# Corporate Reimbursement Policy

## Guidelines for Global Maternity Reimbursement

**File Name:** guidelines_for_global_maternity_reimbursement
**Origination:** 10/2003
**Last Review:** 12/2020
**Next Review:** 12/2021

## Description of Procedure or Service

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.

Other 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. They are reimbursed separately.

## Benefits Application

Please refer to the member's benefits booklet for availability of benefits. This policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, certificate language should be reviewed before applying the terms of the policy.

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 per member certificate language are medical conditions whose diagnoses 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 below), including but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within 10 days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, and episiotomy repair and birth injuries are not considered complications of pregnancy.

## Billing for Maternity Care

**A. Global Maternity Coverage**
Normally, a provider should file global maternity care when they provide prenatal care, labor and delivery and postpartum care.

**B. Prenatal, Delivery and/or Postpartum Services Billed Separately**
It would be appropriate for the provider to file prenatal, delivery and/or postpartum services separately if:
1. the member's coverage started after the onset of pregnancy

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

Please see Billing/Coding section for further instructions regarding required reporting of date of first prenatal visit and date of postpartum visit.

**C. <u>Multiple Births</u>**

**The correct method of reporting multiple deliveries is as follows:**

**1. Vaginal deliveries only**
   a. Baby A: File the appropriate "global vaginal delivery" code. (Reimbursed at 100% of the allowable.)
   b. 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% of the allowable each for Babies B and beyond.)
   c. 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% of the allowable for Babies B and beyond.)
   d. 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% of the allowable each for Babies B and beyond.)

**2. Cesarean delivery only**
   a. Baby A and beyond: File **only once** for appropriate "global Cesarean delivery" code. (Reimbursed at 100% of the allowable.)
   b. If antepartum and postpartum care were not provided, then report **only once** the appropriate "Cesarean delivery only" code.
   c. 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.
   d. "Global Cesarean delivery," "Cesarean delivery only," and "Cesarean delivery only; including postpartum care" codes should be reported **<u>only once regardless of the number of babies delivered.</u>**

**3. Vaginal delivery, followed by Cesarean delivery**
   a. Baby A: File appropriate "vaginal delivery only" code with modifier -59 appended. (Reimbursed at 50% of allowable.)
   b. Baby B and beyond: File appropriate "global Cesarean delivery" or "Cesarean delivery only" code once. (Reimbursed at 100% of allowable.) 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 a vaginal delivery.

c. If antepartum care was not provided, but postpartum care following hospital discharge was provided, code the appropriate code for "vaginal delivery only" for Baby A with **modifier -59** appended. (Reimbursed at 50% of allowable.) Report the appropriate "Cesarean delivery only; including postpartum care" code once for Babies B and beyond. (Reimbursed at 100% of allowable.)

d. "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.**

**D.** **Services unrelated to pregnancy**, but performed by the provider 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.

**E.** **Referral to Perinatologist**
When a member is referred to and evaluated by a perinatologist, that 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.

## Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

**Quality Reporting:**
In support of quality tracking and in accordance with HEDIS guidelines, we require that claims (in addition to the global billing claim) be submitted for the following:

**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 following applicable diagnosis codes:*
*Z34.01', Z34.02', Z34.03', Z34.80', Z34.81', Z34.82', Z34.83', Z34.90', Z34.91', Z34.92', Z34.93', O09.A0, O09.A1, O09.A2, O09.A3, O09.00', O09.01', O09.02', O09.03', O09.10', O09.11', O09.12', O09.13', O09.211', O09.212', O09.213', O09.219', O09.291', O09.292', O09.293', O09.299', O09.40', O09.41', O09.42', O09.43', O09.511'. O09.512', O09.513', O09.519', O09.521', O09.522', O09.523', O09.529', O09.611', O09.612', O09.613', O09.619', O09.621', O09.622', O09.623', O09.629', O09.70', O09.71', O09.72', O09.73', O09.811', O09.812', O09.813', O09.819', O09.821', O09.822', O09.823', O09.829', O09.891', O09.892', O09.893', O09.899', O09.90', O09.91', O09.92', O09.93', O36.80x0', O36.81x0', O36.82x0', O36.8310, O36.8311, O36.8312, O36.8313, O36.8314, O36.8315, O36.8319, O36.8320, O36.8321, O36.8322, O36.8323, O36.8324, O36.8325, O36.8329, O36.8330, O36.8331, O36.8332, O36.8333, O36.8334, O36.8335, O36.8339, O36.8390, O36.8391, O36.8392, O36.8393, O36.8394, O36.8395, O36.8399, , O36.84x0', O36.85x0', O36.89x0'*

**Date of postpartum visit.**
The postpartum visit should occur 4-6 weeks after delivery. Submit a claim with the actual date the post partum service was rendered. *Use CPT Category II Code 0503F (Postpartum care visit) and ICD - 10 code Z39.2'*

## Scientific Background and Reference Sources

**Policy entitled: Maternity Reimbursement**

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

**Policy renamed: Guidelines for Global Maternity Reimbursement**

Medical Policy Advisory Group - 03/24/2006

Senior Medical review – 10/2012

American Congress of Obstetricians and Gynecologists (ACOG) 2012

Senior Medical Director review – 11/2013

Senior Medical Director review – 5/2015

## Policy Implementation/Update Information

**Policy entitled: Maternity Reimbursement**

10/03 Original policy issued.

10/03 Medical Policy Advisory Group review. Reaffirm.

04/07/05 Medical Policy Advisory Group reviewed policy on 03/10/2005. Corrected a typo.

**Policy renamed: Guidelines for Global Maternity Reimbursement**

7/21/05 Titled changed from “Maternity Reimbursement” to “Guidelines for Global Maternity Reimbursement”. For clarity, added the following statement to the Benefits Application section “In the absence of maternity benefits, elective cesarean delivery (primary or repeat) is not eligible for coverage.”

5/08/06 Medical Policy Advisory Group review 3/24/06. Policy number added to the Key Words Section. The following added to the Multiple Birth section of the Policy: 3. a. i. "(100%)", 3. b. i. " -51 modifier and (50%)”, 4 a. i. "(100%)", 4. b. i. "-51 modifier and (50%)". 4. b. i Changed CPT code 59650 to 59620.

3/26/07 In the section, “Benefits Application" added the word "and" before "episiotomy” in the third paragraph. Added the following to the Multiple Birth section of the Policy: 2. c. "If antepartum and/or postpartum care were not provided, then procedure code 59409 should be reported reflecting the appropriate number of deliveries in the units fields." 3.c. " If antepartum and/or postpartum care were not provided, then procedure code 59610 should be reported reflecting the appropriate number of deliveries in the units fields." 4.c. "If antepartum and/or postpartum care were not provided, then procedure code 59618 should be reported reflecting the appropriate number of deliveries in the units fields. Medical Policy reviewed by Senior Medical Director of Network Support.

05/05/08 Policy reviewed 4/4/2008 by Vice President and Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy. No changes to policy criteria.

6/22/10 Policy Number(s) removed (amw)

10/16/12 Description section revised. In the "Billing for Maternity Care" section, modifier 51 was changed to modifier 59. (adn)

10/16/12 Item C in the "Billing for Maternity Care" section dealing with multiple births has been extensively revised. Added Item D. Notification 10/16/12 for effective date 12/28/12. (adn)

12/10/13 Routine policy review. No change to current policy. (adn)

5/13/14 Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)

5/26/15 Corrected typo, removed the word "only" from section "Billing for Maternity Care" Item C.1.a. ("vaginal delivery only" should read "vaginal delivery"). Added quality reporting guidelines to the Billing/Coding section. "In support of quality tracking and in accordance with HEDIS guidelines, we require that claims (outside of the global billing claim) be submitted with the following: date of first prenatal visit and date of postpartum visit." Notification given 5/26/2015 for effective date of 7/28/2015. (adn)

7/26/16 In the section "Billing for Maternity Care" Item C.1.a. "Baby A: File the appropriate "vaginal delivery" code" was revised to read "Baby A: File the appropriate "**global** vaginal delivery" code". (an)

9/30/16 In the Billing for Maternity Care section, Item B.4. revised to read: another provider **in a different practice** assumes care of the member prior to completion of global services. Added Item 5. Separate billing for pre/post-natal and delivery services is allowed when "during the member's pregnancy, there was a change in the member's benefit package or certificate number due to an employer change only." Codes *O09.A0, O09.A1, O09.A2, O09.A3* added to Billing/Coding section. (an)

12/29/17 Routine review. Removed ICD-9 codes. ICD-10 codes added. Code range for O36.83xx was expanded for 2018. No change to policy statement. (an)

12/14/18 Routine annual policy review. No change to policy statement or criteria. (an)

1/14/20 Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)

12/31/20 Routine policy review. Medical Director approved 12/2020. No changes to policy statement. (eel)