OBSTETRICS

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, most obstetrical services have the same *specific elements* as other services listed elsewhere in the *Schedule*.

Obstetrical Care includes the following kinds of services:

a. Prenatal visits (major or minor or high risk) and postnatal care in the office are assessments (see General Preamble GP14).

b. Labour-Delivery services have the *specific elements* of *IOP* Surgical Procedures identified with prefix # (see Surgical Preamble SP1).

c. Anaesthetic services have the same *specific elements* as other services provided by an anaesthesiologist (see General Preamble GP58).

d. Postnatal care in hospital/*home* (P007) is the initial assessment of a well patient postpartum with subsequent assessments of the well patient in the hospital or *home* until the patient's first visit to the physician's office. The *specific elements* for each visit are those for assessments (see General Preamble GP14).

e. Attendance at labour is a service of being in constant or periodic attendance on a patient, during stages one and two of labour but without completion of the delivery, to provide all aspects of care. This includes the initial assessment, and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's conditions, intervening except where intervention is a separately billable service. The *specific elements* are those of assessments (see General Preamble GP14) except element H, but include providing premises, equipment, supplies and personnel for any aspects of the *specific elements* of the service that are performed outside the place in which the encounter(s) with the patient occurs.

f. Attendance at delivery, *specific elements* as for Surgical Assistants' Services (see General Preamble GP54).

For all other procedures listed in this section the *specific elements* are those of *IOP* surgical procedures identified with prefix # (see Surgical Preamble SP1) except for removal of Shirodkar suture for which the *specific elements* are those for surgical *IOP* procedures not identified with prefix #.

Fee schedule codes listed below which do not include providing all premises, equipment and personnel used to perform the *specific elements* of the service are identified with prefix #.

OBSTETRICS

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. A prenatal major assessment includes a full history, and an examination of all parts or systems (and *may include* a detailed examination of one or more parts or systems), an appropriate record and advice to the patient. All other prenatal visits include the necessary history, examination, appropriate record and advice to the patient. All prenatal visits (major and minor and high risk) include pregnancy-related counselling as a form of providing advice to the patient or the *patient's representative*.

A prenatal general assessment is payable after another general assessment only if the reason for the first assessment does not pertain to the establishment of the antenatal care.

Normal (uncomplicated) prenatal care includes a prenatal general assessment visit, then monthly visits to 28 weeks, followed by visits every 2nd *week* to 36 weeks, then weekly visits until delivery. However, complicated pregnancies may require additional visits. Labour, delivery and postpartum care are listed separately.

2. If an uncomplicated obstetrical patient is transferred from one physician to another physician for obstetrical care, the appropriate assessment benefit may be claimed by the second physician, followed by prenatal visits. This statement does not apply to physicians substituting for each other or when the second physician sees the patient for the first time in labour. If the obstetrical patient is referred to a consultant for obstetrical care because of the complexity, obscurity or seriousness of the case, the consultant may claim a consultation in addition to the prenatal visits.

3. Illnesses resulting from or associated with pregnancy or false labour requiring added *home* or hospital visits, shall be claimed on a per visit basis.

4. When a pregnant patient visits her physician for a condition unrelated to her pregnancy and apart from her routine scheduled prenatal visits, the physician may claim the appropriate assessment.

5. Fee schedule codes in this section are subject to the provisions of the Surgical Preamble where applicable.

6. An assessment is payable for illness resulting from, or associated with, pregnancy or false labour even if the patient progresses to delivery within the next two days. This does not apply to patients who are assessed in the first stage of labour and admitted, or are transferred, to the delivery room from the antenatal floor in labour.

7. The listings under the heading Referred Services may be claimed by the consultant physician in addition to the appropriate consultation or visit fee. They may not be claimed by physicians providing obstetrical care to their own patients.

8. If a consultant is requested by another physician to perform a surgical induction of labour, or emergency removal of a Shirodkar suture (except at delivery) assuming someone else has inserted the suture, the consultant should claim a consultation fee for this(these) service(s).

9. Medical induction or stimulation of labour may be claimed once per pregnancy by any one physician and only when carried out for a recognized obstetrical complication(s). The fee listed is applicable regardless of the time spent by the physician, therefore, detention may not be claimed.

10. The listings for "Attendance at labour and delivery" and for "Attendance of obstetric consultant(s) at delivery" may not be claimed by any physician when a patient is transferred to a second physician for normal obstetrical care.

11. Ordinary immediate care of the *newborn* is included in the labour-delivery fee and when the service is rendered by the anaesthetist, it is included in the anaesthetic benefit. A life threatening emergency situation requiring active resuscitation of the *newborn* provided by any physician may be claimed under codes G521, G522, G523. When indicated, endotracheal intubation and tracheo-bronchial toilet should be billed under G211 and not as G521, G522, G523.

12. When an obstetrician routinely transfers all *newborn*s to another physician, the latter may not claim a consultation for these transferals. If the baby is well, the physician should claim *newborn* care in hospital plus attendance at maternal delivery (H007/H267) if this service is provided. If the baby is sick, the physician may claim a general assessment and attendance at maternal delivery (H007/H267) if this service is provided plus daily visits for as long as his/her services are required.

13. If an obstetrician who normally cares for *newborn*s him/herself or transfers the care of newborns to a family physician, refers a *newborn* to a paediatrician because of the complexity, obscurity or seriousness of the case, the latter may claim for this service according to the following guidelines:

a. If attendance at maternal delivery is provided, C263 may be claimed in addition to H267 if a general assessment of the baby is carried out. A postnatal consultation of the baby, (C265) may not be claimed in addition to attendance at maternal delivery (H267).

b. If attendance at maternal delivery (H267) is not provided, a postnatal consultation (C265) may be claimed, if rendered, whether or not a prenatal consultation has already been claimed.

PREAMBLE

14. Physicians may claim for assisted breech delivery (P020) when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and head.

15. See General Preamble GP65 for After Hours Premiums.

16. If claims are being submitted in coded form, the obstetrician should add the suffix “A” to the listed procedural code, the assistant should add the suffix “B” to the listed procedural code, and the anaesthetist should add the suffix “C” to the listed procedural code.

OBSTETRICS

PRENATAL CARE

		Asst	Surg	Anae
P003	General assessment (major prenatal visit)		77.20	

Antenatal preventative health assessment

The service rendered by the *most responsible physician* for conducting the initial review of antenatal risk. The review must examine all current psychosocial, genetic and medical issues affecting antenatal risk and must be documented in writing in the patient's permanent medical record. Maximum once per pregnancy. P005 rendered same patient same *day* same physician as any other consultation or visit except P003 and P004 is an insured service payable at nil.

P005	Antenatal preventative health assessment		45.15	
P004	Minor prenatal assessment		33.70	

High risk prenatal assessment

A high risk prenatal assessment is an assessment by a maternal-fetal medicine *specialist* requiring a minimum of 20 minutes in direct contact with the patient for the management of a documented significant maternal and/or fetal risk factor(s) where the mother and/or fetus are at significant risk for serious complications during the pregnancy.

P002	High risk prenatal assessment		74.70	

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Medical management of early pregnancy - initial service

Medical management of early pregnancy - initial service when a physician renders an initial assessment and administration of cytotoxic medication(s) for the termination of early pregnancy or missed abortion. The cost of the drug(s) is not included in the fee for the service.

A920	Medical management of early pregnancy - initial service		161.15	

Payment rules:
Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are *not eligible for payment* when rendered the same *day* to the same patient by the same physician as A920.

Medical management of ectopic pregnancy – initial service

Medical Management of ectopic pregnancy – initial service when a physician renders an initial assessment and administration of cytotoxic medication(s) for the termination of an ectopic pregnancy. The cost of the drug(s) is not included in the fee for the service.

A922	Medical management of ectopic pregnancy - initial service		207.80	

Payment rules:
Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are *not eligible for payment* when rendered the same *day* to the same patient by the same physician as A922.

[Commentary:
As with all insured services, A920 and A922 must be provided in accordance with professional standards - such as those published by the Society of Obstetricians and Gynaecologists of Canada.]

PRENATAL CARE

Asst	Surg	Anae

Medical management of early or ectopic pregnancy - follow-up visit

Medical management of early or ectopic pregnancy - follow-up visit is for a visit that is a follow-up of A920 or A922, whether rendered by the same physician who rendered the A920 or A922 service or by another physician.

A921 Medical management of early or ectopic pregnancy - follow-up visit 33.70

Payment rules:

1. Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are *not eligible for payment* when rendered the same *day* to the same patient by the same physician as A921.

2. A921 is limited to two per patient per pregnancy. Services in excess of this limit will be adjusted to another assessment fee.

P001 Medical management of non-viable fetus or intra-uterine fetal demise between 14 and 20 weeks gestation 399.00

Payment rules:

1. P001 is *only eligible for payment* if the length of gestation is confirmed by ultrasound.

2. Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service, including cervical ripening and oxytocin infusion if rendered) are *not eligible for payment* when rendered the same *day* to the same patient by the same physician as P001.

3. Z774 is eligible for payment in addition to P001 if uterine curettage is required for postpartum hemorrhage due to retained products.

[Commentary:

P001 is only payable for the active medical management of the patient. It is not payable when the fetus delivers spontaneously prior to initiating intervention.]

LABOUR - DELIVERY

			Asst	Surg	Anae
#	P006	Vaginal		498.70	
#	P020	Operative delivery, i.e. mid-cavity extraction or assisted breech delivery		535.60	6
#	E502	- vaginal birth after caesarean section (VBAC) whether successful or unsuccessful ... add		51.00	

[Commentary:
P006 and P020 include the repair of a tear or episiotomy extension, first or second degree, when rendered.]

#	P018	Caesarean section	6	579.80	7
#	P041	Caesarean section including tubal interruption	6	609.20	7
#	P042	Caesarean section including hysterectomy	8	837.25	8
#	E500	- for the third and each subsequent delivery, subject to the payment rules set out below, for each additional delivery, to P006, P018, P020, P041 or P042 ... add		148.60	
#	E499	- for the second caesarian delivery, subject to the payment rules set out below, to P018, P041 or P042 ... add		397.75	

Payment rules:

1. For vaginal deliveries of two or more *infant*s, P006 or P020 as appropriate is eligible for payment for the first delivery, in addition to 85% of P006 or P020 as appropriate for the second delivery, and E500 for the third and each subsequent delivery.
2. For vaginal delivery of the first *infant* followed by caesarean section, one of P018, P041 or P042 as appropriate is eligible for payment, in addition to 85% of P006 or P020 as appropriate, and E500 for the third and each subsequent delivery.
3. For multiple deliveries by caesarean section only (*with or without* trial of labour), one of P018, P041 or P042 as appropriate is eligible for payment, in addition to E499 for the second delivery and E500 for the third and each subsequent delivery.
4. Despite payment rules above, for spontaneous vaginal deliveries between 20 and 23 weeks gestational age, only P006 is eligible for payment, regardless of the number of fetuses delivered.
5. Despite payment rules above, for multiple deliveries by caesarean section only between 20 and 23 weeks gestational age, only one of P018, P041 or P042 as appropriate is eligible for payment, in addition to E499 for the second delivery. E500 is *not eligible for payment* for the third or subsequent deliveries.
6. For delivery of one or more fetuses known to be stillborn in addition to delivery of one or more live fetuses, only the delivery of live fetuses is eligible for payment in accordance with the payment rules above. If all fetuses are known to be stillborn, only one of P006, P018, P020, P041 or P042 as appropriate, is eligible for payment.

Attendance at labour

P038	- when patient transferred to another centre for delivery	211.20

Attendance at labour and delivery

Payable to a physician other than an obstetric consultant for attending labour and delivery when the physician either assists at vaginal delivery or surgery, gives anaesthetic at a caesarean section or operative delivery, or resuscitates the *newborn.*

P009	Attendance at labour and delivery	498.70

Note:
Anaesthesia or Assistant units are *not eligible for payment* when the same physician claims P009 on the same patient.

[Commentary:
See Obstetrics Preamble p. K1, paragragh "e" for the services included in attendance at labour. P009 or P038 is not payable if any of these component services of attendance at labour are not rendered.]

P010	Attendance of obstetric consultant(s) at delivery	211.20

Note:
Amount payable for attendance of a physician other than an obstetric consultant at only delivery is nil.

Special visit for first obstetrical delivery with sacrifice of office hours

Payable in addition to first obstetric delivery in calendar *day*. Maximum of one per physician per calendar *day*. See General Preamble GP44 for definition of special visit.

C989	- special visit for first obstetrical delivery with sacrifice of office hours ... add	76.40

Sole delivery premium

Payable in addition to labour and delivery fees P006A, P009A, E414, P018A, P020A, P038A or P041A if sole delivery in calendar *day*, to maximum of 25 sole delivery premiums per physician per *fiscal year*.

E411	- sole delivery premium ... add	100%

OBSTETRICS

LABOUR - DELIVERY

			Asst	Surg	Anae

High risk obstetrical premium

Payable in addition to labour and delivery procedures when at least one of the following conditions are present: fetal prematurity (<32 weeks gestational age), severe pregnancy induced hypertension, intrauterine growth retardation (IUGR) less than 10th percentile, or significant placental insufficiency as demonstrated by absent umbilical vessel flow or reverse systolic/diastolic (S/D) ratio.

#	E414	High risk obstetrical premium	add	62.05	
#	P045	Repair of third degree tear or episiotomy extension, must include repair of perianal sphincter and perineum		82.15	6
#	P046	Repair of fourth degree tear or episiotomy extension, must include repair of rectal mucosa, perianal sphincter and perineum		200.00	6

Note:

1. Repair of a tear or episiotomy extension that does not extend into the perianal sphincter (third degree) is included in the labour and delivery fee (P006 and P020) and does not constitute P045 or P046.

2. Repair of the superficial transverse perineal muscle constitutes a repair of a second degree tear or episiotomy extension and does not constitute P045 or P046.

Claims submission instructions:

Claims for P046 submitted by a provider with a specialty other than Obstetrics and Gynecology (20) must be submitted for manual review.

#	Z774	Postpartum haemorrhage - exploration of vagina and cervix, uterine curettage		93.80	6
	P007	Postnatal care in hospital and/or home		55.15	
	P008	Postnatal care in office		33.70	

REFERRED SERVICES - WHEN ONLY SERVICES(S) RENDERED

Repair of laceration

#	P036	- vaginal		54.40	6
#	P039	- cervical		54.40	6
#	P029	Manual removal of retained placenta.....		54.40	6

OBSTETRICS

OBSTETRICAL ANAESTHESIA

			Asst	Surg	Anae
#	P013	Obstetrical anaesthesia		-	6
		Continuous conduction anaesthesia - see General Preamble GP60			
#	P014C	- introduction of catheter for labour analgesia including first dose		-	6
#	E111A	Combined spinal-epidural for labour analgesia, to P014C ... add		50.00	
#	P016C	- maintenance of obstetrical epidural anaesthesia (one unit for each ½ hour to a maximum of 12)		-	
#	E100C	attendance at delivery - per ¼ hour - time units only		-	

Payment rules:

1. Anaesthesia extra units listed on GP61 are *not eligible for payment* with P014C except for E010C, E022C and E017C.

2. G222, Z804 or Z805 are *not eligible for payment* with P014C or P016C.

3. Anaesthesia extra units listed on GP61 are *not eligible for payment* with P016C or E100C.

[Commentary:
Anaesthesia extra units listed on GP61 and G222 are eligible for payment with other C-suffix anaesthesia service rendered the same *day* as P014C/P016C/E100C, unless otherwise listed.]

OBSTETRICS

HIGH RISK PREGNANCIES

			Asst	Surg	Anae
#	Z776	Fetal blood sampling		40.80	
#	Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis or cordocentesis)		165.40	
#	Z734	Double set up examination to rule out placenta previa, or trial of forceps - failed leading to caesarean section (same physician)		58.00	
#	P030	Cervical ripening using topical, oral or mechanical agents, maximum once per pregnancy. Payable in conjunction with P023		58.60	

Note:
Cervical ripening rendered to same patient same *day* by same physician as a consultation or visit is an insured service payable at nil.

#	P023	Oxytocin infusion for induction or augmentation of labour		67.75	

Note:
See Obstetrics preamble #9.

Non stress test

Payable only for high risk pregnancies - must include interpretation of trace, discussion with patient and providing a written report to be retained in the patient's permanent medical record and *may include* application of the fetal monitor and data acquisition. Maximum one per patient per *day*.

#	P025	Non stress test		9.65	
#	Z721	Pharmacological suppression of premature labour by I.V. therapy to be claimed once per physician after 3 hours of supervision in same institution		67.75	
#	Z775	Pharmacological management of P.I.H. and toxemia by I.V therapy to be billed once per patient, per pregnancy		67.75	
#	Z778	Amniocentesis - diagnostic or genetic		102.00	
#	Z779	Chorionic villus sampling		153.00	
#	P031	Prophylactic cervical cerclage - any technique	6	145.10	6
#	P032	Emergency cervical cerclage when the external os is open to 2 cm or more and the membranes visible or prolapsed, any technique	6	250.00	6

[Commentary:
If the criteria for cervical cerclage listed under the definition of P032 are not met, submit claims using P031.]

	UVC	Elective removal of Shirodkar suture		visit.fee	
#	P034	Uterine inversion, manual replacements		125.75	6
#	Z777	Breech presentation - external cephalic version *with or without* tocolysis - to be claimed in hospital after 35 weeks, once per pregnancy		60.35	

Note:
Listings for ectopic pregnancy, hysterotomy, abortion and postpartum tubal interruption are listed under the Female Genital System - Corpus Uteri.

MATERNAL - FETAL PROCEDURES

		Asst	Surg	Anae
# P050	Therapeutic amnio-reduction	6	248.85	6
# P051	Percutaneous fetal blood transfusion - into fetal hepatic vein	8	348.40	8
# P052	Percutaneous fetal blood sample - from umbilical cord or fetal hepatic vein	6	199.10	6
# P060	Percutaneous amnioinfusion	6	248.85	6
	Fetal management			
# P053	- selective fetal reduction of one or more fetuses by bipolar or unipolar cautery of umbilical cord	6	248.85	6
# P054	- selective fetal reduction of one or more fetuses by intracardiac potassium chloride injection	6	248.85	6
	Insertion of fetal shunt			
# P055	- bladder to amniotic cavity	8	398.10	8
# P056	- chest to amniotic cavity	8	398.10	8
# P057	Fine needle fetal body cavity aspiration from fetal abdomen, chest, heart, bladder and/or renal tract	6	199.10	6
# P058	In-utero ligation of umbilical cord vessels	8	464.45	8
# P059	In-utero placental vessel ablation by YAG laser	8	464.45	8

Note:
Procedures listed under Maternal - Fetal Procedures are payable in addition to J149 Ultrasonic Guidance and/or Z552 Diagnostic Laparoscopy, where applicable.