Global Maternity Care

Policy Reimb-029

Origination Date: 06/01/2021

Reviewed/Revised Date: 06/07/2021

Next Review Date: 06/07/2022

Current Effective Date: 08/14/2021

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.

Description:

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services.

Policy Statement and Criteria

1. Commercial Plans

U of U Health Plans covers antepartum care, delivery services and postpartum care consistent with the AMA-CPT and the American Congress of Obstetricians and Gynecologist (ACOG) guidelines.

U of U Health Plans considers the following services as included in the global OB package when the member has been with the Plan for at least 6 months - CPT codes 59400, 59510, 59610 and 59618.

<u>The global OB package includes the following:</u>

A. All routine prenatal visits until delivery (approximately 13 for uncomplicated cases);

B. Initial and subsequent history and physical exams;

C. Recording of weight, blood pressures and fetal heart tones;

D. Routine chemical urinalysis (CPT codes 81000 and 81002);

E. Admission to the hospital including history and physical;

F. Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery;

G. Management of uncomplicated labor;

H. Vaginal or cesarean section delivery (limited to single gestation; for further information, see Multiple Gestation);

I. Delivery of placenta;

J. Administration/induction of intravenous oxytocin;

K. Insertion of cervical dilator on same date as delivery;

L. Repair of first-or second-degree lacerations;

M. Simple removal of cerclage (not under anesthesia);

N. Uncomplicated inpatient visits following delivery;

O. Routine outpatient E/M services provided within 6 weeks of delivery;

P. Postpartum care only;

Q. Educational services e.g. breastfeeding, lactation, and basic newborn care.

U of U Health Plans excludes the following services from the global OB package for CPT codes 59400, 59510, 59610 and 59618 (Excluded services may be reported separately):

A. Insertion of cervical dilator more than 24 hours before delivery;

B. E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services. For further information please refer to the Non-Obstetric Care section of the policy;

C. Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier -25 to identify these visits as separately identifiable from routine antepartum visits. For further information, please refer to High Risk/Complications section of this policy;

D. Inpatient E/M services provided more than 24 hours before delivery;

E. Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).

U of U Health Plans does not reimburse insertion of cervical dilator separately when billed on the same date of delivery.

U of U Health Plans separately reimburses for E/M services associated with high risk and/or complications when modifier -25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global OB CPT codes of 59400, 59510, 59610 or 59618. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made.

Per ACOG coding guidelines, if a patient sees an obstetrician for extra visits to monitor a potential problem and no problem actually develops, the physician is not to report the additional visits; only E/M visits related to a current complication can be reported separately.

U of U Health plans covers services from a Maternal-Fetal Medicine Specialist outside the routine global OB package.

A. If the maternal-fetal medicine specialist has the same federal tax identification number as the OB/GYN physician, the specialist should report the E/M services with modifier -25 to indicate significant and separately identifiable E/M services;
B. If the maternal-fetal medicine specialist is in a different group practice than the physician(s) and other health care professionals supplying the routine antepartum care, modifier -25 is not necessary.

U of U Health Plans follows ACOG coding guidelines and considers an E/M service on the same date of service, by the Same Individual Physician or Other Health Care Professional to be separately reimbursed in addition to an OB ultrasound procedure (CPT codes 76801-76817 and 76820-76828); if the E/M service is a separate and distinct service and is submitted with the appropriate modifier.

U of U Health Plans considers the review and interpretation (modifier -26) of a radiology service, e.g., OB ultrasound, to be included in the E/M service when performed by the Same Individual Physician or Other Health Care Professional on the same date of service for the same patient. These services with a -26 modifier are not distinct from the E/M service when both are provided on the same day. Modifier -25 appended to the E/M code has no impact as to whether the interpretation of the OB ultrasound is considered a separately reimbursable service.

U of U Health Plans covers duplicate OB services consistent with coding rules established by AMA-CPT. This reimbursement rule applies to the following CPT codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, and 59622 billed by the same or different physician on the same or different date of service. CPT codes for global OB care fall into one of three categories:

A. Single component codes (for example, delivery only);

B. Two component codes (for example, delivery including postpartum care);

C. Three-component, or complete, global codes (including antepartum care, delivery, and postpartum care).

U of U Health Plans will consider Itemization of Obstetrical Services in the following circumstances:

A. A patient transfers into or out of a physician or group practice;

B. A patient is referred to another physician during her pregnancy;

C. A patient has the delivery performed by another physician or other health care professional not associated with her physician or group practice;

D. A patient terminates or miscarries her pregnancy;

E. A patient changes insurers during her pregnancy.

Global OB codes are utilized when the Same Group Physician and/or Other Health Care Professional provides all components of the OB package. However, physicians from different group practices may provide individual components of maternity care to a patient throughout a pregnancy. Although OB Related E/M Services should be billed as a global package, sometimes itemization of OB Related E/M Services may occur.

U of U Health Plans covers codes 59425 (Antepartum care only; 4-6 visits) and 59426 (Antepartum care only; 7 or more visits) in situations such as termination of a pregnancy, relocation of a patient or change to another physician, when supporting documentation is provided on a case by case basis.

In these situations, all the routine antepartum care (usually 13 visits) or global OB care may not be provided by the Same Group Physician and/or Other Health Care Professional. The antepartum care only CPT codes 59425 or 59426 should be reported by the Same Group Physician and/or Other Health Care Professional when:

A. The antepartum care provided does not meet the routine antepartum care definition of the global OB package as defined by CPT; or

B. The antepartum care provided is less than the typical number of visits (usually 13) during the global OB package as defined by ACOG.

If the patient is treated for antepartum services only, the physician and/or other health care professional should use CPT code 59426 if 7 or more visits are provided, CPT code 59425 if 4-6 visits are provided, or itemize each E/M visit if only providing 1-3 visits.

Antepartum care only codes 59425 and 59426 should be reported as described below:

A. A single claim submission of CPT code 59425 or 59426 for the antepartum care only, excluding the confirmatory visit that may be reported and separately reimbursed when the antepartum record has not been initiated; and

B. The units reported should be one; and

C. The dates reported should be the range of time covered. For example, if the patient had a total of 4-6 antepartum visits then the physician and/or other health care professional should report CPT code 59425 with the "from and to" dates for which the services occurred.

In the event that all the antepartum care was provided by the same physician and/or other health care professional, but only a portion of the antepartum care was covered by U of U Health Plans, then the number of visits reported and the "from and to" dates must be adjusted to reflect when the patient became eligible under U of U Health Plans coverage.

U of U Health Plans covers Delivery Services only when specific circumstances are met.

Delivery Services include all of the following:

A. Admission to the hospital;

B. The admission history and physical examination;

C. Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician;

D. Intravenous (IV) induction of labor via oxytocin;

E. Delivery of the placenta; any method;

F. Repair of first or second-degree lacerations.

Circumstances in which Delivery Only Services will be covered must include:

A. Only CPT codes 59409, 59514, 59612, and 59620 are billed; and

B. The delivery only codes are reported by the Same Group Physician and/or Other Health Care Professional for a single gestation when:

    i. The same single physician or group practice is not billing for the total OB package; and

ii. Itemization of services is provided; and

iii. Only the delivery component of the maternity care is billed and the postpartum care is performed and billed by another physician or group of physicians.

U of U Health Plans will provide coverage of third and fourth degree lacerations when the following guidelines are met (All must be present):

A. Global OB (59400, 59610) or delivery only (59409, 59410, 59612 and 59614) codes; and

B. Codes are appended using modifier -59; and

C. Medical Record Documentation supporting the use of the modifier is provided.

U of U Health Plans covers CPT 59430, postpartum care only (separate procedure) for the services in the six weeks following the date of the cesarean or vaginal delivery.

The following services <u>are included in postpartum care and are not separately reimbursable</u> services:

A. Uncomplicated outpatient visits related to the pregnancy; and

B. Discussion of contraception.

The following services <u>are not included in postpartum care and are separately reimbursable</u> services, when reported subsequent to CPT code 59430:

A. Evaluation and management of problems or complications related to the pregnancy.

The postpartum care only code should be reported by the Same Group Physician and/or Other Health Care Professional that provides the patient with services of postpartum care only. If a physician provides any component of antepartum along with postpartum care, but does not perform the delivery, then the services should be itemized by using the appropriate antepartum care code and postpartum care only code.

U of U Health Plans cover 59410, 59515 and 59622 (delivery with postpartum care) when specific criteria met.

<u>Criteria for Coverage (A-C):</u>

A. The delivery and postpartum care services are the only services provided; and

B. The delivery and postpartum care services are provided in addition to a limited amount of antepartum care (e.g., CPT code 59425); and

C. Billing is coming from a group physician and/or other health care professional for a single gestation.

The following services are included in delivery only including postpartum care code and are not separately reimbursable services:

A. Hospital visits related to the delivery during the delivery confinement;

B. Uncomplicated outpatient visits related to the pregnancy;

C. Discussion of contraception.

U of U Health Plans' Medical Claim Review Department reviews claim submissions for multiple gestation deliveries.

U of U Health Plans covers reimbursement for twin deliveries, whether vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries when billed in the following manner:

Billing Standards for Twin Billing

Vaginal	Baby A	59400
	Baby B	59409-59
VBAC*	Baby A	59610
	Baby B	59612-59
Cesarean Delivery	Baby A & Baby B	59510
Repeat Cesarean Delivery	Baby A & Baby B	59618
Vaginal and Cesarean Delivery	Baby B	59510
	Baby A	59409-51
VBAC and repeat Cesarean Delivery	Baby B	59618
	Baby A	59612-59

**VBAC-Vaginal Birth after Cesarean*

If there is increased physician work involvement for delivery of the second baby, modifier -22 is added to the global cesarean code (CPT codes 59510 or 59618). Claims submitted with modifier -22 must include medical record documentation which supports the use of the modifier.

U of U Health Plans will only cover assistant surgeon's charges when billed with a non-global cesarean section delivery code (CPT codes 59514 or 59620) and submitted with an appropriate assistant surgeon modifier.

U of U Health Plans considers Home delivery services subject to this policy in the same manner as services performed by physicians and other health care professionals who deliver in the hospital setting.

2. **Medicaid Plans**
   Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

3. **Medicare Plans**
   Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicare policies and coverage, please visit their search website at: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

Applicable Coding

CPT Codes

12041	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12042	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits

59430 Postpartum care only (separate procedure)

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59514 Cesarean delivery only;

59515 Cesarean delivery only; including postpartum care

59525 Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);

59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;

59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

81002 ; non-automated, without microscopy

HCPCS Codes

Not applicable

References:

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.
2. Centers for Disease Control and Prevention, International Classification of Diseases, 10thRevision, Clinical Modification
3. Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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