



Corporate Medical Policy

Guidelines for Global Maternity Reimbursement

File Name: guidelines_for_global_maternity_reimbursement
Policy Number: ADM9065
Origination: 10/2003
Last Review: 4/2008
Next Review: 4/2009

Description of Procedure or Service

Maternity care includes prenatal care, labor and delivery and post-delivery care. Prenatal care is all care related to the pregnancy before the baby's birth. Post-delivery care is all care for the mother.

Global maternity care includes routine antepartum care, delivery and postpartum care. Other antepartum services such as 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 certificate 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 post delivery care.

B. Prenatal, Delivery and/or Postpartum Services Billed Separately

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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. the member switches doctors.

C. Multiple Births

Benefits for multiple deliveries will be based on multiple surgery guidelines (100% and 50%) for dates of service effective 10/1/2003.

The correct method of reporting multiple deliveries is as follows:

1. Global maternity care, vaginal delivery
 - a. First baby
 - i. File 59400 Routine obstetric care including ante partum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care. (100%)
 - b. Subsequent baby(s)
 - i. File 59409-51 Vaginal delivery only (with or without episiotomy and/or forceps) If more than one subsequent baby is delivered the number should be indicated in the units field. (50%)
 - 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.
2. Global maternity care, cesarean delivery
 - a. First baby
 - i. File 59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care (100%)
 - b. Subsequent baby(s)
 - i. File 59514-51 Cesarean delivery only. If more than one subsequent baby is delivered the number should be indicated in the units field. (50%)
 - c. If antepartum and/or postpartum care were not provided, then procedure code 59410 should be reported reflecting the appropriate number of deliveries in the units fields.
3. Global maternity care after previous cesarean delivery, vaginal delivery
 - a. First baby
 - i. File 59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery. (100%)
 - b. Subsequent baby(s)
 - i. File 59612 -51 Vaginal delivery only, after previous cesarean delivery with or without episiotomy, and/or forceps). (50%)
 - 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. Global maternity care after previous cesarean delivery, cesarean delivery
 - a. First Baby
 - i. File 59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery. (100%)

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- b. Subsequent Baby(s)
 - i. File 59620 - 51 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery. (50%)
- 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.

D. Referral to Perinatologist

When a member is referred to a perinatologist, that perinatologist office should bill the Evaluate and Management Consult Code (99241-99245) with the diagnosis the member was referred for (not the maternity diagnosis).

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.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Policy Key Words

Key Words: *ADM9065*, maternity reimbursement, OB, prenatal care, labor and delivery, labor, delivery, post-delivery, postpartum.

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

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: Guidelines for Global Maternity Reimbursement

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.

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.