RB.031.A Maternity Billing and Reimbursement Guidelines

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PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans/ Health Partners Plans lines of business unless noted below.

POLICY STATEMENT

The purpose of this claim payment policy is to define payment criteria for the maternity care and delivery services. The plan will reimburse for the global obstetric package reported with codes 59400, 59510, 59610 or 59618, when the same provider/provider group performs antepartum, delivery and postpartum care. Antepartum care, delivery and postpartum care are included in a global obstetric package and therefore are not reported or reimbursed separately.

The plan will also allow network providers to bill and be reimbursed for individual components of maternity care: Antepartum care: (59425, 59426) Delivery: (59409, 59410, 59414, 59515, 59612, 59620, 59622) and Postpartum care (59430).

When Antepartum care, delivery and postpartum care are paid separately, the plan will not reimburse for global obstetric package. Antepartum care only must be billed using the appropriate evaluation and management codes per encounter.

- If only one to three antepartum visits were provided, report the appropriate E/M codes, according to CPT® guidelines.
  - If four to six visits are provided, report 59425 Antepartum care only: 4-6 visits.
  - If seven or more visits are provided, report 59426 Antepartum care only: 7 or more visits.

Postpartum care only (59430) claims may be denied if global, delivery/postpartum, or postpartum only services have already been paid during the same pregnancy.

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POLICY GUIDELINES

Providers should report the appropriate place of service (POS) code when billing for maternity services. The global obstetric package includes approximately 13 antepartum visits and traditionally extends to 12 weeks following delivery. The global obstetrical package procedure code includes antepartum, delivery and postpartum care. In most circumstances, the average number of antepartum visits for uncomplicated care is 13. Antepartum visits totaling fewer than 13 should be reported separately from the OB package using codes for antepartum care only. A global obstetrical package (CPT Codes: 59400, 59510, 59610, 59618) includes services such as:

- Antepartum Care.
- Delivery.
- Postpartum Care.

When pregnancy is confirmed during a problem visit or preventative visit, these services are not included in global OB package and are reported separately using the appropriate evaluation and management codes 99201-99205, 99211-99215, 99241-99245, 99281-99285 and 99384-99385.

Any evaluation and management services (E&M), inpatient or outpatient, performed that are related to the pregnancy are included in the provision of the antepartum care and are not reported separately. Any other visits or services provided within the antepartum period, should be coded, and reported separately. (e.g., when a patient is seen for a condition unrelated to pregnancy (e.g.., bronchitis, flu), these E&M visits are considered Non-Obstetric {OB} E/M Services and can be reported as they occur. The diagnosis code used with the E/M service should support the condition being treated and/or evaluated was unrelated to the pregnancy.

Antepartum care services include:

- Initial and subsequent history and physical examinations.
- Labor evaluation and management.
- Monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks, and weekly visits until delivery.
- Recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.
- *Antepartum care only* does not include delivery or postpartum care.
    - When reporting this service, you do not report the global maternity package.

Delivery services include:

Admission to L&D, update of history any physical, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery or any E/M service on the calendar day prior to delivery and/or calendar day of delivery.

- Administration of intravenous oxytocin.

- Catheterization or catheter insertion.
- Delivery of the placenta, any method.
- Discussion and consent for contraception (includes Rx for birth control, consent for IUD, consent for tubal, etc.)
- Episiotomy and repair/suturing of lacerations.
- Exploration of uterus.
- Injection of local anesthesia.
- Management of uncomplicated labor including fetal monitoring.
- Placement of a hemostatic pack or agent.
- Placement of internal fetal and/or uterine monitors.
- Preparation of the perineum with antiseptic solution.
- Simple removal of Cerclage (not under anesthesia).
- Vaginal delivery with or without forceps or vacuum extraction.

Delivery codes include admission to the hospital, the hospital history and physical, the exam, and management of un-complicated labor. Any E/M services provided within 24 hours of delivery are also included (E/M services that occur more than 24 hours of the delivery may be separately reported). All inpatient E/M services and postpartum services are also included in the delivery codes.

Postpartum care services include:

- Any uncomplicated inpatient hospital postpartum visits.
- Discussion of contraception (including writing a prescription).
- The recovery room visit.
- Uncomplicated outpatient visits.

Delivery or Delivery with Postpartum Care-only Coding

If a provider performs the delivery only, and does not provide any antepartum or postpartum care, code selection depends on the type of delivery:

- **59409** Vaginal deliveries only (with or without episiotomy and/or forceps.
- **59514** Cesarean deliveries only.
- **59612** Vaginal deliveries only, after previous cesarean delivery (with or without episiotomy and/or forceps).
- **59620** Cesarean deliveries only, following attempted vaginal delivery after previous cesarean delivery.

***Because delivery only is performed, and the provider is not performing the entire global maternity package, *any inpatient E/M visits related to the delivery are separately reported.*

Per CPT Guidelines:

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient post-delivery management and discharge services using Evaluation and Management Services codes (99217-99239).

Delivery and postpartum services (59410, 59515, 59614, 59622) include delivery services and all inpatient and outpatient postpartum services. Medical complications of pregnancy (e.g., cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery(L&D) management may require additional resources and may be reported separately.

Postpartum care only services (59430) include office or other outpatient visits following vaginal or cesarean section delivery.

For information related to Jefferson Health Plans Obstetrical Needs Assessment Form (ONAF) and Maternity Quality Care Plus (MQCP) please refer to the links in the reference section of the policy.

CODING

Note: *The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only.* ***Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment****. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.*

CPT Code	Description
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, and postpartum care
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

HCPCS Code	Description
N/A	

ICD-10 Codes	Description
N/A	

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
Reissue. No revisions.	A	
This is a new policy.	A	5/15/2023

REFERENCES

1. **Obstetrical Needs Assessment Form (ONAF):** https://www.healthpartnersplans.com/providers/resources/form-and-supply-requests/maternity-care-forms
2. **Maternity Quality Care Plus (MQCP):** https://www.healthpartnersplans.com/providers/quality-and-population-health/pay-for-performance-qcp-and-mqcp
3. American College of Obstetricians and Gynecologists https://www.acog.org/practice-management/coding/coding-library
4. Current Procedural Terminology (CPT®), 2023