BlueCross BlueShield of North Carolina

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Global Maternity & Multiple Births Billing Guidelines Quick Reference Guide

Global Maternity

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care until six weeks postpartum.

A global charge should be billed for maternity claims when all maternity-related services, as outlined in Blue Cross and Blue Shield of North Carolina's (BCBSNC's) corporate medical policy "Guidelines for Global Maternity Reimbursement," are provided by the same physician or physicians practicing at the same location. The number of antepartum visits may vary from patient to patient. If global maternity care is provided, all maternity related visits and delivery should be billed under the global maternity code. Individual E&M codes should not be billed to report maternity-related E&M visits. Prenatal care is considered an integral part of the global reimbursement and will not be paid separately

The *Current Procedural Terminology*® (CPT) manual identifies the following CPT codes as global maternity services:

- **59400** - Routine obstetric care including antepartum care, vaginal delivery (with or 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 or 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

Billing tips:

- An initial visit, confirming the pregnancy, is not a part of global maternity care services (verification of benefits will determine appropriate member liability).
- A global charge should be billed when one or more physicians, practicing at the same location (filing under the same federal tax identification number), provide all components of the patient's maternity care including; four or more antepartum visits, delivery and postpartum care. **Note:** Claims filed for partial maternity care with E&M codes for one to three visits will deny when billed prior to the actual delivery, as all claims related to the maternity care must be received in order to account for the appropriate number of visits.
- Antepartum services such as laboratory tests (excluding dipstick urinalysis), diagnostic ultrasound, amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, and fetal non-stress test are not considered part of global maternity services and should be billed separately.

Quality Reporting – Effective July 28, 2015

In support of quality tracking and in accordance with HEDIS guidelines, we require that claims (outside of the global billing claim) be submitted with **both** of the following:

- Date of first prenatal visit
- Date of postpartum visit

Date of first prenatal visit - Submit a claim reflecting the actual date of the first visit for prenatal care. Use CPT Category II code 0500F (Initial prenatal care visit) or 0501F (Prenatal flow sheet documented in medical record by first prenatal visit) **AND** any of the applicable diagnosis codes as outlined in the "Quality Reporting" section of the Corporate Reimbursement Policy, "Guidelines for Global Maternity Reimbursement".

Date of postpartum visit - The postpartum visit should occur 4-6 weeks after delivery. Submit a claim with the actual date the postpartum service was rendered. Use CPT Category II Code 0503F (Postpartum care visit) and ICD-9 code V24.2 (Routine postpartum follow-up). As of 10/1/2015 use ICD -10 code Z39.2.

Prenatal Delivery and/or Postpartum Services Billed Separately

It is appropriate to file prenatal, delivery and/or postpartum services separately, if:

- the member's coverage started after the onset of pregnancy.
- the coverage terminates prior to delivery.
- the pregnancy does not result in delivery.
- another provider in a different practice assumes care of the member prior to completion of global services.
- during the member's pregnancy, there was a change in the member's benefit package or certificate number due to an employer change only.

In the event a physician in a different practice provides the prenatal and/or postpartum care but does not perform the delivery, the delivering physician may file using the antepartum/postpartum care-only codes, applicable to the number of times the patient was seen by that physician.

Maternity Service	Number of Visits	Coding
Antepartum Care Only	1 to 3 visits	Use the appropriate Evaluation & Management (E/M) codes
Antepartum Care Only	4 to 6 visits	Use CPT code 59425 and one (1) unit
Antepartum Care Only	7 or more visits	Use CPT code 59426 and one (1) unit
Postpartum Care Only		Use CPT 59430

Note: Physicians should reference the CPT manual for the most current and any additional maternity-related CPT codes. Should any of these codes change, the most current code should be submitted on the claim form.

Please reference the "Claim Filing Scenarios" section of this document for examples of when a claim should/should not be billed separately for maternity services rendered by two different physicians.

Multiple Births

Vaginal Deliveries Only

- Baby A: File the appropriate "vaginal delivery only" code. (Reimbursed at 100 percent of the allowable charge; subject to the member's benefits.)
- Babies B and beyond: File appropriate "vaginal delivery only" code with modifier -59 appended. If more than one subsequent baby is delivered, the total number of babies B and beyond should be indicated in the units field. (Reimbursed at 50 percent of the allowable charge each for Babies B and beyond; subject to the member's benefits.)
- If antepartum and/or postpartum care were not provided, then report only the appropriate "vaginal delivery only" code, reflecting the total number of deliveries in the units fields for Babies A and beyond (Reimbursed at 50 percent of the allowable charge for Babies B and beyond; subject to the member's benefits.)
- If antepartum care was not provided, but postpartum care following hospital discharge was provided, report appropriate code for "vaginal delivery only including postpartum care" for Baby A. Report the appropriate "vaginal delivery only" code for Babies B and beyond with modifier -59 appended. If more than one subsequent baby is delivered, the total number of babies B and beyond should be indicated in the units field. (Reimbursed at 50 percent of the allowable charge each for Babies B and beyond; subject to the member's benefits.)

Cesarean Delivery Only

- Baby A and beyond: File **only once** for appropriate "global cesarean delivery" code. (Reimbursed at 100 percent of the allowable charge.)
- If antepartum and postpartum care were not provided, then report **only once** the appropriate "cesarean delivery only" code.
- If antepartum care was not provided but postpartum care following hospital discharge was provided, then report **only once** the appropriate "cesarean delivery only; including postpartum care" code.
- "Global cesarean delivery," "cesarean delivery only," and "cesarean delivery only; including postpartum care" codes should be reported **only once regardless of the number of babies delivered**.

Vaginal Delivery, Followed by Cesarean Delivery

- Baby A: File appropriate "vaginal delivery only" code with modifier -59 appended. (Reimbursed at 50 percent of the allowable charge.)
- Baby B and beyond: File appropriate "global cesarean delivery" or "cesarean delivery only" code once. (Reimbursed at 100 percent of the allowable charge.) When global care was also provided, the global service is applied to the cesarean delivery as the intrapartum work and postpartum care is more pertinent to a cesarean delivery than vaginal delivery.
- If antepartum care was not provided, but postpartum care following hospital discharge was provided, submit the appropriate code for "vaginal delivery only" for Baby A with modifier -59 appended. (Reimbursed at 50 percent of the allowable charge.) Report the appropriate "cesarean delivery only; including postpartum care" code (59515) once for Babies B and beyond (Reimbursed at 100 percent of the allowable charge.)

Coding

The current CPT publication defines the following maternity-related services as:

- **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
+ **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

Note: Physicians should reference the CPT publication for the most current and any additional maternity-related service codes. Should any of the above codes change, the most current code should be submitted on the claim form. BCBSNC system edits are in place to apply correct coding guidelines for CPT, HCPCS, and current ICD diagnosis and procedure codes. BCBSNC system edits enforce and assist in a consistent claim review process. BCBSNC coding edits reflect medical coverage guidelines, benefit plans, and/or other BCBSNC policies. Unbundling, mutually exclusive procedures, duplicate, obsolete, or invalid codes are identified through the use of coding edits.

Claim Filing Scenarios

Scenario 1: Maternity care provided by two different physicians in two different unaffiliated groups

Dr. Blue provides only antepartum and/or postpartum patient care and does not perform the delivery. Therefore, Dr. Blue should file the appropriate CPT code(s) for only the antepartum/postpartum care. Dr. Cross, who is unaffiliated with Dr. Blue's practice, performs the delivery. Therefore, Dr. Cross should file the appropriate CPT code for only the delivery. In this scenario, the prenatal care, labor and delivery, and post-delivery care were provided by two different physicians in two different unaffiliated groups. A global CPT code is not applicable and should not be filed by either physician.

Scenario 2: Maternity care provided by two different physicians practicing at the same location (group)

When two different physicians are practicing at the same location, and both are providing the maternity care (for example, Dr. Blue provides antepartum/postpartum care, and Dr. Cross performs the delivery), a single claim should be filed with the appropriate global maternity CPT code. Two different claims should not be filed since Dr. Blue and Dr. Cross are rendering the maternity care and practice at the same location.

Scenario 3: Sterilization performed in addition to providing all services for a cesarean delivery

Dr. Blue provides all services for a cesarean delivery. In addition to providing all services for a cesarean delivery, Dr. Blue performs a sterilization procedure immediately following the delivery. Dr. Blue's office should bill for the global maternity services first (cesarean delivery), followed by a claim submission with the appropriate CPT code(s) for sterilization services provided during post-cesarean delivery within the same maternity stay.

Scenario 4: Repair of fourth laceration only; physician performs no other maternity-related services

Dr. Blue provides all services for a vaginal delivery. Dr. Cross repairs a fourth-degree laceration to the cervix during the delivery. The claim for Dr. Blue's services should be filed first and reflect the global maternity services (vaginal delivery). Dr. Cross's services for the laceration repair during the delivery should be billed separately. Third and fourth-degree laceration repairs are considered separately identifiable services.

Additional Information

Services Unrelated to Pregnancy (Performed by the physician rendering global maternity care)	Services unrelated to pregnancy, but performed by the physician rendering global maternity care, should be documented and reported separately with the appropriate inpatient or outpatient Evaluation and Management code; using the condition unrelated to pregnancy as the primary diagnosis code. Additionally, the diagnosis should reflect the separately identifiable service.
Surgical Complications	Services related to surgical complications should be filed separately. Physicians should reference the most recent version of the CPT manual for appropriate surgical codes.

Ultrasound During Pregnancy	Ultrasound performed during routine screening during pregnancy is considered an integral part of patient care during pregnancy. Therefore, reimbursement is included in the global maternity care fee. Ultrasound during pregnancy is reimbursed only when used for the diagnosis or treatment of a specified medical condition(s).
Referral to Perinatologist	When a member is referred to and evaluated by a perinatologist, the perinatologist should bill an Evaluation and Management consultation code with the problem diagnosis that necessitated the referral. Maternity health status codes should not be used, as they may cause the visit to be attributed to global maternity care.
Timely Filing	Timely filing limits apply to claim submissions for maternity-related services. Separately allowed services should be billed prior to delivery in order to avoid a timely filing denial.
Member Benefit Application	Benefits may vary according to benefit design; therefore, it is important to verify eligibility and benefits prior to rendering services. Benefits can be verified via **Blue *e***SM or by contacting the Provider BlueLine℠ at 1.800.214.4844. In the absence of maternity benefits, elective cesarean delivery (primary or repeat) is not eligible for coverage. Emergency cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed below as a complication of pregnancy.
Complications of Pregnancy	Complications of pregnancy per member certificate language are medical conditions with diagnoses that are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible, and which require the mother to be treated prior to the full term of pregnancy (except as otherwise stated in the BCBSNC corporate medical Policy, "Guidelines for Global Maternity Reimbursement").
Healthy Outcomes Maternity	Healthy Outcomes Maternity is a confidential program offered to BCBSNC commercial members. The program gives mothers-to-be helpful tools and information, so they can make healthy decisions throughout their pregnancy. If you have a BCBSNC patient who may benefit from the program, please encourage them to contact us at the toll-free number listed on their BCBSNC ID card. This program is not available to State Health Plan, Federal Employee Program, Blue Medicare℠ members, or to members whose ASO employer groups do not offer disease management services. **Note:** Healthy Outcomes Maternity program is separate and apart from any maternity benefits.
Provider Resources	Physicians can reference the following resources for additional information related to filing claims for maternity care: + The BCBSNC maternity reimbursement medical policy available online at: http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/guidelines_for_global_maternity_reimbursement.pdf. + The *Current Procedural Terminology*® manual + Provider Blue Line℠ at 1.800.214.4844

Note: The information provided in this Quick Reference Guide is applicable to BCBSNC commercial health plans. The information provided is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Member benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. The Quick Reference Guide is solely provided for informational purposes only and is based on BCBSNC's medical policy(s) and payment guidelines at the time of publication.