



Reimbursement Policy

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Reimbursement Policy NumberR11

Global Maternity/Obstetric Package

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INSTRUCTIONS FOR USE

Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy. Proprietary information of Cigna. Copyright ©2018 Cigna

Overview

This policy applies to all claims submitted on a CMS1500 claim form.

Cigna provides reimbursement for the Global Maternity/Obstetric Package when reported with the appropriate Current Procedural Terminology (CPT®) code (59400, 59510, 59610 or 59618) by a health care professional, or a group of healthcare professionals using the same Federal Tax Identification Number (TIN) when the health care professional or group provides all components of the antepartum, delivery and postpartum care. The Global Maternity/Obstetric Package is reported after delivery only. It is not appropriate to report the antepartum, delivery or postpartum care separately unless only certain services comprising the Global Maternity/Obstetric Package are provided.

Cigna will provide reimbursement for components of the Global Maternity/Obstetric Package when reported with the appropriate CPT® code for partial care and when the healthcare professional or group provides only part of the Global Maternity/Obstetric Package (e.g.: only the delivery is performed).

Reimbursement Policy

Cigna recognizes the following services as included in the Global Maternity/Obstetric package:

- All routine prenatal visits and routine prenatal high-risk visits. Routine prenatal visits and routine prenatal high-risk visits include but are not limited to the recording of weight, blood pressure, fetal heart tones and routine chemical urinalysis (CPT® codes 81000, 81002)
- Routine postpartum visits
- Management of hospital observation for up to 48 hours for the evaluation of latent phase of labor ("labor check") or uterine contractions without cervical dilatation ("false labor")
- Admission to the hospital including the admission history and physical examination
- Insertion of pharmacologic agents for cervical ripening or placement of mechanical cervical dilation devices prior to induction of labor (CPT® code 59200)
- Administration of intravenous pitocin or oxytocin for induction of labor (CPT® codes 96365-96367)
- Injection of local anesthesia (CPT® codes 64430, 64435)
- Catheterization or catheter insertion (CPT® codes 51701, 51702)
- Placement of internal fetal and/or uterine monitors
- Episiotomy and associated repair
- Management of uncomplicated labor
- Vaginal or cesarean delivery (with or without forceps and/or vacuum extraction) – limited to single gestation (multiple gestation-See the Cigna Multiple Birth Reimbursement Policy)
- Simple removal of cerclage prior to delivery
- Repair of lacerations
- Delivery of placenta (CPT® code 59414)
- Routine inpatient visits following delivery
- Routine outpatient visits for postpartum care

Cigna will reimburse specific medically indicated services outside of the Global Maternity/Obstetric Package, including but not limited to the following:

- Initial Evaluation and Management (E&M) visit to confirm pregnancy when reported with an E&M service code and the diagnosis code Z32.01*.
- E&M visits for complications of pregnancy when only the diagnosis code(s) for the complication(s) of pregnancy are reported (do not report routine prenatal and routine prenatal high-risk diagnosis code(s) in addition to the code(s) for the complication(s) of pregnancy). Complications of pregnancy should be billed after delivery and only when the complication results in additional prenatal visits beyond the average of 13.
- Administration of injections (CPT® code 96372) including but not limited to RhoGAM (CPT® codes 90384, 90385) and 17-Hydroxyprogesterone Caproate**
- Administration of Vaccines (CPT® codes 90460-90474) including but not limited to CPT® codes 90632, 90636, 90656, 90658, 90662, 90670, 90714, 90732, 90740, 90746, 90747)**
- Administration of IV infusions including but not limited to hydration (CPT® codes 96360, 96361)**
- E&M visits for conditions unrelated to pregnancy (including but not limited to asthma, upper respiratory infection) when only the diagnosis code(s) for the condition(s) are reported (do not report routine prenatal, routine prenatal high-risk, or routine postnatal diagnosis code(s) in addition to the code(s) for the condition(s) unrelated to pregnancy)
- Amniocentesis (CPT® code 59000 or 59001)
- Amnioinfusion (CPT® code 59070)
- Chorionic Villus Sampling (CPT® code 59015)
- Cordocentesis (CPT® code 59012)
- Fetal contraction stress test (CPT® code 59020)
- Fetal non-stress test (CPT® code 59025)

- **Fetal scalp blood sampling (CPT® code 59030)**
- **External cephalic version (CPT® code 59412)**
- **Administration of regional anesthesia (e.g.: epidural) (CPT® code 01967)**
- **Maternal/fetal ultrasounds (CPT® codes 76801-76817, 76820, 76821)**
- **Echocardiography (CPT® codes 76825-76828)**
- **Laboratory tests excluding routine chemical urinalysis**
- **Fetal biophysical profile (CPT® codes 76818-76819)**

Cigna will reimburse an Assistant Surgeon during cesarean delivery when billed with a non-global cesarean delivery code (CPT® code 59514 or 59620) and when submitted with an appropriate assistant surgeon modifier. See the Cigna reimbursement policy MAS – Assistant Surgeon – Modifiers 80, 81, 82, Assistant-at-Surgery – Modifier AS, Co-Surgeon (Two Surgeons) – Modifier 62, Surgical Team – Modifier 66 Policy.

*Application of coinsurance/copayments varies based upon the specific benefit plan. Many benefit plans only apply the coinsurance/copayment to the initial E&M visit to confirm pregnancy. The services indicated in this policy as outside of the Global Maternity/Obstetric Package may not require coinsurance/copayment. Please refer to the applicable benefit plan document to determine coinsurance/copayment responsibilities.

** Immunizations, injections and infusions should only be reported with the service code for the administration and the drug/medication/vaccine which was administered. A separate E&M service code should not be reported unless the E&M and the procedure are individually and separately identifiable and when supporting documentation satisfies the key component criteria for the level of the E&M service provided as defined by the Centers for Medicare and Medicaid Services (CMS) in the 1997 Documentation Guidelines. Such documentation should be maintained and available upon request. See the Modifier 25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service Policy

General Background

Cigna agrees with the American Medical Association's (AMA) definition of the "total obstetric package" as including "the provision of antepartum care, delivery and postpartum care."

Antepartum care includes initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery (approximately 13 visits for a routine pregnancy).

Delivery includes admission to the hospital, admission history and examination, management of uncomplicated labor, simple removal of previously placed cerclage, vaginal delivery (with or without episiotomy, with or without forceps) or cesarean delivery.

The postpartum time period is considered six weeks after vaginal delivery and eight weeks after cesarean delivery. For routine cases, this includes one visit at six weeks postpartum following a vaginal delivery and two to three post-partum visits following a cesarean delivery. This may also include additional visits for surveillance of potential problems. During surveillance for a potential postpartum problem, if no problem actually develops, the physician is not to report the additional visits. Management of postpartum complications should be reported with the appropriate E&M service code and only the applicable diagnosis code for the complication (do not report routine postpartum care codes in addition to the code for the postpartum complication).

Partial maternity/obstetric care services:

Occasionally, a physician or other healthcare professional will provide only a portion of the Global Maternity/Obstetric Package. When this occurs, the appropriate CPT® code for the partial care services should

be reported in order to receive separate reimbursement. Below are examples of instances when only a portion of the total obstetric package of services are provided and may be reported separately:

Antepartum care only: CPT® codes 59425 (4-6 visits) and 59426 (7 or more visits) are used to report antepartum care only and should be reported only once. A physician or other healthcare professional should report one of these codes when antepartum care services only were provided; delivery and postpartum care services were not rendered.

Note: when only the first one to three antepartum visits are provided, these visits should be reported with the appropriate E&M code and a routine prenatal and routine prenatal high-risk diagnosis code(s).

Situations such as spontaneous abortion and changing to another physician/healthcare professional are circumstances when it is appropriate for the reporting of antepartum care only with CPT® code 59425 or 59426.

Delivery only: CPT® codes 59409, 59514, 59612 and 59620 are used to report vaginal or cesarean delivery services only. A physician or other healthcare professional would report one of these codes when services for the delivery only were provided; antepartum and postpartum care services were not rendered.

Postpartum care only: CPT® code 59430 is used to report postpartum care only. A physician or other healthcare professional would report this code when postpartum care services only were provided; no antepartum care or delivery services were rendered. E&M codes should not be reported when only the postpartum care services are rendered.

Delivery and postpartum care only: A physician or other healthcare professional may also provide partial care which encompasses only the delivery and postpartum care. When this occurs, the appropriate partial care service code should be reported in order for separate reimbursement to occur (59410, 59515, 59614 or 59622).

Complications of pregnancy/ high risk maternity:

Complications of pregnancy are not considered routine obstetric care and are not included in the Global Maternity/Obstetric Package. Such complications can be reported in addition to the global obstetric package CPT® codes. Complications of pregnancy include, but are not limited to: hemorrhage, placenta previa, pre-eclampsia or eclampsia and severe hyperemesis.

Cigna is in alignment with the American Congress of Obstetricians and Gynecologists (ACOG) coding guidelines which indicate: "if a patient sees an obstetrician for extra visits to monitor a potential problem and no problem actually develops, the physician is not to report the additional visits; only E&M visits related to a current complication can be reported separately".

Management of complications of pregnancy should be reported with the appropriate E&M service code and only the applicable diagnosis code for the complication (do not report routine prenatal or routine prenatal high-risk diagnosis code(s) in addition to the code for the complication). These visits should be reported after delivery only when the complication results in additional prenatal visits beyond the average of 13. In addition, these visits should be appended with Modifier 25.

Conditions unrelated to pregnancy:

Individuals may receive services from the obstetrician or another healthcare professional that is providing maternity/obstetric care for conditions unrelated to the pregnancy (e.g.: influenza, upper respiratory infection). The E&M visits used to manage these conditions should be reported at the time the service is provided with only the appropriate diagnosis code for the condition (do not report routine prenatal, routine prenatal high-risk, or routine postnatal diagnosis code(s) in addition to the code for the condition unrelated to pregnancy).

Example: An individual is seen by the obstetrician for complaints of cough and head congestion at a time other than the scheduled prenatal visit. The obstetrician should report the appropriate E&M code with the diagnosis code which best describes the diagnosed condition.

Pregnancy related services from healthcare professionals other than the primary obstetrician:

Diagnosis codes associated with global maternity care (as outlined in the coding section of the policy) should only be used by health care professionals who are providing partial or all components of the antepartum, delivery and postpartum care. Health care professionals who are not providing partial or all of the global maternity care should use the appropriate diagnosis code for the condition for which they are being consulted or are treating.

Example: A pregnant woman has a history of chronic hypertension. Her primary obstetrician refers her to a maternal fetal medicine specialist for consultation.

The primary obstetrician would submit one of the following ICD10 codes:

O09.AO - O09.93: Supervision of high risk pregnancy
O34.21: Maternal care for scar from previous cesarean delivery
O36.80x0 - O36.80x9: Pregnancy with inconclusive fetal viability
Z33.1: Pregnancy state, incidental
Z34.00-Z34.03: Encounter for supervision of normal first pregnancy
Z34.80-Z34.83: Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.90-Z34.93: Encounter for supervision of normal pregnancy, unspecified
Z39.0-Z39.2: Encounter for maternal postpartum care and examination

The maternal fetal medicine specialist would submit a diagnosis code from this range:

O10.011 - O16.9: Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium

Immunizations/ Injections/ Infusions received in office setting:

When an individual receives an injection or infusion in an office setting without a complete evaluation and exam, only the service code for the administration of the injection/infusion and the service code for drug/vaccine/medication should be reported with the appropriate diagnosis code for the condition being treated. Office visits (CPT® 99201– 99205; 99212 - 99215; 99381 - 99397) will not be separately reimbursed when submitted with infusions (CPT® codes 96365-96371, 96373-96376) or therapeutic injections (CPT® code 96372). Modifier 25 must be appended to the disallowed E/M code if a significant separately identifiable E/M service was performed. **Note:** CPT® code 96372 has been valued to include the work and practice expenses of CPT® code 99211. Modifier 25 will not override this edit. See the Cigna Modifier 25 policy- “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service” for additional guidance.

Ultrasounds:

Ultrasounds should only be performed when medically necessary. Ultrasounds for the following are not considered medically necessary:

- Determination of sex of the fetus
- Provision of a keepsake picture of the fetus
- Visualization of the fetus for non-medical purposes

In addition, Cigna aligns with the recommendation of the Society of Maternal-Fetal Medicine and the Maternal Fetal Medicine Foundation which indicate; “nuchal translucency evaluation should only be performed by physicians/sonographers who hold current certification in nuchal translucency evaluation. Therefore providers should not submit claims for payment of 76813, 76814 unless currently certified in nuchal translucency evaluation by a recognized training program such as the Nuchal Translucency Quality Review Program.”

Please see the Ultrasound in Pregnancy (Including 3D and 4D Ultrasound) Coverage Policy for further information regarding coverage for ultrasounds.

Hospital observation:

Management of hospital observation for 48 hours for the evaluation of latent phase of labor (“labor check”) or uterine contractions without cervical dilatation (“false labor”) is also considered part of the delivery and is included in the Global Maternity/Obstetric Package.

Inpatient admission:

When an individual is admitted to the hospital for inpatient care due to complications of pregnancy, the physician should report these services at the time they occur with the appropriate diagnosis code for the complication.

Admission to the hospital for inpatient care for delivery, management of cervical ripening in preparing for induction, management of induction of labor and management of latent/active labor phase of labor are considered part of the delivery; therefore they are included in the Global Maternity/Obstetric Package and are not separately reimbursable. In general, admissions for cervical ripening in preparing for induction of labor, induction of active phase of labor, or latent phase of labor do not exceed 48 hours and spontaneous or induced active phase of labor does not exceed 24 hours. Therefore admissions for delivery that occur within 72 hours of delivery are generally included in the Global Maternity/Obstetric Package and are not separately reimbursable.

Assistant Surgeon and Cesarean Sections:

A non-global cesarean delivery code (CPT® code 59514 or 59620) is a reimbursable service when submitted with an appropriate assistant surgeon modifier. See the Cigna Modifier MAS – Assistant Surgeon – Modifiers 80, 81, 82, Assistant-at-Surgery – Modifier AS, Co-Surgeon (Two Surgeons) – Modifier 62, Surgical Team – Modifier 66 Policy.

Multiple Births:

See the Cigna Multiple Births Reimbursement Policy.

Coding/Billing Information

- Note:** 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Codes associated with the Global Maternity/Obstetric Package:

CPT®* Codes	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and 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
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Note: Diagnosis codes associated with global maternity care should only be used by health care

professionals who are providing partial or all components of the antepartum, delivery and postpartum care. Health care professionals who are not providing global maternity care should use the appropriate diagnosis code for the condition for which they are being consulted or are treating.

ICD-10-CM Diagnosis Codes	Description
O09.AO- O09.A3	Supervision of pregnancy with history of molar pregnancy
O09.00- O09.03	Supervision of pregnancy with history of infertility
O09.10- O09.13	Supervision of pregnancy with history of ectopic
O09.211- O09.219	Supervision of pregnancy with history of pre-term labor
O09.291- O09.299	Supervision of pregnancy with other poor reproductive or obstetric history
O09.30- O09.33	Supervision of pregnancy with insufficient antenatal care
O09.40- O09.43	Supervision of pregnancy with grand multiparity
O09.511- O09.519	Supervision of elderly primigravida
O09.521- O09.529	Supervision of elderly multigravida
O09.611- O09.619	Supervision of young primigravida
O09.621- O09.629	Supervision of young multigravida
O09.70- O09.73	Supervision of high risk pregnancy due to social problems
O09.811- O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O09.821- O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy
O09.891- O09.899	Supervision of other high risk pregnancies
O09.90- O09.93	Supervision of high risk pregnancy, unspecified
O34.21	Maternal care for scar from previous cesarean delivery
O36.80x0- O36.80x9	Pregnancy with inconclusive fetal viability
Z33.1	Pregnant state, incidental
Z34.00-Z34.03	Encounter for supervision of normal first pregnancy
Z34.80-Z34.83	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.90-Z34.93	Encounter for supervision of normal pregnancy, unspecified
Z39.0-Z39.2	Encounter for maternal postpartum care and examination

Partial Obstetric Package:

CPT®* Codes	Description
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
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
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
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

***Current Procedural Terminology (CPT®) ©2017 American Medical Association: Chicago, IL.**

References

1. Current Procedural Terminology (CPT®) Professional Edition (Chicago, IL: American Medical Association: ©2017).
2. CMS 1997 Documentation Guidelines for Evaluation and Management Services©.
<http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf>
3. The Essential Guide to Coding in Obstetrics and Gynecology, 4th ed. (The American Congress of Obstetricians and Gynecologists ©2010).

Policy History/Updates

Date	Change/Update
03/15/2018	Policy template updated. Removed invalid ICD9 code table. Added R24 Omnibus Reimbursement Policy to Related Policies for Fetal Non-Stress Test Policy
09/06/2016	Updated policy to include new ICD10 codes O09.AO-O09.A3 effective 10/01/2016 and added clarifying statement regarding diagnosis code billing by healthcare professionals other than the Obstetrician.
02/22/2016	Updated policy template. Removed ICD10 codes Z30.011, Z30.09, Z3A.00-Z3A.49.
07/14/2014	Updated template, Added ICD10 diagnosis code tables, removed ICD9 diagnosis codes from the stem except for V72.42 and added ICD10 diagnosis Z32.01 to the stem, updated references.
01/20/2013	Policy template updated
06/03/2011	Policy template updated
08/09/2010	Added Ultrasound in Pregnancy Coverage Policy to Related Policies and to ultrasound section in background
08/01/2010	Effective date of Global Maternity/Obstetric Package policy
07/15/2010	Notification of Global Maternity/Obstetric Package policy.

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