Ohio Administrative Code

Rule 5160-21-04 Reproductive health services: pregnancy-related services.

Effective: July 1, 2021

(A) Coverage.

(1) Unless a different time period is specified, services described in this rule are covered through the pregnancy and the delivery.

(2) Basic pregnancy-related services include but are not limited to antepartum care, delivery, outpatient postpartum care, and family planning services.

(a) Antepartum care. Payment for a visit may be made for either of two purposes:

(i) Basic care (including the taking and subsequent updating of a medical history, physical examination, the recording of vital signs, and routine chemical urinalysis) provided monthly up to twenty-eight weeks' gestation, biweekly thereafter up to thirty-six weeks' gestation, and weekly thereafter until delivery; or

(ii) Initial establishment of a relationship with a pediatrician or other primary care provider who will subsequently furnish early and continuous well-child and primary care for the newborn and will discuss care of the infant with the individual and, as appropriate, the individual's family.

(b) Delivery. Payment may be made for admission to a facility (hospital or freestanding birth center), the taking of a medical history during admission, physical examinations, the management of labor (intrapartum management), and either vaginal delivery (with or without episiotomy and with or without forceps) or delivery by cesarean section.

(i) Separate payment may be made for intrapartum management and for delivery performed as distinct procedures by different providers who are not part of the same practice.

(ii) Additional payment may be made for multiple-birth delivery.

(iii) Additional payment may be made for evaluation and management (E&M) services or medical services rendered for the diagnosis and treatment of medical conditions that complicate labor and delivery management.

(iv) No additional payment will be made for complex delivery nor for additional professional services (e.g., assistance by a second practitioner during delivery).

(c) Outpatient postpartum care. Payment may be made for hospital and office visits involving routine, uncomplicated follow-up care rendered during the postpartum period specified in rule 5160:1-2-16 of the Administrative Code. Postpartum care rendered prior to discharge from the facility is considered incidental to the delivery.

(d) Family planning services. Policies governing payment for these services are set forth in rules 5160-21-02 and 5160-21-02.2 of the Administrative Code.

(3) Payment may be made for one report of a pregnancy that is diagnosed in conjunction with an E&M service not associated with a normal obstetrics/gynecology visit, submitted on either form ODM 10257, "Report of Pregnancy (ROP)" (7/2021), or its web-based equivalent. This payment is separate from the payment for the E&M service (or the encounter or visit of which the E&M service is part).

(4) A pregnancy risk assessment may be used to screen an individual for medical and social factors that may place that individual at risk for preterm birth or other poor pregnancy outcome and to substantiate the individual's need for enhanced pregnancy-related services and other support services. Payment may be made for one such assessment, performed at the initial antepartum visit by a practitioner of obstetric services and submitted on either form ODM 10207, "Pregnancy Risk Assessment" (rev. 7/2021), or its web-based equivalent.

(a) If an individual is determined to be at risk and the practitioner obtains the individual's informed consent, then the practitioner sends to the entity responsible for managing the individual's pregnancy-related care a report with recommendations, in the form and format specified by the entity.

(b) If the individual needs additional support services during the course of pregnancy, then (with the individual's informed consent) the practitioner may relay that information to the entity responsible for managing the individual's pregnancy-related care.

(5) Enhanced pregnancy-related services promote general health, improve the quality of life, and produce better outcomes for a pregnant individual or a fetus during pregnancy or the postpartum period. Such services include but are not limited to the following services:

(a) High-risk patient monitoring (the additional monitoring of an individual who has been determined to be at risk for a preterm birth) performed by a healthcare professional qualified to identify the signs of preterm labor, which has three components:

(i) Counseling and education to assist the individual in identifying and reducing the risk of preterm labor;

(ii) Regular contact with the individual, either in person or by telecommunication, to identify signs of preterm labor; and

(iii) Ready access to the provider in the event the individual begins to show signs of preterm labor;

(b) Group antepartum high-risk pregnancy education (the face-to-face presentation by a medical professional to a group of no more than twelve participants excluding partners, spouses, or coaches) in a session that may consist of one or more classes and cover any of five subject areas related to at-risk pregnancy:

(i) Childbirth preparation (e.g., Lamaze);

(ii) Childbirth refresher;

(iii) Nutrition;

(iv) Parenting; and

(v) Infant safety;

(c) Individual counseling and education, given during an antepartum visit, that entails a face-to-face encounter of at least fifteen minutes in which the primary focus is the specific needs of the individual;

(d) Medical nutrition therapy;

(e) Family planning-related services; and

(f) Tobacco cessation counseling and treatment.

(B) Claim payment.

(1) Payment for covered antepartum care provided in a federally qualified health center (FQHC) or rural health clinic (RHC) is determined in accordance with Chapter 5160-28 of the Administrative Code.

(2) The maximum payment amount for a covered evaluation and management service reported as antepartum care provided in a setting other than an FQHC or RHC is the lesser of the following two figures:

(a) The provider's submitted charge; or

(b) The product of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code and any applicable place-of-service multiplier.

(3) The maximum payment amount for covered delivery is the lesser of the following two figures:

(a) The provider's submitted charge; or

(b) The product of the amount specified in appendix DD to rule 5160-1-60 of the Administrative

Code, any applicable place-of-service multiplier, and the relevant percentage from the following list:

(i) For a single delivery or the first delivery of a multiple birth, one hundred per cent;

(ii) For the second delivery of a multiple birth, fifty per cent;

(iii) For the third delivery of a multiple birth, twenty-five per cent; or

(iv) For each additional delivery of a multiple birth, zero.

(4) Payment for a report of pregnancy or a pregnancy risk assessment is the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code.

(5) Payment of all other claims is made in accordance with the applicable rule of the Administrative Code.