LifeWise
Health Plan of Washington

Payment Policy

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Title	**Maternity Services**		
Number	**CP.PP.375.v2.3**		
Last Approval Date	05/14/24	**Original Effective Date**	11/04/11
Replaces	N/A		
Cross Reference	• *Multiple Births* • *Modifier 22 – Increased Procedural Services* • *Modifier TH - Obstetrical Treatment/Services* • *Unlisted, Non-Specific and Miscellaneous Procedure Codes*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define maternity services and related components, such as antepartum care, labor and delivery, and postpartum care provided in uncomplicated maternity cases that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Policy	Maternity services/care includes antepartum/prenatal services, labor and delivery services and post-partum care. The services billed by a provider represent those that were actually rendered by the provider, whether all of maternity care or any part of maternity care. Services rendered must be within the scope of practice of the provider's license. **<u>Confirmatory Visit</u>** If a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and presents to **confirm pregnancy**, this visit may be separately reported with the appropriate level E/M services code and a diagnosis of confirmation of pregnancy (i.e., International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes Z32.00 through Z32.02). If the obstetric/maternity case record is **initiated at this same visit,** or if the pregnancy has been confirmed by another provider, then the visit would not be reported as a confirmatory visit as it would be considered part of the global OB package and is not billed separately. If only a portion of the antepartum care is rendered (less than 4 visits), then this visit would be billed as an office visit with modifier TH – Obstetrical treatment/services. Once the pregnancy has been confirmed, the start of the maternity care begins. **<u>Global Obstetrical Package – 59400, 59510, 59610, 59618</u>** Global obstetrical care includes antepartum care, labor and delivery, and postpartum care. The global obstetric package is reported using the **date of delivery** as the date of

service **after all the services are rendered** by a provider from a solo practice or multiple providers within the same group practice.

Only **one submission** of global obstetrical care or delivery will be allowed per pregnancy.

NOTE: Reimbursement will be provided for either the global obstetrical care codes or the individual component obstetric codes **but not for both**, regardless of the provider of service.

Services included in global obstetric package

- Initial and subsequent histories
- Physical examinations
- Recording of weight, blood pressures, fetal heart tones
- Routine chemical/dipstick urinalysis
- Monthly visits up to 28 weeks gestation, biweekly visits 29 to 36 weeks gestation, weekly visits from 36 weeks until delivery (both in-office and home visits)
- Hospital & observation care/visits the day before/day of delivery and post delivery
- Evaluation & management (E&M) services within 24 hours following the delivery
- Admission to hospital/labor and delivery
- Admit history & physical
- Management of uncomplicated labor
- Placement of internal fetal and/or uterine monitors; fetal monitoring
- Catheterization or catheter insertion
- Perineum preparation
- Injection of local anesthesia
- Labor/induction of labor/artificial rupture of membranes
- Preoperative counseling for cesarean delivery, preparation of abdomen, and abdominal incision
- Delivery of fetus (vaginal or cesarean) (with/without forceps or vacuum extraction
- Delivery of placenta any method
- Insertion of cervical dilator day of delivery
- Simple removal of cerclage (not under anesthesia)
- Episiotomy and/or repair of first- and second-degree lacerations
- Removal of sutures/staples; care of any incisional issues/infections
- Administration of intravenous oxytocin
- Inpatient post-delivery recovery room E&M services/hospital visit immediately after delivery
- Uncomplicated inpatient hospital post-partum visits
- Uncomplicated outpatient post-partum visits (office visits and/or home visits) up to 6 weeks
- Discussion of contraception
- Uterine repair, wound closure
- Hemostasis pack or agent
- Recovery room visit(s)

Global obstetric services do not include repair of third- or fourth-degree laceration at the time of delivery which can be billed separately.

Antepartum care, labor and delivery and post-partum care codes **are not** reported separately unless the mother changes or obtains new insurance, changes or transfers to a new provider during the pregnancy or miscarries or aborts the fetus. When these circumstances are encountered, the actual maternity services rendered may be billed separately by the following codes:

- Antepartum care only – 59425, 59426
- Delivery only – 59409, 59514, 59612, 59620
- Delivery and Postpartum care – 59410, 59515, 59614, 59622
- Postpartum care only - 59430

Antepartum Care Only – 59425, 59426

Antepartum care codes should be billed when the provider of service renders either a portion of the antepartum care (code 59425), or all the antepartum care (code 59426) but **not** the entire global obstetrical care package.

Only **one submission** of antepartum care will be allowed per provider per pregnancy, reported using the last date of service and one unit.

Services included in antepartum care

- Initial and subsequent history and physical examinations
- Recording of weight, blood pressures, fetal heart tones,
- Routine chemical/dipstick urinalysis.
- Monthly visits up to 28 weeks gestation, biweekly visits 29 to 36 weeks gestation, weekly visits from 36 weeks until delivery (both in-office and home visits)

If a pregnancy results in an unexpected event that necessitates an unexpected termination of the pregnancy, bill for the antepartum care visits that were rendered prior to the termination of the pregnancy either with an antepartum care-only code or an appropriate E&M office visit code(s).

Delivery-Only Care – 59409, 59514, 59612, 59620

Delivery-only care should be billed when **only** the delivery component of maternity care is provided. Delivery-only codes are reported using the **date of delivery** as the date of service after all delivery services have been rendered by a solo practitioner or multiple providers within the same group practice. Delivery-only codes **do not include any outpatient postpartum visit/care.**

Only **one submission of** delivery-care will be allowed per pregnancy unless there are multiple births. See "Multiple Births" Payment Policy for details.

Delivery-only care services includes

- Admission to the hospital/labor and delivery
- Admit history and physical
- Hospital and observation care visits prior to delivery and post-delivery
- Management of uncomplicated labor

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- Placement of internal fetal and/or uterine monitors; fetal monitoring
- Insertion of cervical dilator day of delivery
- Simple removal of cerclage (not under anesthesia)
- Catheterization or catheter insertion
- Preoperative counseling for cesarean delivery, preparation of abdomen, and abdominal incision
- Perineum preparation
- Delivery of fetus (vaginally or cesarean) (with/without forceps or vacuum extraction)
- Delivery of the placenta/fetal membranes, any method
- Episiotomy and or repair of first- and second-degree lacerations
- Injection of local anesthesia
- Induction of labor/artificial rupture of membranes
- Inpatient post-delivery E&M services/hospital visits immediately after delivery
- Administration of intravenous oxytocin
- Uterine exploration, repair, or wound closure
- Hemostasis pack or agent
- Recovery room visit(s)

Delivery-only services do **not** include repair of third- or fourth-degree laceration at the time of delivery which can be billed separately.

Delivery Including Postpartum Care – 59410, 59515, 59614, 59622

Delivery including postpartum care services includes the labor and delivery and **all** postpartum care for **both inpatient and outpatient postpartum services**. These codes must be billed only when labor and delivery and all postpartum care is provided by a provider from a solo practice or multiple providers within the same group practice. Delivery and postpartum care services include all services listed in the "Delivery-Only Care" and "Postpartum Care-Only" sections in this policy.

Delivery including post-partum codes are reported using the **date of delivery** as the date of service after all services have been rendered by a solo practitioner or multiple providers within the same group practice.

Postpartum care includes **both inpatient and outpatient visits** by the delivery provider or providers within the same group practice 6-8 weeks post-delivery. If outpatient postpartum care 6-8 weeks post-delivery is **NOT** also rendered by the delivering provider or providers within the same group practice as the delivering provider, then the Delivery-Only procedure codes must be billed.

These codes **do NOT include ANY** antepartum care.

Only **one submission** of Delivery including postpartum care will be allowed per pregnancy.

Postpartum Care Only – 59430

Postpartum care codes must be billed when the provider of service renders the office/home or outpatient visits following delivery (vaginal or cesarean section) but **did not** render the entire global obstetrical care package or **did not** perform the delivery.

Only **one submission** of postpartum care only will be allowed per pregnancy, reported using the last date of service and one unit.

Postpartum care services include

- Postpartum visits, including uncomplicated outpatient visits related to the pregnancy up to eight weeks postpartum (both in-office and home visits)
- Discussion of contraception
- Removal of sutures, if applicable

Unlisted Maternity Care and Delivery – 59899

Unlisted procedures for maternity care and delivery **must include a description of services performed to be considered for payment.** Services such as admission and history exam, artificial rupture of membranes, and treatment of hemorrhage are included in delivery care services. Services such as facility fees, supplies and cord blood collection should be billed utilizing the appropriate separate CPT or HCPCS code.

Labor management will only be considered for reimbursement if the following criteria are met:

- A transfer of the mother to a different provider occurs for the actual delivery of the newborn; supporting documentation must be submitted along with the claim
- Procedure code 59899 is billed with the following information:
    - One unit of service
    - Code description indicates "labor management" and
    - Name of delivering provider is included in the code description

Only **one submission** of labor management service, as represented by code 59899, will be allowed per pregnancy/delivery. Documentation must describe what specific services are represented by the unlisted code and be made available upon request.

Maternity Complication Services and High-Risk Pregnancies

Medical complications of pregnancy and problems complicating labor and delivery management may require additional resources.

In the event that medical complications that necessitate additional antepartum or postpartum visits develop, additional visits for the complications can be billed **if linked via the claim line diagnosis pointer to an appropriate medical diagnosis code unrelated to the pregnancy** that identifies the medical complication(s). Documentation in the member's chart or medical record must support and detail the need for additional antepartum or postpartum visits.

In the event that maternity complications develop as part of the delivery that necessitate additional work **greater than typically required** to perform the delivery, whether vaginal or caesarean section, Modifier 22 - *Increased Procedural Services* **may be appended to the delivery code** (e.g., global maternity code, delivery only code or delivery and postpartum procedure codes). A diagnosis which reflects the related

	maternity complication or increased delivery services **must be included** in the claim to support the need for Modifier 22. Medical records, chart notes or operative report(s) **must document the need** for the additional services that are due to a maternity complication in order for the maternity claim to be processed correctly and support the potential increased reimbursement. The documentation should contain clear, concise statements indicating the substantial extra work rendered and the specific complication(s) encountered during the pregnancy to support the appending of Modifier 22 to the delivery code. Upon receipt of the records, the records will be reviewed to determine if additional reimbursement is appropriate. Some examples of maternity complications where Modifier 22 may be appended to the **delivery code**, when supported by the documentation, include, but are not limited to, the following: • Gestational diabetes affecting delivery • Placenta previa/placenta accreta • Maternal sepsis • Maternal severe hypertension/preeclampsia of pregnancy, including Hemolysis Elevated Liver Enzymes and Low Platelets (HELLP) syndrome • Cesarean-section delivery of twins/multiples when billed by a global cesarean maternity code • Delivery of a single fetus which required **substantial additional work** and **delivery-only code** was submitted When the pregnancy complication exceeds the scope of licensure of the provider, the mother must be referred/transferred to an appropriate provider who can address the specific complication(s). Such a transfer of care may result in additional antepartum or postpartum services being rendered by the receiving provider. If the referring/transferring provider rendered less than the total global obstetrical care, the provider should submit the appropriate maternity code(s) for the specific obstetrical care rendered such as antepartum care-only or postpartum care-only. **E&M Services** E&M services should not be billed for ***routine*** **antepartum visits** unless the provider has rendered **only** one, two or three antepartum visits. To indicate that three or fewer antepartum visits were rendered, append modifier *TH - Obstetric treatment/services* to the office visit code. High risk conditions or non-obstetric related E&M services should be billed consistent with American Medical Association (AMA) and American College of Obstetrics and Gynecology (ACOG) coding guidelines.
Codes/Coding Guidelines	**Global Obstetrical Package:** • **59400** – Routine obstetric care including antepartum care, vaginal delivery (with/without episiotomy, and/or forceps) and postpartum care • **59510** – Routine obstetric care including antepartum care, cesarean delivery and postpartum care

	• **59610** – Routine obstetric care including antepartum care, vaginal delivery (with/without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery • **59618** - Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery **Antepartum Care only:** • **59425** – Antepartum care only; 4-6 visits • **59426** – Antepartum care only; 7 or more visits **Delivery Only Care:** • **59409** – Vaginal delivery only (with/without episiotomy and/or forceps) • **59514** – Cesarean delivery only • **59612** – Vaginal delivery only, after previous cesarean delivery (with/without episiotomy and/or forceps) • **59620** – Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery **Delivery including Postpartum Care:** • **59410** - Vaginal delivery only (with/without episiotomy and/or forceps); including postpartum care • **59515** - Cesarean delivery only; including postpartum care • **59614** - Vaginal delivery only, after previous cesarean delivery (with/without episiotomy and/or forceps); including postpartum care • **59622** - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care **Postpartum Care only:** • **59430** – Postpartum care only (separate procedure) **Unlisted Maternity Care and Delivery:** • **59899** – Unlisted procedure, maternity care and delivery (specify) **Confirmatory Visit Diagnosis codes:** • **Z32.00** – Encounter for pregnancy test; result unknown • **Z32.01** – Encounter for pregnancy test; result positive • **Z32.02** – Encounter for pregnancy test; result negative
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	Alaska providers are exempt from appending modifier TH to indicate that only three or fewer antepartum visits were rendered.

Laws, Regulations & Standards	None
References:	• American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • American College of Obstetrics and Gynecology (ACOG) papers • OB/GYN Coding Manual: Components of Correct Procedural Coding, ACOG

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	05/14/24; 09/06/23; 10/13/22; 11/01/21; 11/04/20; 12/04/19; 01/10/19; 02/06/18; 03/13/17; 03/14/16; 01/28/16; 02/06/15; 02/08/14; 02/11/13; 02/22/12; 11/04/11	
Version History	02/06/18	Added section "Codes/Coding Guidelines" and code descriptions to all of the codes discussed in the "Policy" section
	01/10/19	Annual Review; no changes
	12/04/19	• Clarified what services are included in the Global OB package and the Delivery Only package • Indicated that only ONE submission of each segment of maternity care would be allowed/reimbursed per pregnancy unless multiples • Clarified what services are included in the "Delivery Including Postpartum Care" section • Clarified what services are included in the "Postpartum Care Only" section • Added in the "Exceptions" section that Alaska providers do not need to append modifier TH to indicate that only 1-3 prenatal visits were rendered
	11/04/20	• Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 paper or 837P electronic claim forms • Added additional services in the Global OB Package and Delivery Only sections • Added the Pregnancy confirmation codes and descriptions in the Codes/Coding Guidelines section
	11/01/21	• Clarified the description under Delivery Including Postpartum care section of the policy
	10/13/22	• Added an introductory paragraph to the Policy statement • Moved the Confirmatory Visit section to the beginning of the Policy • In the Global Obstetric Package section, made some minor revisions to descriptions of services included in the Global OB Package • In the Antepartum Care Only section, added a reference that prenatal visits rendered prior to an unexpected pregnancy termination can be billed • In the Delivery Only section, indicated that the date of delivery should be used for the date of service. Also made minor revisions to the descriptions of services included in the Delivery only codes • In the Delivery Including Postpartum section, indicated that the date of delivery should be used for the date of service. Clarified that if

		the postpartum care 6-8 weeks post-delivery is not also rendered by the delivering provider, then only the Delivery only codes can be billed • In the Postpartum section, clarified that the post-delivery visits include BOTH in office and home visits. • Added a new section Maternity Complications Services
	09/06/23	Annual review; no changes
	05/14/24	• In the Confirmatory Visit section, added the third paragraph to indicate maternity care begins when the pregnancy has been confirmed • In the Global Obstetric Package section, added the last paragraph to indicate circumstances when individual maternity services must be billed • In the Antepartum Care only section, in the second paragraph, indicated that the last date of service should be billed with one unit • In the Postpartum Care only section, o in the second paragraph indicated that the last date of service should be billed with one unit and o in the third paragraph, revised the wording of the first bullet • In the Unlisted Maternity Care and Delivery section, in the last paragraph, added the last sentence indicating that documentation must describe the specific services that are represented by the unlisted procedure code • Added a new section "Maternity Complication Services and High-Risk Pregnancies" which discusses guidelines for billing for a high-risk pregnancy or maternity complications