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) and postnatal care in the office are assessments (see General Preamble GP15).

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 GP15).

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 GP15) 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 #.

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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) include pregnancy-related counselling as a form of providing advice to the patient or the patient's representative(s).

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.

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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 newborns 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 newborns 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.

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 GP64 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.

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PRENATAL CARE

		Asst	Surg	Anae
P003	General assessment (major prenatal visit).		61.00	

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		41.65	
P004	Minor prenatal assessment		31.95	

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.		137.20	

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. . . .		176.90	

Payment rule:
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.]

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		31.95	

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.

OBSTETRICS

LABOUR - DELIVERY

		Asst	Surg	Anae
# P006	Vaginal		445.75	
# P020	Operative delivery, i.e. mid-cavity extraction or assisted breech delivery		477.15	6
# E502	- vaginal birth after caesarean section (VBAC) whether successful or unsuccessful . . . add		51.00	
# P018	Caesarean section	6	514.85	7
# P041	Caesarean section including tubal interruption	6	539.95	7
# P042	Caesarean section including hysterectomy	8	734.35	8
# E500	- multiple births, any method of delivery - each child . . add		145.10	

Note:
If one child is born vaginally and the other(s) by caesarean section, claim P018, P041 or P042 plus one at 85% of P006 or P020, then E500 for third and subsequent births.

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 445.75

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

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 GP47 for definition of special visit.

C989 - special visit for first obstetrical delivery with sacrifice of office hours . . . . . add 36.30

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%

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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	
# P028	Repair of tear or extension of episiotomy to include rectal mucosa, perianal sphincter and perineum		82.15	6
# 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		31.95	
	REFERRED SERVICES - WHEN ONLY SERVICE(S) RENDERED			
	Repair of laceration			
# P036	- vaginal		54.40	6
# P039	- cervical		54.40	6
# P029	Manual removal of retained placenta.		54.40	6

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OBSTETRICAL ANAESTHESIA

		Asst	Surg	Anae
# P013	Obstetrical anaesthesia		-	6
	Continuous conduction anaesthesia - see General Preamble GP60			
# P014	(a) introduction of catheter for analgesia including first dose		-	6
# P015	(b) maintenance and/or supervision (one unit for each ½ hour to a maximum of 6 units)		-	
# P016	(c) maintenance of obstetrical epidural anaesthesia (one unit for each ½ hour to a maximum of 12)		-	
# E100C	(d) attendance at delivery - per ¼ hour - time units		-	

Note:
When P015 and P016 are claimed same patient same hospital same day, the amount payable for P015 is nil.

G224	Pudendal, brachial plexus block (bilateral) - (see General Preamble GP62)		15.55	

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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.

OBSTETRICS

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.

OBSTETRICS

NOT ALLOCATED