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Originated Department	Medical Management

Global Maternity Care

Audience
Medical Management, Claims

Purpose
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

Definition
<p>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. It also indicates what services are and are not separately reimbursable to other maternity services.</p>

Policy/Procedure
<ol style="list-style-type: none"> 1. Mountain Health Co-Op Health Plans covers antepartum care, delivery services, and postpartum care consistent with the AMA-CPT and the American Congress of Obstetricians and Gynecologists (ACOG) guidelines.

These rules apply only when Mountain Health Co-Op Health Plans is the primary insurance.

2. Mountain Health Co-Op Health Plans considers the following services included in the global OB package when the member has been with the Plan for **at least six (6) months: CPT codes 59400, 59510, 59610, and 59618.**

The global OB package includes the following:

- a. All routine prenatal visits until delivery (approximately 13 uncomplicated cases);
- b. Initial and subsequent history and physical exams;
- c. Recording of weight, blood pressure, 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 the 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 six (6) weeks of delivery;
- p. Postpartum care only;
- q. Educational services, e.g., breastfeeding, lactation, and basic newborn care.

3. Mountain Health Co-Op 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 managing 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 more than 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 the 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).

4. Mountain Health Co-Op Health Plans **DOES NOT COVER** reimbursement of the insertion of cervical dilator separately when billed on the same delivery date.
5. Mountain Health Co-Op Health Plans separately reimburses for E/M services associated with high-risk and/or complications when **modifier -25 is appended** to indicate they are significant and separate from routine antepartum care and the claim is submitted with an appropriate high-risk or complicated diagnosis code.
6. Due to the high risk or complications of pregnancy, a patient may be seen more than the typical 13 antepartum visits. These visits are not considered routine and can be reported in addition to the global OB CPT codes **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 an appropriate assessment for the number of antepartum visits can be made.
7. *Per ACOG coding guidelines, if a patient sees an obstetrician for extra visits to monitor a potential problem and no problem develops, the physician should not report the additional visits; only E/M visits related to a current complication can be reported separately.*
8. Mountain Health Co-Op Health plans cover 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.
9. Mountain Health Co-Op Health Plans follows ACOG coding guidelines and considers an E/M service performed on the same date by the same individual physician or Other Healthcare 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 separate and distinct and is submitted with the appropriate modifier.
10. Mountain Health Co-Op 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
11. Mountain Health Co-Op 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)

12. Mountain Health Co-Op 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.

13. Global OB codes are utilized when the same group physician and/or Other Healthcare 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.

14. Mountain Health Co-Op 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.

Suppose the patient is treated for antepartum services only. In that case, 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 4-6 antepartum visits, the physician and/or other health care professional should report CPT code **59425** with the "from and to" dates for which the services occurred.

If all the antepartum care was provided by the same physician and/or other health care professional, but only a portion of it was covered by Mountain Health, then the number of visits reported and the "from and to" dates must be adjusted to reflect when the patient became eligible under Mountain Health Co-Op coverage.

15. Mountain Health Co-Op 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:
 1. The same single physician or group practice is not billing for the total OB package, **and**
 2. Itemization of services is provided; **and**
 3. 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.

16. Mountain Health Co-Op 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.

17. Mountain Health Co-Op 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 **are included in postpartum care and are NOT separately reimbursable** services:

- a. Uncomplicated outpatient visits related to the pregnancy; **and**
- b. Discussion of contraception.

The following services **are not included in postpartum care and ARE separately reimbursable** services when reported with CPT code **59430**:

- a. Evaluation and management of problems or complications related to pregnancy.

The postpartum care-only code should be reported by the same group physician and/or Other Healthcare Professional who only provides the patient with postpartum care. Suppose a physician provides any component of antepartum care and postpartum care but does not perform the delivery. In that case, the services should be itemized using the appropriate antepartum and postpartum care-only codes.

- 18. Mountain Health Co-Op Health Plans cover **59410, 59515, and 59622** (delivery with postpartum care) when specific criteria are met.

Criteria for Coverage (A-C):

- 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 comes from a group physician and/or other health care professional for a single gestation.

The following services **are included in delivery only, including the postpartum care code, and are NOT separately reimbursable** services:

- a. Hospital visits related to the delivery during the delivery confinement **and**
- b. Uncomplicated outpatient visits related to the pregnancy **and**
- c. Discussion of contraception.

- 19. Mountain Health Co-Op Health Plans’ Medical Claim Review Department reviews claim submissions for multiple gestation deliveries.

- 20. Mountain Health Co-Op 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:

Service	Infant	CPT Code
Vaginal	Baby A	59400
	Baby B	59409-59
Vaginal Birth after Cesarean (VABC)	Baby A	59610
	Baby B	59612-59
Cesarean Delivery	Baby A and Baby B	59510
Repeat Cesarean Delivery	Baby A and 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

If there is increased physician work involvement for the 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 supporting the modifier's use.

21. Mountain Health Co-Op Health Plans will only cover the assistant surgeon's charges when billed with a nonglobal cesarean section delivery code (CPT codes **59514** or **59620**) and submitted with an appropriate assistant surgeon modifier.

22. Mountain Health Co-Op Health Plans considers home delivery services subject to this policy in the same manner as services performed by physicians and other healthcare professionals who deliver in the hospital setting without exception.

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	
<i>Not Applicable</i>	

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, 10th Revision, Clinical Modification
3.	Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)

Vendors	
•	Health Plan Services (HPS)

Review/Revision/Approval History	
Date	Description
06/01/2024	New Policy

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Disclaimer

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The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding 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 they apply to an individual member.

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