BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Maternity

Active

Section: General Coding
Policy Number: 025
Effective Date: 04/01/24

Description

This policy addresses coding and reimbursement for obstetrical care and associated services.

Definitions

Global Obstetric (OB) Codes: Codes in the Maternity Care and Delivery section of CPT® that include the complete package of routine services provided to an OB patient (i.e., antepartum, delivery, and postpartum care).

Component OB Codes: Codes in the Maternity Care and Delivery section of CPT that are used when less than the complete global package of services has been provided to an OB patient. These codes identify the specific categories of antepartum, delivery and post-partum services that have been provided.

Same Provider/Group Practice: All physicians or other health care professionals from the same group practice reporting the same Federal Tax Identification Number.

Policy Statement

Global Obstetrical Care

Maternity care includes antepartum, delivery and postpartum care services. When the same provider or group practice manages all of the patient's antepartum, delivery and postpartum care, global obstetrical (OB) care is being provided, and a global OB code (59400, 59510, 59610, 59618) should be submitted. Individual component antepartum, delivery and postpartum codes (59409, 59410, 59425, 59426, 59430, 59514, 59515, 59612, 59614, 59620, 59622) will be accepted in place of a global code, however, Blue Cross and Blue Shield of Minnesota (Blue Cross) will not reimburse both the global and the component codes.

There are situations where the applicable component OB codes should be submitted instead of the global codes. For example:

- More than one group practice provides the patient's OB care (e.g., the patient relocates to another city during the pregnancy or postpartum period).
- Only one group practice provides all OB care for the patient, but the services are less than the usual obstetric package (e.g., the patient receives initial prenatal care late in the pregnancy).
- The patient changes insurers during the pregnancy and the global package needs to be split between insurers.

Blue Cross follows the American College of Obstetricians and Gynecologists (ACOG) guidelines regarding the services that are included in the OB global and component antepartum, delivery and postpartum care codes.

Antepartum Care Services
According to ACOG, routine obstetric care includes approximately 13 antepartum visits, and both the global obstetric and component antepartum codes include the following services:

- Initial and subsequent history
- Physical examinations
- Recording of weight, blood pressures, fetal heart tones
- Routine urine dipstick (chemical) urinalysis (81000, 81002)
- Monthly visits up to 28 weeks gestation (5-6 visits)
- Biweekly visits to 36 weeks gestation (4 visits)
- Weekly visits from 36 weeks until delivery (3-4 visits)

When reporting antepartum care only, one of the following antepartum only codes should be selected:

- 59425 - Antepartum care only, 4-6 visits
- 59426 - 7 or more visits
- For 1-3 antepartum care visits, report the appropriate Evaluation and Management (E/M) code(s)

Pregnancy Confirmation/ Initial Obstetrical Visit
Pregnancy confirmation during a problem-oriented or preventive visit is not considered part of the antepartum care and the appropriate E/M code may be submitted separately for that visit.

The initial obstetrical visit may be billed separately with an appropriate E/M code. An obstetrical profile (80055 or 80081) and any laboratory procedure codes (other than urinalysis) may also be submitted separately.

Delivery
The global obstetric and component delivery codes include the following services:

- Admission to the hospital (including the admitting history and physical examination) (99221, 99222, 99223)
- Management of uncomplicated labor including fetal monitoring (59050, 59051).
- Vaginal or cesarean delivery (with or without episiotomy, forceps, or vacuum extraction)
- Delivery of the placenta (59414)
- Routine inpatient care immediately after the delivery (99231, 99232, 99233)
- IV Induction of labor (96365, 96366, 96367)
- Insertion of cervical dilator on day of delivery (59200)
- Simple removal of cerclage (not under anesthesia)
- Repair of first- and second-degree lacerations (12001, 12002, 12004, 12005, 12006, 12007)

Multiple Gestation Deliveries
Consistent with ACOG, multiple gestation deliveries should be reported as follows:

Type of Delivery	Twin A	Twin B	Description
Both vaginal	59400 or 59610	59409-59 or 59612-59	Communicates that one global maternity package is being reported along with an additional vaginal delivery (without antepartum and postpartum care).
Vaginal birth after cesarean delivery (VBAC)	59610	59612-59	Communicates that one global maternity package is being reported along with an additional vaginal delivery (without antepartum and postpartum care).
One vaginal and one cesarean	59409-51 or 59612-51	59510 or 59618	Communicates that both a cesarean and a vaginal birth were performed.
VBAC and repeat cesarean	59612-51	59618	Communicates that both a cesarean and a vaginal birth were performed.
Both cesarean	See description	See description	59510 or 59618 because only one cesarean incision was performed.

Multiple procedure reductions will be applied to claims submitted with multiple gestation deliveries. Refer to *Commercial Surgery/Interventional Procedure – 005 Multiple Surgical Reduction Reimbursement Policy.*

Postpartum Care

The following services are included in the global and postpartum care codes:

- Recovery room visit
- Uncomplicated inpatient hospital postpartum visits (99231, 99232, 99233)
- Uncomplicated maternity related outpatient visits within 6 weeks of delivery
- Discussion of contraception
- Removal of sutures (if appropriate)

The postpartum care only code, 59430, should be submitted when another provider from a different group practice performs the delivery. This code should be submitted with one unit of service and the date of service should be the delivery date.

Deductibles, Copays, Coinsurance
For contracts subject to Minnesota legislative mandated benefits and others that waive deductibles, copays, or coinsurance on antepartum care, Blue Cross will process claims submitted with global OB codes 59400, 59510, 59610, 59618 as if the component antepartum, delivery and postpartum codes had been submitted. The global maternity charge will be split based on RBRVS (Resource Based Relative Value System) work values. The provider Remittance Advice will report procedure code 59426 with a payment at 100 percent of the allowance and a delivery code 59410, 59515, 59614 or 59622 with a payment determined according to the contract's benefits.

For contracts that are not subject to Minnesota legislative mandated benefits and/or where antepartum care is subject to regular contract benefits, the global codes 59400, 59510, 59610 and 59618 will process with the charge and code as submitted.

Increased Procedural Services
In those situations where the amount of work required to provide a service is substantially greater than typically required (e.g., repair of third- or fourth-degree lacerations at the time of delivery, multiple gestation delivery, etc.), modifier 22 may be submitted along with supporting documentation. Refer to *Commercial Surgery/Interventional Procedure - 004 Modifier 22 Reimbursement Policy.*

Prolonged Physician Services
Delivery codes are not time-based and, therefore, Blue Cross will not reimburse prolonged physician services (codes 99354, 99355, 99356, 99357, 99358, and 99359, 99415, 99416, 99417, G2212) for labor and delivery. According to CPT guidelines, "The use of time-based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook." Refer to *Commercial Evaluation and Management – 006 Prolonged Services Reimbursement Policy.*

Assistant-at-Surgery Services
Delivery-only cesarean section codes (59514, 59620) are eligible for reimbursement when submitted with the appropriate assistant-at-surgery modifier. For further information regarding assistant-at-surgery reimbursement, refer to *Commercial Surgery/Interventional Procedure – 001 Assistant-at-Surgery Reimbursement Policy.*

Free-Standing Birth Centers
Free-standing birth centers are licensed health care facilities that perform low-risk deliveries following a low-risk pregnancy. A low-risk pregnancy is a normal, uncomplicated pregnancy. A freestanding birth center is not a hospital or licensed as part of a hospital. All free- standing birth centers must be accredited by the Commission for the Accreditation of Birth Centers (CABC) and licensed by the Minnesota Department of Health (MDH).

Low-risk deliveries, and services related to the delivery, performed in a free-standing birthing center should be reported on an 837I transaction including the following data:

- **Type of Bill** (TOB) 084x Special Facility – Freestanding Birthing Center; TOB 084x will be considered outpatient.
- **Revenue Code** 0724 – Birthing Center; Ancillary services and/or items relating to delivery or labor 0724 are included under this revenue code and should not be reported separately.
- **HCPCS Code** – Report the appropriate HCPCS code with revenue code 0724 for delivery, or S4005 when labor does not result in delivery.

Note: Professional services related to the mother's and newborn's cares are reported on the 837P only.

Licensed Traditional Midwife Services
Professional services by licensed traditional midwives must be reported on an 837P transaction using Place of Service code 25 – Birthing Center and the appropriate HCPCS code.

HCPCS Code
Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, free-standing birthing center or home visits for pre- or post-natal care, standby services, and post-delivery home visits.
Fragmented services may be reported in certain circumstances:

- If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes).
- If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code.
- Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service).
- Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal period. Urine dip sticks are considered part of the global package.

Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: 22 51 59
ICD-10 Diagnosis: N/A
ICD-10 Procedure: N/A
CPT/HCPCS: Refer to Appendix
Revenue Codes: 0724

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Minnesota Administrative Uniformity Committee (AUC) Companion Guides
OB/GYN Coding Manual, American College of Obstetricians and Gynecologists (ACOG)

Policy History

09/22/2015	Initial Committee Approval
10/12/2020	Annual Policy Review
04/25/2023	Revised
03/26/2024	Annual Policy Review

BlueCross BlueShield Minnesota

Appendix

12001	12002	12004	12005	12006	12007	12041	12042	12044	12045
12046	12047	13131	13132	13133	59000	59012	59015	59020	59025
59030	59050	59051	59200	59400	59409	59410	59412	59414	59425
59426	59430	59510	59514	59515	59610	59612	59614	59618	59620
59622	76818	76819	76825	76826	76827	76828	80055	80081	81000
81002	96365	96366	99202	99203	99204	99205	99211	99212	99213
99214	99215	99221	99222	99223	99231	99232	99233	99234	99235
99236	99238	99239	99342	99343	99344	99345	99347	99348	99349
99350	99415	99416	99417	99418	G0316	G0317	G0318	G2212	S0273
S0274	S4005								