. We consider this included in the fee established for delivery. However, if serious complications (for example, fetal distress) occur, the nursing staff are unable to handle the situation and the physician is required to attend the patient, additional call-out fees will be paid. Claims under these circumstances must be supported by the specifics of the situation and included in a note record/comment field attached to the claim.

Q: What can be billed in the post natal care period following a vaginal delivery?

A: Fee item 14094, post-natal office visit. Fee item 14094 may be billed once only in the six weeks following vaginal delivery. Postnatal care following Caesarean section should be billed under one of the inclusive fee items (14108 or 14109), as applicable.

Q: Can fee item 00790 (antepartum foetal heart monitoring) be billed during labour?

A: Fee item 00790 is not payable with a prenatal visit, hospital visit, or during the intrapartum (during delivery) care. It is paid if the patient is not in labour.

10.11 Full Service Family Practice Incentive Program – General Practitioner

1. General Practitioner Obstetrical Delivery Bonuses

Eligibility:

The incentive payments are available to all general practitioners in BC who, in addition to being paid the delivery fee items 14104, 14105, 14108, and 14109 for the patient, provide the maternity care and are also responsible, or share responsibility, for providing the patient's general practice medical care.

Locum coverage is considered part of the usual care provided by the host general practitioner. Practice groups providing on-call patient coverage or access to patient records are considered to be sharing the responsibility of that patient's care and are eligible to bill one bonus for the patient.

General practitioners specializing in general practice or obstetrics who receive referrals from other general practitioners for maternity care are considered to share in the general practice medical care of the patient. General practitioners who are paid by service contract, sessional, or salary payments are eligible to receive the obstetrical premium payments.

Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible. Emergency room physicians who happen to be on duty and deliver a baby have not shared the general practice maternity care and are not eligible.

The following GP obstetrical fee items provide a 50 % bonus on the delivery fee items 14104, 14105, 14108, 14109.

G14004 Incentive for Full Service GP – Obstetric Delivery Bonus associated with Vaginal Delivery and Postnatal Care

Notes:

i) Payable to the Family Physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's general practice medical care

ii) Payable only when fee item 14104 billed in conjunction

iii) Maximum of one bonus under fee item G14004, G14008, G14009 per patient delivered

iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.

G14005 Incentive for Full Service GP – Obstetric Delivery Bonus associated with management of labour and transfer to a higher level of care facility for delivery.

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care.
ii) Payable only when fee item 14105 billed in conjunction.
iii) Maximum of one bonus under fee item G14004, G14008, G14009 per patient delivered.
iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.
v) If claimed by a different GP in a different location, G14005 may be paid on the same patient delivered in addition to G14004, G14008 or G14009 paid to the GP attending delivery.

G14008 Incentive for Full Service GP -Obstetrics Delivery Bonus associated with post natal care after an elective c-section

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care.
ii) Payable only when fee item 14108 billed in conjunction
iii) Maximum of one bonus under fee item G14004, G14008, G14009 per patient delivered
iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.

G14009 Incentive for Full Service GP – Obstetric Delivery Bonus related to attendance at Delivery and Postnatal Care associated with Emergency Caesarean Section

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's general practice medical care
ii) Payable only when fee item 14109 billed in conjunction
iii) Maximum of one bonus under fee item G14004, G14008, G14009 per patient delivered
iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.

Note: There is no restriction to the number of bonuses billed per day providing all of the other criteria is met. However, the combined total of all bonuses (G14004, G14005, G14008 and G14009) within a calendar year cannot exceed the maximum of 25.