Select Health

CODING/REIMBURSEMENT POLICY

OBSTETRICAL SERVICES

Policy # 16
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Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Obstetrical services are defined, for the purpose of this policy, to be those services necessary for the management of pregnancy.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Benefits are payable for these services provided to patients according to the terms, limitations, and exclusions of the subscriber/member contract. All services reported must be supported in the medical record and reimbursement will not be made for services reported that are not clearly documented.

If there is a change in insurance coverage during the pregnancy, providers may be required to report the antepartum, delivery, and postpartum care separately, based on the effective dates of each policy.

Billing Guidelines for Obstetrical Care

When billing for obstetrical services, refer to the Maternity Care and Delivery section of CPT® for the appropriate codes

Evaluation and Management

The visit at which the pregnancy is confirmed marks the official start of antepartum care and is considered to be part of the global obstetrical package or part of the antepartum services. This visit cannot be separately billed by the delivering clinician in a solo practice or by any member of the delivering clinicians' group practice.

Any E/M service performed that is related to this pregnancy is considered included in reimbursement for global obstetrical package or reimbursement of the antepartum services. However, conditions unrelated to the pregnancy may be separately reimbursed using an appropriate E/M level of service. These conditions may include, but are not limited to the following:

- Chronic hypertension
- Diabetes (i.e., Type I, Type II)
- Management of cardiac, neurological, or pulmonary problems
- Other conditions with a diagnosis other than complication of pregnancy (e.g., urinary tract infection)

Subsequent Prenatal Visits

Subsequent prenatal visits are considered part of the global obstetrical package or part of the antepartum services.

The frequency of the prenatal visits should be determined by the individual needs of the woman and the assessment of her risks. Generally, a woman with an uncomplicated pregnancy requires monthly visits for the first 28 weeks of gestation, bi-weekly visits from 28−36 weeks of gestation, and weekly visits from 36 weeks to delivery.

These visits cannot be billed separately by the delivering clinician in a solo practice or by any member of the delivering clinicians' group practice.

Antepartum Care:
Antepartum care is usually considered part of the global obstetrical package. There are occasions when these services can be separately billable using the appropriate antepartum codes. The following is a list of some occasions when this may occur:

- A pregnancy can be terminated by miscarriage/abortion and therefore the physician does not perform the global service traditionally associated with maternity care. (i.e., the abortion can be spontaneous, missed or induced.)

- The patient moves from one location to another (e.g., from Utah to California) and cannot complete the care in one geographic location with one clinician or one clinician group.

- One clinician may provide all the antepartum care, but because of complications at the time of delivery (e.g., cephalopelvic disproportion), the patient is referred to another clinician for the delivery itself.

An antepartum code can only be used once per provider during pregnancy and must be used with a quantity of "1". **Code 59425 should be used if the patient had a total of 4−6 antepartum visits. If the patient had a total of 7 or more visits, then CPT code 59426 should be used. If the patient had a total of 1−3 visits, then the appropriate level of E/M services should be reported using the date of service on which the visit occurred.**

The antepartum code should also be billed using the first date seen for these services in the "from" field and the last date seen in the "to" field, unless the provider is also billing for the delivery. In these cases, the provider should use the "delivery date" for the date of the antepartum service.

Admit and Attendance at Labor
Admit and attendance at labor is considered part of the delivery services associated with either a global obstetrical package or a delivery-only service. Therefore, these services are not separately billable.

Delivery of Viable Infant
The delivery of a viable infant at any time, regardless of the period of gestation, should be considered as a delivery and should be reimbursed as part of the global obstetrical package or as a delivery-only service, as appropriate.

Global Obstetrical Package
The following services are considered integral parts of *Routine Obstetrical Care* and are not separately billable.

Antepartum services include:
- Initial and subsequent history (this includes service for the initial visit where pregnancy is confirmed)
- Physical examinations
- Recording of weight, blood pressures, and fetal heart tones
- Routine chemical urinalysis

- Typically, there are monthly visits up to 28 weeks gestation, bi-weekly visits 28−36 weeks gestation, and weekly visits 36 weeks through delivery.

Delivery and Postpartum services include:

- Admission to the hospital;
- Admission history and physical examination;
- Management of uncomplicated labor including, but not limited to, fetal monitoring, catheterization, preparation of perineum, and antiseptic solution, etc.;
- Vaginal and/or cesarean delivery; and
- Delivery of the placenta.
- Exploration of uterus
- Episiotomy and repair
- Repair of 1st and 2nd degree cervical or vaginal laceration(s). The repair of 3rd and 4th degree lacerations can be reimbursed by appending a 22 modifier to the global OB service (or the delivery service if billed separately) if the provider documents the details of the repair and the additional work required. In 2014, ACOG expanded the options for coding laceration repairs. As an alternative to appending the 22 modifier to the OB global service, the integumentary repair codes (12041−12047 and 13131−13133) may be submitted with supporting documentation.
- Treatment to control bleeding
- Hospital visits following vaginal or cesarean section delivery; and
- Office visits related to the pregnancy up to 90 days postpartum.

Postpartum Care:

Postpartum care is usually considered part of the global obstetrical package.

When postpartum care is provided as a separately identifiable service, the clinician must provide all the hospital and office visits following vaginal or cesarean section delivery in order to bill for this service.

If the clinician provides only the office visits related to the pregnancy from discharge up to 90 days postpartum, it would be appropriate to submit a claim for this service using 59430 with a 52 modifier to identify a reduction in the total service.

The postpartum code 54930 **should be billed using the date of the final postpartum visit, using a quantity of "1".**

Multiple Gestations

When multiple gestations occur, the global obstetrical package or delivery-only services are based on the following table:

Description	Global Package		Delivery Only	
	Baby 'A'	Baby 'B'	Baby 'A'	Baby 'B'
Twin Birth; both vaginal	59400	59409-51	59409	59409-51
Twin Birth; both vaginal after previous c-section (VBAC)	59610	59612-51	59612	59612-51
Twin Birth; one vaginal, one c-section	59510	59409-51	59409-51	59514
Twin Birth; one VBAC one failed VBAC	59618	59612-51	59612-51	59620
Twin Birth; both c-section	59510	N/A*	N/A*	N/A*
Twin Birth; both failed VBAC	59618	N/A*	N/A*	N/A*

Partial Obstetrical Service

If partial obstetrical care is provided, rather than the global obstetrical package, the portion of care provided should be documented in the patient record and billed accordingly.

Billing Scenarios (Solo Practice)

When Should a Clinician in a Solo Practice Use the Global OB Package Codes?

● If the clinician provides all of the elements of the global obstetrical package, as defined in the *Global Obstetrical Package* section of this policy, they can generate a claim using the appropriate global obstetrical package codes.

● If the clinician employs ancillary personnel (i.e., physician extenders) to assist in the provision of care to their patient, they can generate a claim using the global obstetrical package codes using their provider number, if all of the services defined in the *Global Obstetrical Package* section of this policy were either personally provided or provided "incident to" their professional service.

> To qualify under the "incident to" provision, the physician extender must be under the "immediate personal supervision" of the clinician. (For the purpose of this policy, immediate personal supervision means, the supervising clinician must be present in the office, clinic, or facility at the time the physician extender provided the service.)

When Should a Clinician in a Solo Practice Use the Global OB Package Codes with a –52 Modifier?

> *Definition:*
> -52 Reduced Service: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service …

● If the clinician provides the antepartum and postpartum care and is involved in the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, but misses the actual delivery (e.g., stepped out of the room for a moment) then returns to deliver the placenta and provides vaginal repair, they should generate a claim using the -52 modifier on the global OB package care code.

> In this case, the documentation in the medical record should indicate that the clinician stepped out of the room. The use of the -52 modifier indicates a reduction in services.

● If the clinician provides the antepartum and postpartum care but due to an emergent event (e.g., delivery at home, delivery en route) misses the delivery but is waiting at the hospital for the patient's arrival, then admitted the patient, delivers the placenta, and does vaginal repair, they should generate a claim by using the appropriate global obstetrical package code with a –52 modifier.

> In this case, the documentation in the medical record should indicate that the clinician was waiting for the patient. The use of the -52 modifier indicates a reduction in services.

● If the clinician provides the antepartum and postpartum care but the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, were provided by delivery room personal (e.g., a resident, nurse-midwife, nurse-practitioner, physician assistant, or labor and delivery nurse) and there is documentation in the patient record to indicate that the solo practitioner personally directed the patient care, then the solo practitioner should bill the appropriate global obstetrical package code with a -52 modifier.

When Should a Clinician in a Solo Practice Use the Antepartum and Postpartum Codes Only?

● If the clinician provides the antepartum and postpartum care but due to an emergent event (e.g., delivery at home, delivery en route) misses the delivery and was unable to admit the patient, deliver the placenta, or provide vaginal repair, they should then generate a claim for the antepartum and postpartum care only, using the appropriate CPT codes.

In this case, the clinician who provided the delivery of the placenta and vaginal repair should generate a claim using the appropriate CPT codes.

● If the clinician provides the antepartum and postpartum care but another clinician provides the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, then the solo practitioner can only generate a claim for the antepartum care and the postpartum care, using the appropriate CPT codes.

In this case, the delivering clinician should generate a claim for the delivery only, using the appropriate CPT code.

● If the clinician provides the antepartum and postpartum care but the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, were provided by any delivery room personal (e.g., a resident, nurse-midwife, nurse-practitioner, physician assistant, or labor and delivery nurse) and there is no specific documentation in the patient record to indicate that the solo practitioner personally directed the patient care, the solo practitioner should bill only for the appropriate antepartum and postpartum care, using the appropriate CPT codes.

Billing Scenarios (Group Practice)

When Should a Clinician in a Group Practice Use the Global OB Package Codes?

● If the clinician in a group practice provides all of the elements of the global obstetrical package, as defined in the *Global Obstetrical Package* section of this policy, they can generate a claim using the appropriate global obstetrical package code.

● If the clinician employs ancillary personnel (i.e., physician extenders) to assist in the provision of care to patients, a claim can be generated using the global obstetrical package code, if all of the services defined in the *Global Obstetrical Package* section of this policy were either personally provided by the clinician or were provided "incident to" the clinician or one of the group practitioners' professional service.

To qualify under the "incident to" provision, the physician extender must be under the "immediate personal supervision" of the one of the group practice clinicians. (For the purpose of this policy, immediate personal supervision means, the supervising clinician must be present in the office, clinic, or facility at the time the physician extender provided the service.)

● If the clinician provides the antepartum and postpartum care, however, a "covering" group member provides the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, then a claim can be generated using the appropriate global obstetrical package code.

When Should a Clinician in a Group Practice Use the Global OB Package Codes with the –52 modifier

Definition:
-52 Reduced Service: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the services provided can be identified by its usual procedure number and the addition of the modifier '-52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service…

● If the clinician provides the antepartum and postpartum care and is involved in the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, misses the actual delivery (e.g., stepped out of the room for a moment) then returns to deliver the placenta and does the vaginal repair, it would be appropriate to generate a claim using the -52 modifier on the global OB care code.

In this case, the documentation in the medical record should indicate that the clinician stepped out of the room. The use of the -52 modifier indicates a reduction in services.

● If the clinician provides the antepartum and postpartum care, but due to an emergency event (e.g., delivery at home, delivery en route), misses the delivery but is waiting at the hospital for the patient's arrival, then admitted the patient, delivers the placenta, and provides vaginal repair, they can then generate a claim by using the appropriate global obstetrical package code with a –52 modifier.

In this case, the documentation in the medical record should indicate that the clinician was waiting for the patient. The use of the -52 modifier indicates a reduction in services.

● If the clinician provides the antepartum and postpartum care but the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, were provided by delivery room personal (e.g., a resident, nurse-midwife, nurse-practitioner, physician assistant, or labor and delivery nurse) and there is documentation in the patient record to indicate that the clinician or a member of the group practice directed the patient care (e.g., by phone), then the clinician/group should bill the appropriate global obstetrical package code with a -52 modifier.

When to use the Antepartum and Postpartum Codes Only:

● If the clinician provides the antepartum and postpartum care but due to an emergency event (e.g., delivery at home, delivery en route), misses the delivery and was unable to admit the patient, deliver the placenta, or provide the episiotomy or vaginal repair, then they should generate a claim for the antepartum and postpartum care only, using the appropriate CPT codes. The documentation in the patient medical record should indicate this circumstance.

In this case, the clinician who provided the delivery of the placenta and vaginal repair should generate a claim for those services.

● If the clinician provides the antepartum and postpartum care but the "delivery services", as defined in the *Global Obstetrical Package* section of this policy, were provided by delivery room personal (e.g., a resident, nurse-midwife, nurse-practitioner, physician assistant, or a labor and delivery nurse) and there is no specific documentation in the patient record to indicate that the any member of the group practice directed the patient care, then the group practitioner should bill only for the appropriate antepartum and postpartum care, using the appropriate CPT codes.

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Select Health Advantage **will follow the commercial plan policy.**

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care **will follow the commercial plan policy.**

Applicable Codes	Descriptions
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
59414	Delivery of placenta (separate procedure)
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, & postpartum care
59514	Cesarean delivery only;
59515	Cesarean delivery only; including postpartum care
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

Sources

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5. CMS. National Correct Coding Initiative Policy Manual for Medicare Chapter 7 CPT Codes 50000−59999 (Revised January 1, 2014) CHAPTER VII Surgery: Urinary, Male Genital, Female Genital, Maternity Care. Retrieved August 27, 2014.
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