Commercial Reimbursement Policy

Subject: **Maternity Services – Professional**	
Policy Number: **C-19004**	Policy Section: **Surgery**
Last Approval Date: **07/18/2024**	Effective Date: **09/08/2022**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for global obstetrical codes once per period of a pregnancy when appropriately billed by a single provider or provider group reporting under the

same federal Tax Identification Number (TIN) unless provider, state, or federal contracts and/or requirements indicate otherwise.

Reimbursement is based on all aspects of the global obstetric care package (antepartum, delivery and postpartum) being provided by the provider or provider group reporting under the same TIN. If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery and postpartum services, the global obstetrical codes may not be used. Providers are to submit for reimbursement only the elements of the obstetric package that were provided.

The Health Plan will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

Global Services
If Global, Delivery Only, Delivery/Postpartum, Antepartum Only or Postpartum Only services have been paid for the same pregnancy, a claim for Global services may be denied or may cause a previously paid claim for overlapping services to be recouped.

Delivery Only
If Global, Delivery Only, or Delivery/Postpartum services have been paid for the same pregnancy, a claim for Delivery Only services may be denied.
Delivery Only services will be separately reimbursed to assistant surgeons only for cesarean deliveries if appended with the appropriate modifier.

Delivery/Postpartum
If Global, Delivery Only, Delivery/Postpartum or Postpartum Only services have been paid during the same pregnancy, a claim for Delivery/Postpartum services may be denied or may cause a previously paid claim for overlapping services to be recouped.

Antepartum Only
If Global or Antepartum Only services have been paid during the same pregnancy, a claim for Antepartum Only services may be denied.

Postpartum Only
Postpartum Only claims may be denied if Global, Delivery/Postpartum, or Postpartum Only services have already been paid during the same pregnancy.

Included in the Global Package

The following elements of the global package are not separately reimbursable when any CPT code for global services is billed:

- Initial and subsequent history and physical exams when pregnancy diagnosis has already been established.
- All routine prenatal visits until delivery (typically monthly through 28 weeks, then biweekly until 36 weeks and weekly until delivery) – usually 13 visits.
- Additional visits for a high-risk pregnancy, potential problems, or history of problems that do not actually develop or are inactive in the current pregnancy.
- Collection of weight, blood pressure and fetal heart tones.
- Routine urinalysis.
- Admission to the hospital including history and physical.
- Inpatient Evaluation and Management (E/M) services that occur within 24 hours of delivery.
- Management of uncomplicated labor (including administration of labor inducing agents).
- Insertion of cervical dilators on the same date of the delivery.
- Simple removal of cerclage.
- Vaginal (including forceps or vacuum assisted delivery) or cesarean delivery of single gestation.
- Delivery of placenta.
- Repair of first or second-degree lacerations.
- Uncomplicated inpatient visits following delivery.
- Routine outpatient E/M services within 6 weeks of delivery.
- Discussion of contraception.
- Postpartum care only.
- Education on breastfeeding, lactation, exercise, or nutrition.
- Augmentation of labor, amniotomy, and vacuum extraction are not eligible for separate reimbursement (these services are included in the global reimbursement for labor and delivery).

Not Included in the Global Package

The following services may be billed separately from the global obstetrical package:

- Initial E/M visit to diagnose pregnancy when the activities in the antepartum record are not initiated.
- Laboratory testing (excluding routine urinalysis).
- Additional antepartum E/M visits (in excess of 13) for a high-risk complication that is active in the current pregnancy. These additional visits are to be submitted for payment

only at the time of delivery. These visits must be submitted with Modifier 25 and an appropriate high-risk diagnosis.
- Additional E/M visits for conditions unrelated to pregnancy. These visits may be reported as they occur and must clearly not be related to pregnancy.
- Maternal or fetal echocardiography procedures.
- Amniocentesis.
- Chorionic villus sampling.
- Fetal contraction stress testing and nonstress testing.
- Biophysical profile.
- Amnioinfusion.
- Insertion of cervical dilator that occurs more than 24 hours before delivery.
- Inpatient E/M encounters that occur more than 24 hours before delivery.
- Management of surgical problems arising during pregnancy.
- Care provided by maternal fetal medicine specialists.
- Ultrasound.
- External cephalic version.

Antepartum/Postpartum Care
Providers should use the appropriate E/M codes for antepartum and postpartum care. We reserve the right to request medical documentation to perform post-pay review of paid claims.

Related Coding

Code	Description	Comments
59430	Postpartum care only (separate procedure)	90-day postpartum period applies.

Exemptions

Georgia	Anthem Blue Cross and Blue Shield allows reimbursement for the maternity global package or antepartum care only visits to include maternity ultrasounds and two non-stress tests unless such service is related to a problem-oriented diagnosis. Maternity non-stress tests more than two per pregnancy per patient are not eligible for separate reimbursement unless such service is related to a problem-oriented diagnosis.
Kentucky	Anthem Blue Cross and Blue Shield allows reimbursement for the maternity global package or antepartum care only visits to include

	maternity ultrasounds unless such service is related to a problem-oriented diagnosis.
Ohio	Anthem Blue Cross and Blue Shield does not allow separate reimbursement for Maternity ultrasounds more than two per pregnancy/fetus per patient unless such service is related to a problem-oriented diagnosis.

Policy History

07/18/2024	Review approved: no changes
09/08/2022	Review approved: updated Definition and Reference section; updated language to Georgia exemption; removed reference to Maternity Ultrasound in the Outpatient Setting Medical Policy
07/19/2019	New policy (C-19004) Maternity Services developed to replace (C-08005) Routine Obstetrics approved and effective 12/01/2019; postpartum care period for CPT code 59430 (postpartum care only) changed from 45 days to 90 days; initial approval for (C-08005) Routine Obstetrics policy 04/18/2008 and approved for retirement 07/19/2019; effective 01/01/2021 for Georgia, Kentucky, and Ohio

References and Research Materials

This policy has been developed through consideration of the following:

- AMA CPT 2024 - Professional Edition
- CMS
- Optum EncoderPro 2024
- The American College of Obstetrics and Gynecologists

Definitions

Global Obstetric Care Package	The total obstetrical package (e.g., CPT codes 59400 and 59510) include antepartum care, the delivery, and postpartum care.
General Reimbursement Policy Definitions	

Related Policies and Materials

Modifiers 59 and XE, XP, XS and XU: Distinct Procedural Services - Professional
Global Surgical Package - Professional
Modifier 22 - Professional

Use of Reimbursement Policy
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.