<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Obstetrical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>This policy addresses reimbursement for global and non-global obstetric (OB) services. Global OB care includes antepartum care, delivery services, and postpartum care. A physician, group practice or clinic that manages the patient's care throughout the entire antepartum, delivery and postpartum periods is providing global OB care.</td>
</tr>
</tbody>
</table>
| Policy Statement | Current Procedural Terminology (CPT®) codes for routine OB care fall into one of three categories:  
- Single component codes (e.g., delivery only, postpartum only)  
- Two-component codes (e.g., delivery including postpartum care)  
- Three-component, or complete, global codes (e.g., antepartum care, delivery, and postpartum care).  
Medica will provide reimbursement to physicians/providers who submit either global OB codes or individual component OB codes but not for both. Billing with CPT codes from both categories would be considered inappropriate and the component code(s) would be denied. Medica will not require the bundling of component codes. |
| Antepartum Care | Antepartum services included in global antepartum or OB care: Medica follows the American College of Obstetricians and Gynecologists (ACOG) coding guidelines which consider basic components of the global antepartum or global OB service to be:  
- Routine prenatal visits until delivery (approximately 13 for uncomplicated cases)  
- Recording of weight, blood pressures, fetal heart tones  
- Routine chemical urinalysis (CPT codes 81000 and 81002)  
- Hospital and Observation Care Evaluation and Management (E/M) services within 24 hours of delivery  
Antepartum services not included in global antepartum or OB care: Medica considers the following antepartum services to be separately reimbursable in addition to the global antepartum or global obstetric service code:  
- Confirmatory Evaluation and Management (E/M) visit to diagnose pregnancy  
- Comprehensive first OB visit  
- Laboratory tests other than routine chemical urinalysis  
- Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76820, 76821, 76825, 76826, 76827, 76828)  
- Fetal biophysical profile (CPT codes 76818 - 76819) |
• Amniocentesis, any method (CPT codes 59000 or 59001)
• Chorionic villus sampling (CPT code 59015)
• Fetal contraction stress test (CPT code 59020)
• Fetal non-stress test (CPT code 59025)

Antepartum services for complications/high risk: If a patient is seen more than 13 antepartum visits due to high risk or complications of pregnancy, these visits are not included in the global OB services and can be billed in addition to the global OB codes 59400, 59510, 59610, and 59618. Report these visits by submitting E/M codes with modifier 25, and a diagnosis code from the Complication/High Risk Diagnosis Code List.

Delivery Services
Medica follows ACOG coding guidelines which consider basic components of the delivery or global OB service to be:

• Admission to the hospital
• Admission history and physical examination
• Management of labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery, external and internal fetal monitoring provided by the attending physician
• IV induction of labor via oxytocin. Under normal circumstances, the physician does not personally start and directly supervise the induction; therefore, the service is part of the global delivery or global service.

NOTE: Insertion of cervical dilator (CPT 59200) is considered to be included in the antepartum, delivery, or global obstetric service on the same date of service as delivery.

Postpartum Care
Medica follows ACOG guidelines and considers the postpartum period to be 42 days following the date of the cesarean or vaginal delivery.

Postpartum care included in global OB care: The following services are included in postpartum care and are not separately reimbursable services:

• Hospital visits during the delivery confinement
• Office or other outpatient visits for follow-up care and any delivery-related complications

Contraceptive management services during the postpartum period: When submitted with the following CPT codes, contraceptive management services provided during the postpartum period may be reimbursed separately:

• 11981 (insertion, non-biodegradable drug delivery implant)
• 57170 (diaphragm or cervical cap fitting with instructions)
• 58300 (insertion of intrauterine device, IUD)
NOTE: Evaluation and Management (E/M) services provided for contraceptive management are considered part of postpartum care and will not be reimbursed separately.

Multiple Gestation Deliveries
Twin deliveries: The diagnosis code identifies twin deliveries. Reporting twin deliveries follows ACOG coding guidelines as listed below. Note: Multiple procedure reductions will be applied to OB codes having a delivery component. (Refer to the Multiple Procedure Policy for additional information.)

<table>
<thead>
<tr>
<th>Type of Delivery</th>
<th>Twins 1 and 2</th>
<th>Code-Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal</td>
<td>Baby 1</td>
<td>59400</td>
</tr>
<tr>
<td></td>
<td>Baby 2</td>
<td>59409-59</td>
</tr>
<tr>
<td>Vaginal Birth after Cesarean (VBAC)</td>
<td>Baby 1</td>
<td>59610</td>
</tr>
<tr>
<td></td>
<td>Baby 2</td>
<td>59612-59</td>
</tr>
<tr>
<td>Cesarean Delivery</td>
<td>Baby 1 &amp; Baby 2</td>
<td>59510</td>
</tr>
<tr>
<td>Repeat Cesarean Delivery</td>
<td>Baby 1 &amp; Baby 2</td>
<td>59618</td>
</tr>
<tr>
<td>Vaginal Delivery + Cesarean Delivery</td>
<td>Baby 2</td>
<td>59510</td>
</tr>
<tr>
<td></td>
<td>Baby 1</td>
<td>59409-51</td>
</tr>
<tr>
<td>VBAC + repeat Cesarean Delivery</td>
<td>Baby 2</td>
<td>59618</td>
</tr>
<tr>
<td></td>
<td>Baby 1</td>
<td>59612-51</td>
</tr>
</tbody>
</table>

Triplet or Greater Deliveries: Triplet or greater deliveries are reviewed manually by Medical Claims Review (MCR) nurses.

Increased Procedural Services
Obstetrical services submitted with modifier 22 (increased procedural services) are manually reviewed. The determination to allow additional reimbursement for obstetrical services submitted with modifier 22 is based on review of documentation that supports use of the modifier. (Refer to the Increased Procedural Services policy for additional information.)

NOTE: According to ACOG guidelines, repair of a third or fourth degree laceration at the time of delivery would be reported by appending modifier 22 to the global or delivery code. If a global or two-component obstetrical code is billed in this circumstance, the standard for additional reimbursement is based on the allowable amount for the delivery component only.

Laboratory Tests
The American Medical Association (AMA), ACOG, and the Centers for Medicare and Medicaid Services (CMS) consider routine urine dipstick (chemical) analysis (CPT codes 81000 and 81002) included in global obstetric care. CPT codes 81001 and 81003 are not considered included in the global OB service, and are reimbursed when submitted with an OB diagnosis code.

Assistant Surgeon Services
For reimbursement of assistant surgeon services, append the appropriate assistant surgeon modifier to the cesarean delivery-only code (59514 or 59620). (Refer to the Assistant Surgeon Policy for additional details.)

**Prolonged Physician Services**
According to ACOG coding guidelines, prolonged services are not reported for services involving indefinite periods of time such as labor and delivery management. Therefore Medica does not separately reimburse prolonged physician services (CPT codes 99354, 99355, 99356, 99357, 99358, and 99359) for labor and delivery.

**Home Delivery**
Home delivery services are not covered by Medica.

**Definitions**

**Modifier 22** – Increased Procedural Services. When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physician and mental effort required). Note: This modifier should not be appended to an E/M service.

**Modifier 25** – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

**Modifier 51** – Multiple Procedures. When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure or service may be identified by appending modifier 51 to the additional procedure or service code.

**Modifier 59** – Distinct Procedural Service. Under certain circumstances it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual.
**Modifier XE** – Separate encounter. A service that is distinct because it occurred during a separate encounter.

**Modifier XP** – Separate practitioner. A service that is distinct because it was performed by a different practitioner.

**Modifier XS** – Separate structure. A service that is distinct because it was performed on a separate organ/structure.

**Modifier XU** – Unusual non-overlapping service. The use of a service that is distinct because it does not overlap usual components of the main service.

**Same Physician or Other Health Care Professional** – Unless stated otherwise in this policy, all physicians or health care professionals of the same group reporting the same federal Tax Identification Number.

### Code Lists

- [Evaluation and Management Code List 2018](#)
- On or after date of service 10/1/2015: [OB Related ICD-10-CM Diagnosis Code List 2018](#)
- On or after date of service 10/1/2015: [Complications High Risk ICD-10-CM Code List 2018](#)

### Resources

- Centers for Medicare and Medicaid Services (CMS)
- *CPT Assistant*, American Medical Association
- Healthcare Common Procedure Coding System (HCPCS)
- The American College of Obstetricians and Gynecologists Website ([www.ACOG.org](http://www.ACOG.org))

### Effective Date

- 01/01/2002

### Revision Updates

- 11/06/2018 Updated ICD-10-CM code lists
- 08/10/2018 Annual policy review; update ICD-10-CM code lists
- 09/22/2016 Annual policy review
- 01/01/2016 Annual code update
- 10/01/2015 Annual policy review; addition of ICD-10-CM code lists
- 01/01/2015 Accepted new X modifiers; edits will be applied to the X modifiers effective February 14, 2015

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