

Corporate Payment Policy 16
GLOBAL MATERNITY/OBSTETRIC PACKAGE
(EXCLUDING HOME BIRTHS)

Updated Effective September 1, 2021

Description

BCBSVT provides reimbursement for the Global Maternity/Obstetric Package when reported with the appropriate Current Procedural Terminology (CPT®) code(s) (59400, 59510, 59610 or 59618) by a health care professional, or a group of healthcare professionals using the same group/practice National Provider Identification number (NPI), when the health care professional or group provides all components of the routine 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 or if the member switches insurance carriers during pregnancy.

BCBSVT 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) or if the member switches insurance carriers during pregnancy.

Policy/ Eligible Services

The following payment policy outlines the billing requirements and reimbursement of the Global Maternity/Obstetric Package. This policy addresses billing for the professional component of maternity/obstetric services only; it does not address the facility component (e.g., room and board fees for an inpatient stay).

I. Introduction

a. Obstetrical Services

Obstetrical (or OB) services are defined as any of the below listed CPT® codes. This follows the coding guidelines defined by the American Medical Association (AMA).

CPT® codes for OB care fall into one of three categories:

- Single component codes (for example, delivery only)
- Two component codes (for example, delivery including postpartum care)
- Three-component, or complete, global codes (including antepartum care, delivery, and postpartum care)

The codes are as follows: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, and 59622.

b. Global Maternity/Obstetric Care

As defined by the AMA, "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the same physician group and/or other health care professional or group provides all components of the obstetric (OB) package, report the global OB package code

The *Current Procedural Terminology* (CPT®) book identifies the global OB codes as:

- CPT® Code 59400 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- CPT® Code 59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care
- CPT® Code 59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- CPT® Code 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

BCBSVT reimburses for these global OB codes when all of the antepartum, delivery, and postpartum care is provided by the same physician group and/or other health care professional or group. BCBSVT will adjudicate claims submitted with either a single date of service or a date span when submitting global OB codes. To facilitate claims processing, report one unit, whether submitted with a date span or a single date of service.

Services unrelated to pregnancy but performed by the provider rendering global maternity care should be documented and reported separately with the appropriate inpatient or outpatient Evaluation and Management code, using **the condition unrelated to pregnancy as the primary diagnosis code.**

Services for High Risk Pregnancies or for Complications of Pregnancy

These visits should be reported after delivery when the complication results in additional prenatal visits beyond the average of 13. In addition, these visits should be appended with Modifier 25. See Section VI (High Risk/Complications) below for more details.

Complications of pregnancy 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.

II. Services included in the Global Maternity/Obstetric Package

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

a. Antepartum Care

- i. Per CPT® guidelines and the American Congress of Obstetricians and Gynecologists (ACOG), the following are included in the global OB Maternity package Routine prenatal visits (i.e., those E/M visits reported with a normal pregnancy diagnosis, excluding the initial visit for diagnosis of pregnancy), which typically include the following services. This is not an all-inclusive list**
 - All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)
 - Initial and subsequent history and physical exams
 - Recording of weight, blood pressures and fetal heart tones, fetal position and fetal movement
 - Routine chemical urinalysis (CPT codes 81000 and 81002)
 - Screening with recommended intervention
 - Evaluating and monitoring any pregnancy-related symptoms, such as fluid leakage, edema, or vaginal spotting, hormonal changes, nausea and vomiting, vaginitis, bowel dysfunction, etc.
 - Evaluating beginning signs of labor, such as contractions and dilation
 - AmniSure® ROM (rupture of fetal membranes) test (CPT® code 84112)
 - Admission to the hospital including history and physical
 - Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
 - Educational services per ACOG, e.g., genetic screening, basic newborn care, evaluating and monitoring any pregnancy-related symptoms, psychosocial risk factors, dietary counseling, oral health, working, child birth classes, anticipating preterm labor, breech presentation, elective delivery, cesarean delivery on maternal request, and trial of labor after cesarean delivery, breastfeeding, lactation, umbilical cord blood banking, neonatal

interventions, reproductive life plans and contraception, individual risk factors, medication use

- o Per the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists Guidelines for Perinatal Care, Eighth Edition:
 - Patient education is an essential element of pre-natal care. Per ACOG, topics for specialized counseling include nutrition, weight gain, exercise, dental care, nausea and vomiting, vitamin and mineral toxicity, teratogens and air travel.
 - Both fetal and maternal outcomes can be affected by maternal nutritional status during pregnancy. Dietary Counseling and interventions based on special or individual needs usually are most effectively accomplished by referral to a nutritionist or registered dietician. Such circumstance may include diabetes, restricted dietary preferences, obesity or having had bariatric surgery. In addition, per 8 V.S.A. § 4089c and the BCBSVT Corporate Medical Policy Nutritional Counseling
 - BCBSVT provides benefits for nutritional counseling for gestational diabetes when rendered by a certified, registered or licensed healthcare professional with specialized training in the education and management of diabetes. There is no limit on the number of visits for nutritional counseling for treatment of diabetes. For all other nutritional counseling BCBSVT covers up to three outpatient nutritional counseling visits each plan year.
 - ii. Routine prenatal visits are typically monthly visits up to 28 weeks' gestation, bi-weekly visits up to 36 weeks' gestation, and weekly visits until delivery. The typical number of total routine prenatal visits is thirteen.
 - iii. Routine antepartum visits **should not be billed** separately from the global maternity global CPT® codes.
- b. Labor and Delivery Care
- i. Admission to the hospital including taking admission history and performing physical examination

- ii. 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")
 - iii. Management of uncomplicated labor
 - iv. Insertion of pharmacologic agents for cervical ripening or placement of mechanical cervical dilation devices prior to induction of labor (CPT® code 59200)
 - v. Administration of intravenous pitocin or oxytocin for induction of labor (CPT® codes 96365-96367)
 - vi. Injection of local anesthesia (CPT® codes 64430, 64435)
 - vii. Catheterization or catheter insertion (CPT® codes 51701, 51702)
 - viii. Placement of internal fetal and/or uterine monitors
 - ix. Episiotomy and associated repair
 - x. Vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery
 - xi. Augmentation of labor and amniotomy
 - xii. Vacuum extraction
 - xiii. Simple removal of cerclage prior to delivery
 - xiv. Repair of lacerations
 - xv. Delivery of placenta (CPT® code 59414)
- c. Postpartum Care
- i. Routine postpartum visits (hospital and office) following vaginal or cesarean section delivery
 - ii. A 45-day postpartum period applies for maternity delivery codes
 - iii. Insertion of a Bakri balloon for treatment of postpartum hemorrhage

III. Services Excluded from the Global Maternity/Obstetric Package

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

- a. Initial Evaluation and Management (E&M) visit to confirm pregnancy when reported with an E&M service code. Initial E/M to diagnose pregnancy is separately reimbursable and should be reported in conjunction with the use of ICD-10-CM diagnosis code Z32.01.
- a. Laboratory tests (excluding routine chemical urinalysis)
- b. Administration of injections (CPT® code 96372) including but not limited to RhoGAM (CPT® codes 90384, 90385) and 17-Hydroxyprogesterone Caproate

- c. Administration of Vaccines (CPT® codes 90470-90474) including but not limited to CPT® codes 90632, 90636, 90656, 90658, 90662, 90669, 90670, 90703, 90714, 90732, 90740, 90746, 90747
- d. Administration of IV infusions including but not limited to hydration (CPT® codes 96360, 96361)
- e. Amniocentesis (CPT® code 59000 or 59001)
- f. Amnioinfusion (CPT® code 59070)
- g. Chorionic Villus Sampling (CPT® code 59015)
- h. Cordocentesis (CPT® code 59012)
- i. Fetal contraction stress test (CPT® code 59020)
- j. Fetal non-stress test (CPT® code 59025) (eligible for separate reimbursement per fetus; standard multiple surgery reimbursement rules apply)
- k. Fetal scalp blood sampling (CPT® code 59030)
- l. External cephalic version (CPT® code 59412)
- m. Insertion of cervical dilator (CPT® code 59200) more than 24 hours before surgery
- n. Administration of regional anesthesia (e.g.: epidural) (CPT® code 01967)
- o. Maternal/fetal ultrasounds (CPT® codes 76801-76817, 76820, 76821) (see Ultrasound section)
- p. Echocardiography (CPT® codes 76825-76828)
- q. Fetal biophysical profile (CPT® codes 76818-76819)
- r. Genetic Testing (if prior approval is obtained; see BCBSVT's prior approval list as well as BCBSVT's Corporate Medical Policy for Genetic Testing for more details)
- s. E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services. For further information please refer to the Non-Obstetric Care section of the policy.

- t. Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical 13 antepartum visits; per the American College of Obstetricians and Gynecologists (ACOG) these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits. For further information, please refer to High Risk/Complications section of this policy.
- u. Inpatient E/M services provided more than 24 hours before delivery
- v. Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy)

IV. Breakdown of Obstetrical Services

- a. The Global OB codes described above are utilized when the same physician group and/or other health care professional provides all components of the OB package. However, clinicians from different group practices may provide individual components of maternity care to a patient throughout a pregnancy. Although Obstetric (OB) Related E/M Services should be billed as a global package, itemization of Obstetric (OB) Related E/M Services may occur in the following situations:
 - i. A patient transfers into or out of a physician or group practice during her pregnancy
 - ii. A patient is referred to another physician or group practice during her pregnancy
 - iii. A patient has the delivery performed by another physician or other health care professional not associated with her physician or group practice
 - iv. A patient terminates or miscarries her pregnancy
 - v. A patient changes insurers during her pregnancy

b. Antepartum (before delivery) care only:

Providers that render antepartum care only should bill in one of the following three ways:

- For 1-3 antepartum care visits, bill appropriate E/M code(s) for each visit
- For 4-6 antepartum care visits, bill CPT® 59425 (Antepartum care only; 4-6 visits); or
- For 7 or more antepartum care visits, bill CPT® 59426 (Antepartum care only; 7 or more visits).

These codes may be used for situations such as termination of a pregnancy, relocation of a patient, or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global OB care may not be provided same physician group and/or other health care professional.

If the same physician group or other health care professional did not render all of the patient's routine antepartum care (or the antepartum care provided is less than the typical number of visits (usually 13)),

the provider must bill using one of the three options listed above for antepartum care provided, even if the provider also rendered delivery and postpartum care.

As described by ACOG and the AMA, the antepartum care only codes (CPT® code 59425 and 59426) should be reported as described below:

- A single claim submission of CPT® code 59425 or 59426 for the antepartum care only, excluding the confirmatory visit that may be reported and separately reimbursed when the antepartum record has not been initiated.
- The units reported should be one.
- The dates reported should be the range of time covered. For example, if the patient had a total of 4-6 antepartum visits, then the physician and/or other health care professional should report CPT® code 59425 with the "from and to" dates for which the services occurred.

In the event that all the antepartum care was provided, but only a portion of the antepartum care was covered under BCBSVT, then adjust the number of visits reported and the "from and to" dates to reflect when the patient became eligible under BCBSVT coverage.

There may be situations where all components of the global obstetric package were provided by the same physician group or other health care professional but the member switches insurance carriers during pregnancy. In these cases, neither insurance carrier wants to pay the complete global obstetric package. It may be that only the antepartum care (or a portion of the antepartum care) was covered under BCBSVT. Alternatively, some of the antepartum care may have been provided under a carrier other than BCBSVT while the remaining antepartum care, delivery, and postpartum care were provided while the BCBSVT insurance plan was in effect. In either case, the provider should bill BCBSVT for only those services rendered while the BCBSVT insurance plan was in effect.

By way of example, if a member sees her provider four times for antepartum care under Insurance Plan A but then switches to BCBSVT coverage, subsequently has ten more antepartum visits, delivers at term with no complications, and both plans offer complete maternity benefits, the billing should occur as follows:

- The four antepartum visits should be reported to Insurance Plan A using CPT® 59425 (antepartum care only; 4-6 visits).
- Since the delivery and most of the antepartum care occurred while the member had coverage with BCBSVT, the provider should bill BCBSVT using CPT® 59426 (antepartum care for seven or more visits) along with the delivery code that includes postpartum care (CPT® 59410 or 59515).

Services provided during the antepartum period that would typically be excluded from the Global Maternity/Obstetric package may be separately billable and reimbursed (see Section III, above).

c. Delivery Services Only:

Per CPT®: "Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery." The following are the CPT®-defined delivery-only codes:

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

The delivery-only codes should be reported by the same physician group and/or other health care professional for a single gestation when:

- The total OB package is not provided to the patient by the same physician or group practice and itemization of services needs to occur; or
- Only the delivery component of the maternity care is provided and the postpartum care is performed by another physician or group of physicians and /or other healthcare professional.

If the same physician group and/or other health care professional provided the delivery component in addition to postpartum care services, please refer to the Delivery Only including Postpartum Care section of this policy, below. For deliveries involving twin or triplet gestations, see the Multiple Births section of this policy, below. According to CPT® and ACOG coding guidelines, the following services are included in the delivery-only services codes and should not be reported separately:

- Admission to the hospital
- The admission history and physical examination
- Management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps, with or without vacuum extraction), or cesarean delivery, external and internal fetal monitoring provided by the attending physician
- Intravenous (IV) induction of labor via oxytocin (CPT® codes 96365 - 96367)
- Delivery of the placenta; any method (CPT® codes 59414)
- Repair of first or second-degree lacerations

BCBSVT will not separately reimburse for these services when one of the delivery-only codes is reported. BCBSVT considers insertion of cervical dilator (CPT® 59200) to be included if performed on the same date of delivery.

Per ACOG coding guidelines, reporting of third- and fourth-degree lacerations should be identified by appending modifier 22 to the delivery only codes (CPT® codes 59409, 59410, 59612 and 59614). Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier; see BCBSVT's -22 Modifier Payment Policy.

d. Postpartum Care Only

For postpartum care only, bill using CPT® 59430 - Postpartum care only (separate procedure).

BCBSVT follows ACOG guidelines and considers the postpartum period to be six weeks following the date of the cesarean or vaginal delivery. The following services are **included** in postpartum care and are not separately reimbursable services:

- Uncomplicated outpatient visits related to the pregnancy
- Discussion of contraception

The following services are not included in postpartum care and are separately reimbursable services, when reported subsequent to CPT® code 59430:

- Evaluation and management of problems or complications related to the pregnancy

The postpartum care only code should be reported by the same physician group and/or other health care professional that provides the patient with services of postpartum care only. If a physician or provider provides any component of antepartum along with postpartum care, but does not perform the delivery, then the services should be itemized by using the appropriate antepartum care code (see Antepartum Care Only section of policy) and postpartum care code (CPT® code 59430).

e. Delivery Only including Postpartum Care (with minimal or no antepartum care)

Sometimes a provider or group performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT® book has codes for vaginal and cesarean section deliveries that encompass both of these services. The following are CPT®-defined delivery plus postpartum care codes:

- 59410 - Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
- 59515 - Cesarean delivery only; including postpartum care

- 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

The delivery including postpartum care codes should be reported by the same physician group and/or other health care professional for a single gestation when:

- The delivery and postpartum care services are the only services provided; or
- The delivery and postpartum care services are provided in addition to a limited amount (less than thirteen) of antepartum care (e.g., CPT® code 59425).

The following services are **included** in delivery only including postpartum care code and are not separately reimbursable services:

- Hospital visits related to the delivery during the delivery confinement
- Uncomplicated outpatient visits related to the pregnancy
- Discussion of contraception

Services provided during the delivery and postpartum period that would typically be excluded from the global obstetric/maternity package may be separately billable and reimbursed (see Section III, above).

V. Non-Obstetric Care

Per ACOG guidelines, when a patient is seen for a condition unrelated to pregnancy (e.g., bronchitis, flu) during the antepartum stage, these E/M visits are considered Non-Obstetric (OB) E/M Services and can be reported as they occur. The diagnosis code used in conjunction with the E/M service should support the non-OB condition being treated and/or evaluated. BCBSVT will reimburse non-OB related E/M services rendered during the antepartum stage of care only when the appropriate diagnosis code being used clearly identifies the condition is not related to pregnancy care and is the primary diagnosis on the claim.

VI. High Risk/Complications

A patient may be seen more than the typical thirteen antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global OB CPT® codes of 59400, 59510, 59610 or 59618. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. Per ACOG coding guidelines, 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.

BCBSVT will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code and is submitted after the delivery.

A patient may see a Maternal-Fetal Medicine (MFM) Specialist in addition to a regular OB/GYN physician. According to ACOG, the MFM services fall outside the routine global OB package. Therefore, the reporting of these services is dependent on whether the MFM specialists are part of the same group practice as the OB/GYN physician. If the MFM specialist has the same group NPI number as the OB/GYN physician, the specialist should report the E/M services with modifier 25 to indicate significant and separately identifiable E/M services; use of modifier 25 will indicate that the MFM service is not part of the routine antepartum care supplied by that physician group. However, if the MFM specialist is in a different group practice than the physician(s) and other health care professionals supplying the routine antepartum care, modifier 25 is not necessary.

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 providing pregnancy-related services but 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.

VII. **Ultrasounds**

a. Ultrasounds

BCBSVT follows the ACOG guidelines for obstetric ultrasound examinations and will reimburse for one routine ultrasound per pregnancy.

When in-office ultrasounds are performed as part of any antepartum visit only the technical component (TC) is eligible for reimbursement. The professional component is considered inclusive to the E/M prenatal visit even if the -25 modifier is appended and is considered inclusive to all of the prenatal visits billed as part of the global maternity CPT® codes. Providers who are performing obstetrical ultrasounds in their office are required to bill the ultrasound code with the -TC modifier only. Obstetrical ultrasounds billed with no modifier or with the -TC and -26 modifiers on the same line will be denied inclusive provider liability. Providers will not append modifier -59 (Distinct Procedural Service) to the obstetrical ultrasounds when performed in an office setting.

Per the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists Guidelines for Perinatal Care, Eighth Edition, indications for first-trimester ultrasonography include:

- To confirm the presence of an intrauterine pregnancy.
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose to evaluate multiple gestations
- To confirm cardiac activity
- As an adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in patients at high risk
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy
- To evaluate suspected hydatidiform mole

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

- To confirm a positive pregnancy test
- Determination of sex of the fetus
- Provisions of a keepsake picture of the fetus
- Visualization of the fetus for non-medical purposes

i. First Trimester Ultrasound

A first trimester ultrasound exam, billed with CPT® code(s) 76801 and +76802, or ultrasound pregnant uterus (transvaginal), billed with CPT® code 76817, may be reimbursed separately if used to do the following: estimate gestational age, help screen for certain genetic disorders, check the number of fetuses, check the fetus's heart rate, or check for ectopic pregnancy. Indication for the ultrasound must be documented.

A first trimester ultrasound billed with CPT® code(s) 76813 and +76814 (Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, trans abdominal or transvaginal approach) is considered medically necessary when used as part of combined first-trimester screening or integrated screening for aneuploidy. An ultrasound examination with nuchal translucency measurement before 14 0/7 weeks of gestation provides accurate dating of pregnancy and an effective screening test for trisomy 13, trisomy 18, and trisomy 21 when combined with maternal age

and serum markers. However, a complete anatomic assessment is not possible before at least 14 weeks of gestation.

ii. Second or Third Trimester Ultrasound

Per ACOG guidelines, one standard ultrasound exam is usually performed at 18-22 weeks of gestation and is generally billed using CPT® code(s) 76805 and +76810 (Ultrasound, pregnant uterus, real time image documentation, fetal and maternal evaluation, after first trimester (>14 weeks 0 days), transabdominal approach single or first gestation). These codes are reported and reimbursed separately from the global codes.

Subsequent/follow-up obstetric ultrasounds (CPT® code 76816) submitted with a routine diagnosis will be denied as not medically necessary regardless of other non-routine diagnoses submitted. Subsequent routine obstetric ultrasounds will be denied if the same or different provider performed the initial routine ultrasound exam.

iii. Limited Examination

A limited examination billed with CPT® code 76815 (Ultrasound pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume, 1 or more fetuses)) may be medically necessary when a specific question requires investigation. For example, in most routine nonemergency cases, a limited examination could be performed to confirm fetal heart activity in a bleeding patient or to verify fetal presentation in a laboring patient. In most cases, limited sonographic examinations are appropriate only when a prior complete examination is on record. A limited ultrasound may be medically necessary when a focused, brief assessment is made of one or two elements. This code is reported and reimbursed separately from the global codes.

iv. Follow up ultrasounds

A follow up ultrasound billed with CPT® code 76816 (Ultrasound pregnant uterus, real time with image documentation, follow-up (e.g., 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)) may be medically necessary to reexamine a previously discovered condition. This code is reported and reimbursed separately from the global codes.

v. Detailed anatomic ultrasounds

BCBSVT considers a fetal ultrasound with detailed anatomic examination, billed with CPT® 76811 and 76812, is medically necessary if a problem is suspected based on risk factors or other tests. For example, if there are signs that the fetus is not growing well, the fetus's growth rate can be tracked throughout pregnancy with specialized ultrasound exams. Depending on what the suspected problem might be, specialized techniques may be used, such as Doppler ultrasonography and 3-D ultrasonography. This code is reported and reimbursed separately from the global codes.

VIII. Stress Tests

The Fetal Non-Stress Test CPT® code 59025 is considered medically necessary to monitor fetal movement.

This code should be reported subsequently with modifier 76, to identify the repeated procedure(s) by the same physician; or with modifier 77 appended, to identify that the repeated procedure(s) was performed by another physician.

Multiple non-stress tests performed on twin gestations should be reported in the following manner:

- The initial test for the first fetus is reported using CPT® code 59025. If subsequent testing is performed on the same fetus, CPT® code 59025 is then reported a second time with modifier 76, to identify the repeated procedure by the same physician, or with modifier 77, to identify that the non-stress test was repeated by another physician.
- The initial test for the second fetus is reported using CPT® code 59025 with modifier 59 appended, to identify that a separate fetus is being evaluated. If subsequent testing is performed on the second fetus, CPT® code 59025 with modifier 59 is reported a second time with modifier 76, to identify the repeated procedure by the same physician, or use modifier 77, to identify that the non-stress test was repeated by another physician.

Fetal contraction stress tests billed using CPT® code 59020 are considered medically necessary to monitor the fetal heart rate during contractions.

IX. Assistant Surgeon during a cesarean delivery

BCBSVT 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.

X. Multiple Births:

- a. Multiple vaginal deliveries

Multiple vaginal deliveries are eligible for separate reimbursement based on the ACOG recommendation:

- The appropriate delivery code is allowed at 100% of the allowed amount for the first birth. Global vaginal delivery codes include CPT® codes 59400 and 59610; codes for delivery only are CPT® codes 59409 and 59612; CPT® codes 59410 and 59614 include delivery and postpartum care.

- The appropriate vaginal “delivery only” code, with modifier 59 appended, should be billed for each additional birth and will be allowed at 50% of the allowed amount. “Delivery only” codes are 59409 and 59612.

b. Multiple Cesarean-section deliveries

For C-section deliveries (single delivery method), either the global, postpartum inclusive, or “delivery only” C-section code should be billed as appropriate and is allowed at 100% of the allowed amount. Global C-section codes include 59510 and 59618; CPT® codes 59514 and 59620 are for delivery only; CPT® codes 59515 and 59622 include delivery and postpartum care.

The Plan follows ACOG guidelines and does not allow additional reimbursement for multiple births when all babies are delivered by C-section. “Delivery only” codes include 59514, and 59620. Modifier 22 can be attached to the global or “delivery only” C-section code if the physician work required for the multiple births is substantially greater than typically required.

- Documentation supporting the additional work must be submitted with the claim in order for additional reimbursement for Modifier 22 to be considered.
- Examples of when additional reimbursement may be allowed include but are not limited to: increased intensity, time, technical difficulty of procedure, and severity of patient’s condition.

c. Combined vaginal and cesarean section deliveries

Combined vaginal and C-section deliveries: The provider should report the appropriate vaginal delivery code for the first delivery, and the C-section “delivery only” code with modifier 59 appended, for any additional C-section deliveries. Additional deliveries are subject to the standard multiple surgical reimbursement methodology.

XI. Laboratory Services

BCBSVT separately reimburses the following laboratory services from the global allowance, including but not limited to:

- Alpha-fetoprotein screening (CPT® codes 82105, 82106)
- Antibody screening, including rubella (CPT® codes 87862)
- Antigen; hepatitis, surface (CPT® codes 87304)
- Blood glucose (CPT® code 82947)
- Blood typing; ABO and/or Rh factor (CPT® codes 86900, 86901)

- Chlamydia screening (CPT® codes 87110, 87270, 87320)
- Culture, bacterial (including commercial kits and urine cultures) (CPT® codes 87801, 87804, 87086, 87088)
- Giardia screening (CPT® codes 87269, 87329)
- Group B streptococci (CPT® codes 87802)
- Human Chorionic Gonadotropin (hCG) (CPT® code 84702)
- HIV testing/HTLV-1 (CPT® code 86687)
- Hepatitis B (CPT® code 86704)
- Hepatitis C (CPT® code 87552)
- Obstetrical panel (CPT® code 80055)
- Immunoassay for infectious agent antibody (CPT® codes 86317, 86318, 87389)
- Complete blood count (CPT® codes 85004, 85007, 85025, 85027)
 - Hemogram, automated and manual differential white blood count (CBC)
 - Hemogram, platelet count, automated and manual differential
 - Hemogram and platelet count, automated
 - Hemogram and platelet count, automated and automated partial differential white blood count (CBC)
 - Hemogram and platelet count, automated and automated complete differential white blood count (CBC)
- Rh antibody test (CPT® code 86901)
- Syphilis test (CPT® code 86593)
- Thyroid testing including thyroid-stimulating hormone (CPT® code 84443)
- Tuberculosis (TB)
- Urinalysis (CPT® code 81001)

- Urine Culture (CPT® code 87086)

Not Eligible for Payment

Prolonged physician attendance codes are not appropriate for labor and delivery. The Plan follows ACOG guidelines.

Prolonged Services with Direct Patient Contact CPT® codes 99354-99357 are included in the labor and delivery services and are not separately reimbursed.

Standby Services CPT® codes 99360 are included in the labor and delivery services and are not separately reimbursed.

All other services not eligible for payment are noted in the individual sections above.

Benefit Determination Guidance

Payment for maternity services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible maternity services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Other Information

Eligible Places of Service include: Home – 12, Office – 11, Inpatient Facility – 21, and Birthing Center - 25

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Related Policies

BCBSVT Corporate Payment Policy 18 - Home Births

BCBSVT Corporate Payment Policy 6 – 22 Modifier

BCBSVT Corporate Medical Policy; Nutritional Counseling

References

The American College of Obstetricians and Gynecologists. (2020). *2020 OB/GYN Coding Manual: Components of Correct Procedure Coding*. Washington: ACOG.

The American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care; Eighth Edition, 2017*

8 V.S.A. § 4089c. Diabetes treatment

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Screening for fetal aneuploidy. Practice Bulletin No. 163. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;127:e123–37. (Level III)

American Institute of Ultrasound in Medicine. Prudent use and clinical safety. Laurel (MD): AIUM; 2012. Available at: <http://www.aium.org/officialStatements/34>. Retrieved July 25, 2016. (Level III)

American College of Radiology. ACR–ACOG–AIUM–SRU practice parameter for the performance of obstetrical ultrasound. Reston (VA): ACR; 2013. Available at: http://www.acr.org/~media/ACR/Documents/PGTS/guidelines/US_Obstetrical.pdf. Retrieved July 25, 2016. (Level III)

The American College of Obstetricians and Gynecologists Frequently Asked Questions Special Procedures <https://www.acog.org/Patients/FAQs/Ultrasound-Exams>

Diagnostic Coding in Obstetrics and Gynecology, The American Congress of Obstetricians and Gynecologists, 2016

Document Precedence

The Blue Cross and Blue Shield of Vermont (BCBSVT or Plan) Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and BCBSVT’s claim editing software logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
- 2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
- 3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
- 4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and BCBSVT’s claim editing solution, BCBSVT’s claim editing solution takes precedence.

Policy Implementation/Update information

New Policy effective April 2018.

Updated in October 2019 to include information about changes to insurance during pregnancy and reimbursement for first trimester ultrasound.

Updated in October 2020 (for January 1, 2021 effective date) to update information about ultrasound reimbursement, update information about prolonged service codes and stand by codes and deleted the diagnosis list.

Updated in December 2020 (for January 1, 2021 effective date) to delete CPT 99201.

Updated effective September 2021 with the following changes: (1) moved the “document precedence” section to the end of the policy, (2) removed appendices, (3) added guidance for billing services unrelated to pregnancy and those related to pregnancy complications, (4) clarified antepartum services included in the global package, (5) clarified billing for initial diagnosis of pregnancy, (6) clarified when first-trimester ultrasound are indicated, and (7) added a reference to the BCBSVT corporate medical policy on nutritional counseling and the Vermont mandate related to coverage of diabetes treatment.

Approved by

Date: June 2021



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