



Manual: Reimbursement Policy

Policy Title: **Maternity Care**

Section: Surgery

Subsection: Maternity

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Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid plans. This policy also applies to Summit Health plans for these lines of business.

This policy applies to professional providers and birthing centers.

Reimbursement Guidelines

A. Single Claim for All Global OB and Delivery Services

All delivery charges, antepartum care, postpartum care, and any additional surgical services from the date of delivery (e.g., 58611 *tubal at time of cesarean delivery*) must be submitted on the same claim.

Note: Multiple Procedure Fee Reductions apply to global OB and delivery-only codes. (RPM022⁰) These procedure codes are assigned a multiple procedure indicator of “2” on the Medicare Physician Fee Schedule Database (MPFSDB).

Other non-surgical services which may be reported separately in addition to the global OB package may be submitted on separate claims.

B. Initial Prenatal Visit

In addition to billing with the appropriate global maternity services, please report the initial prenatal visit with CPT code 0500F (Initial prenatal care visit) with a date of service of the initial prenatal visit as a no-charge line item. This can be done on a separate claim at the date of the first prenatal visit, or on the same claim as the global maternity billing, based on what will work best for your billing system.

Why: Moda Health uses the Healthcare Effectiveness Data and Information Set (HEDIS) to measure our quality performance (most health plans do). HEDIS requires that we gather this information on all of our members receiving maternity care.

Results:

- Reduce medical records requests to your office to collect this information.
- CPT code 0500F is for reporting purposes only and will not affect your reimbursement in any way.
- Will not delay the processing of your claim in any way, in accordance with Moda Health claim processing policy and state law.

C. Maternity Global Period

The CMS Physician Fee Schedule assigns maternity procedure codes a global days indicator of MMM and does not identify the number of days for a Maternity global period.

- For claims processed on or after July 1, 2018 (regardless of service date):
 - The global maternity period for vaginal delivery is 49 days (59400, 59410, 59610, & 59614).
 - The global maternity period for cesarean delivery is 90 days (59510, 59515, 59618, & 59622). A cesarean delivery is considered a major surgical procedure.
- For claims processed prior to July 1, 2018, Moda Health uses a Maternity Global Period of 45 days.
- The date of delivery is day zero. The day after delivery is postpartum day one, just as the surgery global period days are calculated. (RPM011^A)

D. Global OB Package

Moda Health reimburses global maternity codes for services provided during the maternity period for uncomplicated pregnancies. Services considered part of the global OB package (see section E) will not be reimbursed separately. The global maternity reimbursement includes antepartum care, delivery, and postpartum care.

The global obstetrical package code must be billed when one physician, one midwife, or the same physician group practice provides all of the patient's routine obstetric care, which includes the antepartum care, delivery, and postpartum care. (AMA¹) For this purpose, a physician group practice is defined as a clinic or an obstetric clinic with an electronic health record (EHR), or where there is no EHR, but one hard-copy patient record and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. All locations of a multi-location clinic with an EHR (or one hard-copy patient record) are considered the same physician group practice.

One primary care provider is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care. The clinic is expected to bill globally for all prenatal, delivery, and postpartum care services provided by the clinic, using the primary care provider's individual National Provider Identifier (NPI) as the performing provider. An exception to this rule occurs when the group practice clinic includes both physicians and nurse midwives. If the member's primary OB provider is a nurse midwife, but the delivery must be performed by a physician (e.g. complications, need for cesarean), then the billing office for the group practice may split the global OB package to ensure the midwife and the physician each get reimbursed at the correct rate for their portion of services.

Example # 1:

The patient received antepartum care with Dr. Smith. Dr. Jones, who is in the same practice as Dr. Smith, provides the delivery. Dr. Smith does the postpartum care. In this case, the billing office must code and bill the entire package under the patient's primary physician using a global maternity package code. Provide an in-office relative value unit (RVU) or payment allocation of reimbursement to the delivering physician. (Webb¹⁰)

Moda Health will reimburse:

- One provider for delivery.
- One provider for post-partum care
- One assistant surgeon for a cesarean delivery, if documented.

It may be appropriate to reimburse more than one provider for antepartum care when the patient transfers care during the antepartum period. (See [Transfer of Antepartum Care](#) for more information.)

E. Services Included in the Global OB/Maternity Package

Maternity care and the global OB package have three distinct stages: antepartum care, delivery, and postpartum care. The global OB package includes a large number of services which are considered bundled into the global OB code or the antepartum care, delivery, and postpartum care codes and are not eligible to be reported separately. The bundled services are summarized below.

1. Stage I: Antepartum care

Antepartum care begins with conception and ends with delivery. Antepartum care includes the following services which may not be billed separately:

- Initial history and physical, subsequent physical exams, and routine urinalysis.
Note: Please report the initial prenatal visit with CPT code 0500F (Initial prenatal care visit) with a date of service of the initial prenatal visit as a no-charge line item. (See section B for more information.)
- Monthly visits up to 28 weeks of gestation.
- Biweekly visits to 36 weeks gestation.
- Weekly visits from 36 weeks until delivery.
- Note: these antepartum care visits may be office visits or home visits (e.g. midwife visits in home).
- At each of these visits, the recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis (code 81000 or 81002) are included as part of the global obstetrical package. Therefore, these services are not reported separately.
- Pap smear at first prenatal visit. *Note:* This applies only to the Pap smear procedure. The laboratory processing is separately identifiable and payable.
- Education on breast feeding, lactation and pregnancy (HCPCS level II codes S9436–S9438, S9442–S9443)
- Exercise consultation or nutrition counseling during pregnancy (HCPCS level II codes S9449–S9452, S9470)

The initial visit to establish pregnancy is allowable under the member's medical benefit. Once the pregnancy has been confirmed, the global maternity period begins.

Note: See [High-Risk Pregnancy and/or Complications of Pregnancy](#) for more information.

2. Stage II: Intrapartum Care or Delivery

Delivery begins with the passage of the fetus and the placenta from the womb into the external world. Delivery care (and reimbursement for delivery procedure codes) includes the following services which may not be billed separately:

- Admission to hospital.
- Admission history and physical exam.
- Management of labor including fetal monitoring.
 - Note:** See [Labor Care by Midwife When Care Transferred to MD for Delivery](#) for details and requirements for this circumstance.
- Placement of internal fetal and/or uterine monitors.
- Catheterization or catheter insertion.
- Preparation of the perineum with antiseptic solution.
- Delivery, any method:
 - Vaginal delivery with or without forceps or vacuum extraction.
 - Cesarean delivery.
 - The decision for surgery to do a cesarean delivery is included in the Intrapartum Care and Delivery; it is not eligible to be separately reported.
 - Use of modifier 57 will not bypass an edit denying an E/M code as included in the maternity global.
- Delivery of the placenta, any method (59414, *Delivery of placenta (separate procedure)*), may not be separately coded in addition to the code for the delivery service). (AMA^{1,3})
- Injection of local anesthesia.
- Induction of labor with pitocin or oxytocin. This is considered an inherent part of the delivery service(s) provided. There is no separate procedure code assignment for this service. (AMA^{1,6})
- Artificial rupture of membranes (AROM) before delivery. This is an inclusive component of the delivery code reported. Therefore, it would not be appropriate to report a separate code for this service. (AMA^{1,9})
- **Note:** If a C-section is performed by a separate provider not providing the antepartum and postpartum care, the reimbursement for the cesarean delivery-only procedure code includes payment for the post-surgical (postpartum) care while in the hospital. If the surgeon will be providing post-surgical care after discharge, then cesarean delivery including postpartum care must be reported instead.

3. Stage III: Postpartum Care

Postpartum care begins after delivery. Postpartum care includes the following services which may not be billed separately:

- Exploration of uterus.
- Episiotomy and repair.
- Repair of cervical, vaginal or perineal lacerations. (AMA^{1,4,5})
- Placement of a hemostatic pack or agent.
- Recovery room visit.

- Hospital visits.
- Office visits or home visits (e.g. midwife care) during the Maternity Global Period.
- Treatment and care of any incisional problems or infections (episiotomy, cesarean).
- Education and assistance with lactation, breast and nipple care, and breast feeding.
- Treatment and care of nipple problems and/or infection during the Maternity Global Period.

F. Criteria for Splitting the Global OB Package

Maternity care and delivery must be billed as a single code except when certain circumstances occur which require the package to be broken into components. Circumstances which require splitting the global OB package include the following:

- The patient has a change of insurer during her pregnancy.
- The patient has received part of her antenatal care somewhere else, e.g. from another group practice.
- The patient leaves her care with your group practice before the global OB care is complete.
- The patient misses all postpartum visit appointments (“no show”).
- The patient must be referred to a provider from another group practice or a different licensure (e.g., midwife to MD) for a cesarean delivery.
- The patient has an unattended, precipitous delivery.
- Termination of pregnancy without delivery (e.g. miscarriage, ectopic pregnancy).

Additional information about billing in these circumstances is provided below under “Billing a Split OB Package.”

It is the provider’s responsibility to obtain information from the patient if the patient has received antepartum care elsewhere or is concurrently seeing another provider for antepartum care. A single visit for evaluation to confirm a pregnancy is not considered prior antepartum care.

If patient starts antepartum care late in the pregnancy, but your clinic is the only source of antepartum care and at least five antepartum visits have occurred before delivery, then the global maternity codes must be used.

G. Billing a Split OB Package

CPT codes for antepartum care only, delivery only, delivery including postpartum care, and postpartum care only are provided for use when criteria is met for splitting the global OB package. Report the services performed using the most accurate, most comprehensive procedure code available. No code exists for delivery including antepartum care without postpartum care.

Antepartum care only, 1 to 3 visits	--	Use the appropriate Evaluation and Management (E/M) codes. Select level based upon the history, examination, and medical decision making documented in the record for that visit.
Antepartum care only, 4 to 6 visits	--	Use CPT code 59425. Units = 1.
Antepartum care only, 7 or more visits	--	Use CPT code 59426. Units = 1.
Postpartum care only	--	Use CPT code 59430. Units = 1.

Delivery only -- See CPT book. Code selection based on type of delivery.
Delivery, including -- See CPT book. Code selection based on type of delivery.
postpartum care

1. Change of insurance during pregnancy.

When a patient changes insurance during her antepartum care but stays with the same group practice for her care, the visits performed during her eligibility with carrier A will be billed to carrier A, and the visits performed during her eligibility with carrier B will be billed to carrier B, along with the delivery and postpartum care if performed by the clinic/group. All services to carrier B will be billed with the delivery date as the date of service.

Example # 2:

The patient presents to your clinic for obstetrical care in the 8th week of her pregnancy. She is seen monthly, and in her 21st week she has a change of insurer. She continues to be seen monthly for the remainder of her first 28 weeks, then biweekly to 36 weeks, and then weekly until her delivery at 39 weeks for a total of 13 visits. The clinic performs the vaginal delivery and provides the postpartum care.

The billing office bills the first four visits to carrier A with CPT code 59425 using the date of the first visit as the From date and the date of their last visit before the change in insurance as the To date. The additional 9 visits are billed to carrier B with CPT code 59426. This claim also bills the delivery and postpartum care with CPT code 59410. The delivery date must be used as the date of service for all services on both claims.

Example # 3:

The patient presents to your clinic for obstetrical care in the 8th week of her pregnancy. She is seen monthly for the first 28 weeks, then biweekly to 36 weeks, and then weekly until her delivery before her 40-week visit for a total of 13 visits. She has a change of insurer between her 36-week and 37-week visits. The clinic performs a cesarean section delivery and provides the postpartum care.

The billing office bills the first ten visits to carrier A with CPT code 59426 using the date of the first visit as the From date and the date of their last visit before the change in insurance as the To date. The final three visits (weeks are billed to carrier B with individual E/M codes using the date of each visit as the date of service for those line items. This claim also bills the cesarean delivery plus postpartum care with CPT code 59515 using the delivery date for the date of service.

2. Transfer of Antepartum Care.

Patients change OB provider groups during antenatal care for a variety of reasons, which may include relocating to another city, personal preference, or developing high-risk conditions requiring a specialized OB provider for the remainder of their antenatal care.

When a patient changes clinics during her antepartum care, each clinic bills the insurer for the services performed.

- a. First OB practice group (before the patient transferred care to another clinic).
 - i. When fewer than four antepartum care visits have been performed, the visits are billed using evaluation and management (E/M) visit procedure codes. Each visit is billed with a separate E/M code and the date of service the visit occurred, and the E/M level is selected based upon the history, examination, and medical decision making documented in the record for that visit.
 - ii. If four or more visits have been performed, the appropriate antepartum care only code is reported (4 to 6 visits, use CPT code 59425) (7 or more visits, use CPT code 59426). The date of service is reported as a range, with the date of the first visit in the From date field and the date of the last visit in the To date field.
- b. Second OB practice group (patient transfers care to this clinic and delivery is performed).

The clinic who completed the antepartum care and delivery reports an antepartum care only code or individual E/M visits based on the number of antepartum visits performed, and bills the appropriate delivery including postpartum care code based on the type of delivery.

Example # 4:

The patient presents to Dr. Anderson's clinic for obstetrical care in the 8th week of her pregnancy. She is seen monthly, and in her 21st week she moves to another city and establishes care with Dr. Baker. Dr. Anderson's office sends copies of her records to Dr. Baker's office. Dr. Baker sees her monthly for the remainder of her first 28 weeks, then biweekly to 36 weeks, and then weekly until her delivery at 39 weeks for a total of 13 visits. Dr. Baker performs the vaginal delivery and provides the postpartum care.

Dr. Anderson's billing office bills the first four visits to the insurer with CPT code 59425 using the date of the first visit as the From date and the date of her fourth visit as the To date.

Dr. Baker's billing office performed 9 visits after the transfer of care and bills for these services with CPT code 59426. This claim also bills the delivery and postpartum care with CPT code 59410 on the same claim. The delivery date is used as the date of service for all these line items.

3. Delivery by Another Group Practice

A variety of circumstances may result in one physician group practice providing antepartum care and another physician from an unrelated group practice performs the delivery. Again, each group practice bills for the services performed.

Example # 5:

The patient has received antepartum care with Dr. Smith but delivers unexpectedly while visiting family out of town. Dr. Davison, who is unaffiliated with Dr. Smith's office,

provides the delivery care. The patient returns home to receive her postpartum care from Dr. Smith.

Dr. Smith's billing office bills for the antepartum and postpartum services provided by Dr. Smith. Dr. Davison's office bills for a delivery only. The specific code will be based on the type of delivery.¹⁰

4. Precipitous Delivery

If the patient delivers vaginally prior to admission or prior to the physician/midwife's arrival, the delivery charge cannot be billed. The delivery or global maternity service also may not be reported with modifier 52. (RPM003 ^F) If the provider arrives in time to deliver the placenta, CPT code 59414 (*Delivery of placenta, separate procedure*) may be reported. (AMA²) The antepartum care only, and postpartum care only procedure codes may also be reported as appropriate.

Thus, if the patient has a precipitous delivery but all of the patient's routine obstetric care was provided, the services must be reported with the antepartum care code, the postpartum care code, and the delivery of placenta service code (if performed).

5. Miscarriage or Other Termination of Pregnancy

Sometimes the patient is receiving antepartum care and the unexpected happens (e.g., the patient miscarries or has an ectopic pregnancy which ruptures). In these cases, the billing office must carefully review the record and bill only for the number of antepartum visits performed (1 – 3 use E/M codes; 4 – 6 use 59425; 7 or more use 59426) and any other separately eligible antepartum services the patient received. Any surgical care which is needed is also eligible to be separately reported. The surgical global period for that service applies.

6. Transfer from Midwife to MD within same group practice.

A midwife may provide antepartum care and manage early labor and then the patient may need to be transferred to the care of a physician for further care and delivery, whether vaginal or cesarean. In these situations, the maternity global may be split.

- The midwife reports the antepartum care, and postpartum care if performed.
- The physician reports the delivery services, and postpartum care if performed.
- Payment to the midwife for the pre-delivery management of labor is handled via the clinic's internal accounting process (e.g., similar to call-share coverage payments).

7. Patient misses all postpartum visit appointments ("no show").

When the patient is scheduled for postpartum visits but does not keep any of the postpartum visit appointments during the Maternity Global Period, then a global maternity procedure code may not be billed because the postpartum care for the global OB period was not completed. In this situation, only the portion(s) of the maternity care performed may be billed.

- Report the appropriate antepartum care code (59425, 59426) if performed.
- Report the appropriate delivery only procedure code (59409, 59514).

8. For other scenarios, refer to the CPT manual for the correct coding.

H. High-Risk Pregnancy and/or Complications of Pregnancy

1. CPT guidelines for maternity care and delivery specify that normal antepartum care includes monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery.
2. For the patient at risk who is seen more frequently or for other medical/surgical intervention, the visits included in the schedule above are included in the global OB package.
3. The *additional* necessary visits *only* may be reported separately. See examples below. Select a code representing the appropriate level of Evaluation and Management service. The documentation must reflect the necessity of these visits as well as any additional laboratory or radiologic tests performed.

4. Examples:

Example # 6:

Patient is seen at 12 weeks gestation and would not routinely be seen again until 16 weeks. Another visit is performed at 14 weeks gestation, due to High-Risk needs.

- The visit at 12 weeks is the first visit of the month and is included in the routine visit schedule. Reimbursement for the 12-week visit is included in the global OB package; do not separately report.
- The 14-week visit is not on the routine schedule, is the second visit of the month, and is eligible to be reported separately.

Example # 7:

Patient is seen at 28 weeks gestation and would not routinely be seen again until 30 weeks. Another visit is performed at 29 weeks gestation, due to high-risk needs.

- The visit at 28 weeks is the first visit of the month and is included in the routine visit schedule. Reimbursement for the 28-week visit is included in the global OB package; do not separately report.
- The 29-week visit is not on the routine schedule and is eligible to be reported separately.

Example # 8:

Patient is seen twice a week from 37 weeks gestation onward, due to high-risk needs. The routine OB package only includes weekly visits at this stage of pregnancy.

- The first visit each week is included in the routine visit schedule. Reimbursement is included in the global OB package; do not separately report.
- The second visit each week is not on the routine schedule and is eligible to be reported separately.

5. Surgical care during the antepartum period may be coded and reimbursed separately. This could include incompetent cervix, hernia repair, appendicitis, etcetera.

6. Delivery of High-Risk Pregnancy

When a patient who is considered high-risk during her pregnancy has an uncomplicated delivery with no special monitoring or other activities, the delivery is to be coded as usual. Use of a -22 modifier is not supported for an uncomplicated delivery such as this. With regard to "high-risk" pregnancy, there are no codes to indicate the level of "risk." *CPT* designates procedure codes; therefore, only services provided, not potential risks, are coded. (AMA⁷)

I. Services Not Bundled in the Global OB Package

Some procedures are not bundled with the global maternity package and may be reported at the time of service. Physicians may perform these procedures during routine antepartum or postpartum OB visits or schedule them as separately identifiable visits. However, do not bill a separate E/M visit performed on the same day as a planned procedure. Common separately eligible ancillary procedures and services include the following: (JustCoding News¹⁰)

- Obstetric ultrasound
- Cerclage
- Insertion of a cervical dilator
- Echocardiography
- External cephalic version done in the clinic
- Fetal biophysical profile
- Administration of Rh immune globulin
- Amniocentesis
- Fetal nonstress test (NST)
- Routine OB/maternity laboratory services such as HIV testing, Blood glucose testing, sexually transmitted disease screening, and antibody screening such as for Rubella or Hepatitis
- Blood typing and Rh factors
- Thyroid testing
- Fetal scalp blood sampling.
- External cephalic version.
- Administration of regional anesthesia (e.g., epidural).
- Tubal ligation performed at the same operative session as cesarean delivery, or later during the postpartum period.
- Management of inpatient or outpatient problems complicating pregnancy (e.g., diabetes, hypertension, toxemia, premature rupture of membranes, etc.).
- Complications of pregnancy or delivery which require additional trips to the operating room. Report with modifier 78. (CMS¹¹)
- Surgical care during the antepartum period may be coded and reimbursed separately. This could include incompetent cervix, hernia repair, appendicitis, etcetera.

J. Midwife Care

1. Eligible providers

Our Standard Plans consider midwives to be eligible providers when they are who are licensed and certified in the state where they practice, including, but not limited to:

- a. Certified Nurse Midwife (CNM)

- b. Nurse Practitioner Midwife (NPM)
- c. Certified Professional Midwife (CPM).
- d. Certified Midwife (CM).
- e. Licensed Direct-Entry Midwife (LDM, LDEM).

2. Providers which are not eligible

Other types of non-licensed, non-certified midwives and/or birth providers are not considered eligible providers, including, but not limited to:

- a. Practical midwife.
- b. Lay midwife.
- c. Trained birth attendant.
- d. Doula.

3. Provider Taxonomy and Specialty for Midwives

All providers who provide Maternity and obstetrics care are considered to be in the same specialty for billing and coding purposes, regardless of the level of licensure of the various providers involved.

- a. Midwives are in the exact same specialty as an MD who is also providing antepartum, labor and delivery, and postpartum care.
- b. Taxonomy codes 207V00000X – Obstetrics and Gynecology (for an MD/DO) and 367A00000X – Advanced Practice Midwife are both considered to be the exact same specialty. The difference in taxonomy codes is created by a different licensure level between a midwife and a physician, not a different specialty.
- c. For example, per CPT coding guidelines, when a patient is seen in the office and subsequently admitted to the hospital, all of the office evaluation is included in the initial hospital visit E/M code and may not be billed separately. If the midwife saw the patient at home or in the office and determined a hospital admit to an MD care in the same Obstetric clinic was needed, the physician's E/M service includes the midwife's E/M services in the pre-hospital setting; these are two practitioners of the same clinic and same specialty, and do not qualify for billing separate visit codes.

4. Labor Care by Midwife When Care Transferred to MD for Delivery

A patient may be laboring with a midwife in attendance providing labor care and then need to be transferred to the care of a physician for further care and delivery, whether vaginal or cesarean. Management of labor including fetal monitoring is considered part of intrapartum care and delivery ([see section E.2](#)). No CPT code exists to report management of partial labor prior to transfer of care to the physician.

- a. The midwife reports the antepartum care.
- b. The physician reports the delivery services.
- c. Whomever performs the postpartum care (midwife or MD) reports the postpartum care code.

d. For the midwife's pre-delivery management of labor:

- i. If the midwife and physician are in the same group practice, payment to the midwife for the pre-delivery management of labor is handled via the clinic's internal accounting process (e.g., similar to call-share coverage payments).
- ii. If the midwife and physician are in different group practices (different clinic name, different tax ID numbers), the midwife's pre-delivery management of labor is considered included in the antepartum care and is not eligible to be separately reported.

5. Home Visits

Home visits for antepartum care or for postpartum care are billed in the same way as office visits for antepartum and postpartum care. These home visits are included in the global service codes or the antepartum and postpartum service codes. Home visits are only eligible to be separately reported when they exceed the frequency specified by the CPT guidelines for services included in the global OB/Maternity Package.

6. Home Births

Eligible professional fees by the Certified Nurse Midwife or Nurse Practitioner Midwife are eligible for coverage. Other home birth expenses are not eligible for reimbursement and are generally excluded by the member's contract. This includes but is not limited to: travel, portable hot tubs, supplies, and transportation of equipment, etc.

K. Multiple Gestation Guidelines (Twins, Triplets, etc.)

1. Obstetrical Ultrasounds

Obstetrical ultrasound code descriptions (76801 – 76828) specify "single or first gestation," "each additional gestation," "per fetus," "fetal," etc. In some cases, the CPT book also includes parenthetical guidelines instructing how to bill the service for the second fetus. These guidelines must be followed when submitting claims for multiple gestations.

Procedure codes which specify "single or first gestation" may not be billed with two units to report procedures for twins. These procedure codes allow a maximum of one (1) unit per date of service. Additional billed units will be denied. The exam for the second fetus must be reported with the "each additional gestation" procedure code.

Example # 9:

76801 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation)

76802 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure))

Patient is seen for initial ultrasound including determination of the number of gestational sacs and fetuses and to take gestational/fetal measurements.

- For first gestation/fetus, bill 76801 x 1 unit.
- For twins (one additional gestation/fetus), bill with 76802 x 1.
- For quadruplets (three additional gestations/fetuses), bill with 76802 x 3.

Example #10

76815 (Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses)

A mother pregnant with twins is seen for a limited ultrasound to determine placental location, fetal position and/or qualitative amniotic fluid volume.

- The code description for a limited scan is performed (76815), is “1 or more fetuses.”
- Report 76815 x 1 unit to cover scans of both twins.
- 76816 and indicate number of fetus’ in units (76815 x2 for twins)

Example #11

76816 (Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus)

A mother pregnant with twins is seen for a follow-up ultrasound for a re-evaluation to check the growth of both twins.

- The code description for a follow-up scan is performed (76816), is “per fetus.”
- Report 76816 x 2 units to cover scans of both twins.

Example #12

76818 (Fetal biophysical profile; with non-stress testing)

76819 (Fetal biophysical profile; without non-stress testing)

A mother pregnant with twins is seen for a fetal biophysical profile of both twins.

- The unit of service is per fetus profiled.
- Fetal biophysical profile assessments for the second and any additional fetuses, may be reported separately by code 76818 or 76819 with modifier -59 or -XS appended. (AMA¹²)
- For twins with non-stress testing, report 76818 x 1 and 76818-XS x 1.

2. Delivery of Multiple Gestations

Global billing for multiple gestations must include one global procedure code and a “delivery only” code for each subsequent delivery. The specific codes submitted will depend on the method of delivery and number of infants delivered. When submitting claims for deliveries of more than one newborn, Moda Health requires that all delivery charges, any global services, and any additional surgical services from the date of delivery (e.g. 58611 *tubal at time of cesarean delivery*) be submitted on the same claim. The appropriate diagnosis code for the multiple gestations must be reported.

Multiple surgery fee reductions apply to multiple delivery services for multiple gestations. The code submitted for the second delivery and any subsequent deliveries must include a modifier 51 and a modifier 59 to indicate separate newborn. In most cases the delivery of the first newborn is considered primary and allowed at 100% and the delivery of all subsequent newborns are considered secondary and reimbursed at 50% of the contracted allowable. An exception to this rule may occur if the global OB service cannot be billed for the first newborn and the subsequent newborn is delivered by cesarean.

The table below provides a summary of billing examples for multiple gestations, depending upon whether the deliveries are performed vaginally, via cesarean, or a combination of both. This summary addresses only scenarios where a global OB procedure code is appropriate:

Delivery Method	First Newborn	Subsequent Newborn(s)	Coding / Reimbursement
Vaginal	59400	59409-51-59	Deliveries of the subsequent newborns are reimbursed at 50% for multiple procedure reductions.
Vaginal Birth After Cesarean (VBAC)	59610	59612-51-59	Deliveries of the subsequent newborns are reimbursed at 50% for multiple procedure reductions.
Vaginal delivery(ies) followed by Cesarean delivery(ies)	59400 (vaginal) or 59610 (VBAC)	59514-51-59 or 59620-51-59	If two or more newborns are delivered vaginally and subsequent newborn(s) are delivered by Cesarean, use the appropriate vaginal global OB code, the appropriate vaginal delivery-only code (see above), and then the appropriate Cesarean delivery-only code (59514 or 59620) for each subsequent newborn delivered by cesarean. Deliveries of the subsequent newborns are reimbursed at 50% for multiple procedure reductions.
Cesarean delivery (all babies) Elective or after failed vaginal delivery (not VBAC attempt)	59510	No separate code. 59510 includes delivery of all gestations. If significant extra difficulty, append modifier -22 and submit explanation and op report with claim.	"If both twins are delivered via cesarean delivery, then report code 59510, Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, since only one cesarean delivery is performed. If the cesarean delivery is significantly more difficult, then append modifier '-22' to code 59510. When reporting modifier '-22' with 59510, a copy of the operative report should be submitted to the third-party payer with the claim." (AMA ¹)

Delivery Method	First Newborn	Subsequent Newborn(s)	Coding / Reimbursement
Attempted VBAC unsuccessful, cesarean delivery of all babies	59618	59620-51-59	Deliveries of the subsequent newborns are reimbursed at 50% for multiple procedure reductions.

L. Assistant Surgeon Charges (Single or Multiple Births)

Assistant surgeon charges are eligible for cesarean delivery-only codes. Assistant surgeon charges are denied for cesarean delivery global service codes or delivery including postpartum care, because the assistant surgeon service is limited to the surgery only and does not extend to the antepartum or postpartum care. (AMA⁸) A maximum of one assistant surgeon is eligible for reimbursement.

When billing assistant surgeon charges, please use the appropriate modifier(s) for each delivery. Assistant surgeon reimbursement will be a percentage of the primary physician's contracted rate, subject to the member's contract benefits.

Vaginal and VBAC deliveries are not eligible for assistant surgeon; these procedure codes are assigned an assistant surgeon indicator of "0" on the Medicare Physician Fee Schedule Database (MPFSDB). Claims for assistant surgeon services for vaginal deliveries will be considered on appeal only. Submit the written appeal to the attention of Provider Appeals in accordance with the provider appeals process. Phone requests for adjustment will not be considered.

M. Anesthesia for unplanned cesarean delivery or hysterectomy (01967 / 01968, 01969)

When neuraxial analgesia/anesthesia (e.g., spinal, epidural) is provided for a planned vaginal delivery which ultimately results in a cesarean delivery or an emergency cesarean hysterectomy, two anesthesia procedure codes must be reported. 01967 is the primary/"parent" code, and 01968 or 01969 are the related add-on codes.

Add-on codes normally are required to be billed by the same provider and on the same date of service as the principle/primary procedure code. However, special considerations apply to unplanned cesarean deliveries. Therefore, Moda Health will allow 01968 and 01969 even when 01967 has been billed for the preceding date of service or by a different provider or provider group.

Rationale:

When the neuraxial labor analgesia/anesthesia is initiated prior to midnight, and the cesarean delivery or cesarean hysterectomy is performed after midnight, the total anesthesia service is provided as a continuous service, but the two portions actually occur on different, sequential dates. Thus, the primary/"parent" code 01967 may legitimately be billed for a different date of service immediately preceding the date for the add-on code(s).

When a cesarean delivery is performed after a lengthy vaginal labor, the vaginal neuraxial analgesia/anesthesia (01967) and the cesarean anesthesia (01968, 01969) may be performed and billed by two separate anesthesia providers.

N. Nitrous Oxide for Pain Management During Labor

1. The use of nitrous oxide inhaled gas for pain management during labor is separately reimbursable when:
 - a. Performed by a physician anesthesiologist or certified registered nurse anesthetist (CRNA).
 - b. Submitted with CPT code 01999 (Unlisted anesthesia procedure). (AMA²³)
 - c. Appropriate medical records documentation of the anesthetic procedure and services performed must be available for review upon request.
2. Nitrous oxide during labor is not eligible for reimbursement and will be denied to provider responsibility when any of the following occur:
 - a. Submitted with CPT codes:
 - i. 01960 (Anesthesia for vaginal delivery only).
 - ii. 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)).
 - iii. 99151-99157 (Moderate conscious sedation codes).
 - b. Performed by:
 - i. Naturopathic physicians (NDs).
 - ii. Registered nurses (RNs who are not CRNAs).
 - iii. Other provider types outside of anesthesiologist or CRNA.
3. The above decisions have been made with the input of a same specialty medical physician consult review. (Various^{14, 15, 16, 17, 18, 19, 20, 21, 22})

O. Birthing Centers

1. Birthing centers are expected to bill a global packaged service, not hourly or per diem charges. The coding described below includes immediate postpartum care for both the mother and the baby.

Note, Medicare documentation and guidelines do not address birthing center coding and billing. Therefore, we reference Medicaid guidelines as our source for birthing center billing and coding. (OHA¹³, TMHP²⁴)

 - a. Single gestations – Report procedure code 59409 only once for a single vaginal delivery, regardless of the total days that the client was in the facility for labor management, delivery and immediate postpartum care.
 - b. For delivery of twins or multiple gestations –
 - i. Oregon & Alaska plans:
 - 1) Report procedure code 59409 for the delivery of the first twin.
 - 2) On a separate line item, report procedure code 59409 with a modifier indicating a separate and distinct procedure (e.g. -XS, -59) for the delivery of the second twin.

- 3) No additional codes or units may be reported, regardless of the total days that the client was in the facility for labor management, delivery, and immediate postpartum care.
 - ii. Texas plans:
 - 1) Report procedure code 59409 for the delivery of all babies. No provision is made for billing additional units for the delivery of multiple gestations in the Texas Medicaid guidelines for birthing centers. (TMHP²⁴)
 - 2) No additional codes or units may be reported, regardless of the total days that the client was in the facility for labor management, delivery, and immediate postpartum care.
 - c. For management of labor only –
When labor was managed in the birthing center but delivery did not result (e.g., mother was transferred to the hospital for cesarean delivery, etc.), the birthing center may report procedure code S4005 and attach a report documenting the circumstances.
 - d. Postpartum care. No separate charges may be submitted for postpartum care. These services are included in the facility fee for the labor and delivery.
 - e. Newborn care. No separate charges may be submitted for newborn care. These services are included in the facility fee for the labor and delivery.
2. If the facility employs the midwife, a separate claim may be submitted for the midwife's professional services. List the midwife as the rendering provider (not the birthing facility) on the claim for professional services.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
AHA	=	American Hospital Association
AMA	=	American Medical Association
AROM	=	Artificial Rupture Of Membranes
CM	=	Certified Midwife
CMS	=	Centers for Medicare and Medicaid Services
CNM	=	Certified Nurse Midwife
CPM	=	Certified Professional Midwife
CPT	=	Current Procedural Terminology
E/M	=	Evaluation and management (services, visit)
EHR	=	Electronic Health Record
EOCCO	=	Eastern Oregon Coordinated Care Organization

Acronym		Definition
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HEDIS	=	Healthcare Effectiveness Data and Information Set
HIPAA	=	Health Insurance Portability and Accountability Act
HIV	=	Human Immunodeficiency Virus
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
LDEM	=	Licensed Direct-Entry Midwife
LDM	=	Licensed Direct-Entry Midwife
MD	=	Medical Doctor
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
NPI	=	National Provider Identifier
NPM	=	Nurse Practitioner Midwife
NST	=	Non-stress test, fetal
OB	=	Obstetric, Obstetrics, Obstetrician
OHA	=	Oregon Health Authority
RVU	=	Relative Value Unit
VBAC	=	Vaginal Birth After Cesearean

Definition Of Terms

Term	Definition
High-Risk Maternity	Maternity care complicated by a documented condition during the patient's pregnancy requiring direct face-to-face practitioner care beyond the usual service.
Maternity Global	Services provided in uncomplicated maternity cases including antepartum care, delivery and postpartum care.
Maternity Period	For billing purposes, the obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period (45 days after vaginal delivery).
Precipitous Delivery	The patient delivers the baby vaginally prior to admission or prior to the physician/midwife's arrival.

Code Definitions

Code	Code Description
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
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
59412	External cephalic version, with or without tocolysis
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
59514	Cesarean delivery only;
59515	Cesarean delivery only; including postpartum care
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
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
S4005	Interim labor facility global (labor occurring but not resulting in delivery)

Coding Guidelines

The delivery date is used as the date of service for:

- Any OB global code
- Most antepartum care codes. (See [Transfer of Antepartum Care](#))

- Any delivery-only code
- Any delivery + postpartum code
- Any postpartum care only code.

“If both twins are delivered via cesarean delivery, then report code 59510, Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, since only one cesarean delivery is performed. If the cesarean delivery is significantly more difficult, then append modifier '-22' to code 59510. When reporting modifier '-22' with 59510, a copy of the operative report should be submitted to the third-party payer with the claim.” (AMA¹)

The answers to most obstetrical billing questions can be found in the “*Physician’s Current Procedural Terminology (CPT)*” manual or the CPT Assistant Archives (1990 – present). Maternity Care and Delivery is a subsection of the **Surgery** section of the CPT book codes. An understanding of the global package services is needed to code Maternity Care and Delivery Services correctly. For additional resources on CPT coding, contact the American Medical Association (AMA) order desk at (800) 621-8335.

Cross References

- A. “Global Surgery Package for Professional Claims.” Moda Health Reimbursement Policy Manual, RPM011.
- B. “Modifier 22 – Increased Procedural Services.” Moda Health Reimbursement Policy Manual, RPM007.
- C. “Therapeutic Drug Monitoring.” Moda Health Medical Necessity Criteria.
- D. “Modifier 51 - Multiple Procedure Fee Reductions.” Moda Health Reimbursement Policy Manual, RPM022.
- E. “Add-on Codes.” Moda Health Reimbursement Policy Manual, RPM025.
- F. “Modifier 52 – Reduced Services.” Moda Health Reimbursement Policy Manual, RPM003.

References & Resources

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4. American Medical Association. “Maternity Care and Delivery/Surgery, 59400 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, February 2003, p. 15.

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Background Information

Maternity care refers to the health care treatment given in relation to pregnancy and delivery of a newborn child. Maternity care services include care during the prenatal period, labor, birthing, and the postpartum period. The care given to the newborn child after it is delivered is newborn care; it is not included in the maternity care services or the global maternity package.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB

Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****