Commercial Reimbursement Policy

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

Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross (Anthem) 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. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and nonparticipating professionals and facilities as indicated.

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

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

Anthem's reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, State, Federal or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

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, federal, or CMS 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, global obstetrical codes may not be used and 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 a 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.

Policy History

09/08/2022	Biennial review approved: updated Definition and Reference sections; removed reference to Maternity Ultrasound in the Outpatient Setting Medical Policy
07/19/2019	• Initial policy approval. Effective 01/01/2021. New policy (C-19004) Maternity Services developed to replace (C-08005) Routine Obstetrics; Postpartum care period for CPT code 59430 (postpartum care only) changed from 45 days to 90 days. • Initial committee approval for (C-08005) Routine Obstetrics policy 04/18/2008 and approved for retirement 01/01/2021.

References and Research Materials

- Centers for Medicare and Medicaid Services (CMS)
- American Medical Associations Current Procedural Terminology (CPT) 2022
- Optum EncoderPro 2022
- The American College of Obstetrics and Gynecologists

Definitions

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

Related Policies and Materials

Distinct Procedural Services- Modifiers 59 and XE, XP, XS XU
Global Surgical Package
Modifier 22 (Increased Procedural Services)

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.