Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Maternity Care

Policy Number: RM039
Last Review: 12/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

Global service includes prenatal, delivery, and postpartum care services that are included in an uncomplicated pregnancy. The service cannot be submitted separately, by the delivery surgeon/nurse midwives, or by providers in the same group with the same specialty or non-physician providers (NPPs) in the same group as the delivery surgeon/nurse midwives, as they are considered to be of the same specialty as the delivering surgeon/nurse midwives. Additional maternity services will be denied as part of the global service when submitted separately.

Any visits to the delivery surgeon/nurse midwife/non-physician providers unrelated to global pregnancy can be submitted as a separate evaluation and management service (99201-99215). This is also supported by a non-obstetrical diagnosis appended to the evaluation and management service. If an unrelated procedure is also performed, modifier -25 needs to be appended to the evaluation and management service to indicate the separate and distinct services were performed.

Non-Global service

There are circumstances in which members may not receive global obstetrical care/services from the same provider or provider group for several reasons, such as the member moving to another practitioner not

associated with the practice, moving away prior to delivery, losing the pregnancy, or changing insurance plans, should submit claims for nonglobal services with the appropriate procedure code(s).

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

- **Global maternity service codes should be filed when the same physician and/or other qualified health care professional or the same practice performs all the prenatal, delivery, and post-partum services during the global period.**
- **Paramount allows reimbursement for the global maternity care, unless provider, state, or federal contracts and/or requirements indicate otherwise.**
- **Global Maternity Care does not require prior authorization**
- **Reimbursement is based on all aspects of the global obstetric care package (antepartum, delivery and postpartum, as indicated below) being provided by the provider or provider group reporting under the same TIN. If a provider or provider group reporting under the same TIN does not provide all Antepartum, Delivery and Postpartum services, global obstetrical codes may not be used, and providers are to submit for reimbursement only the elements of the obstetric package that were provided.**
- **Non-Global Maternity Care does not require prior authorization**
- **Providers who do not provide global obstetrical services for assorted reasons, as indicated below, should submit claims for nonglobal services with the appropriate procedure code(s).**
- **All services rendered by a non-coverage provider will be reimbursed separately according to fee-for-service methodology, subject to authorization and clinical criteria that may apply to a code or code set.**

The –TH modifier is used to identify prenatal or postpartum obstetrical (OB) treatment services for non-global reporting of evaluation and management (E/M) services.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Global Maternity Care

Global maternity care is defined as beginning with the initial visit and ending with the release of care six weeks after delivery. Global obstetrical care reimbursement includes all of the following: (CPT Codes 59400, 59409, 59410, 59414, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, and 59622).

Antepartum (Prenatal) Care

While CPT does not specify the number of expected antepartum visits, it is expected that at least 14 uncomplicated antepartum visits should occur and be reported (based on American Congress of Obstetricians and Gynecologists (ACOG), HEDIS, and state reporting guidelines):

- One visit every 4 weeks up to 28 weeks (5-6 visits)
- One visits every 2 weeks up to 36 weeks (4 visits)
- One visit every week from 36 weeks until delivery (3-4 visits)

The following services are included in the global antepartum care:

- Initial and subsequent history and physical examinations
- Recording of weight, blood pressures, urine for sugar and albumin, fundal height, and fetal heart tones beginning at 10-12 weeks by Doppler
- Interpretation of fetal non-stress tests
- EPSDT screenings for teenage pregnancies
- Education/Teaching planning, not an all-inclusive listing:
    - Physiology of labor and the delivery process, including detection of signs of early labor
    - Obstetrical anesthesia and analgesia
    - Smoking and substance abuse
    - Hygiene and nutrition
    - Transportation plans

- Planning for home assistance during the postpartum period
- Newborn care plans including infant feeding plans, i.e., breast or bottle feeding
- Family Planning, i.e., tubal sterilization
- Selection of a physician for the newborn, circumcision
- Car seat and safety

Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of the normal prenatal care. When used as a method of treatment, these injections may be paid under the appropriate injection/drug codes in accordance with the member's benefits.

When there are confirmed complications of pregnancy, a member may require more than the 14 antepartum office visits. In these situations, a separate E/M service code may be submitted. Append Modifier 25 to the relevant antepartum E/M service code when services occur outside the standard antepartum schedule and when the 13th visit is exceeded. Submit the claim without a routine maternity diagnosis when the 14th or subsequent antepartum visit has occurred.

Repeat obstetrical ultrasounds during the second and third trimester are indicated as medically indicated when billed with a high-risk ICD-CM code, which includes but is not limited to:

- Threatened abortion
- Missed abortion
- Suspected ectopic
- Suspected hydatidiform mole
- Size/date discrepancy
- Polyhydramnios
- Fetal growth restriction

For problem visits unrelated to the pregnancy, submit the claim at the time of service. A separate E/M service code may be submitted with Modifier 25 appended to the relevant E&M service code. These visits would be appropriately coded with ICD-10 diagnosis codes found outside of Chapter 15: Pregnancy, Childbirth, and Puerperium codes (O00-O9A).

Problem visits unrelated to pregnancy do not count toward the 13-visit total. A problem visit unrelated to pregnancy that occurs on the same day as a scheduled standard antepartum visit is filed at the time of service for the unrelated problem, but the antepartum visit is also counted toward the 13-visit total since standard antepartum care is performed.

A high-risk pregnancy may indicate clinical conditions exist in which obstetrical care is significantly more complex than most pregnancies. These pregnancies may require more frequent and intensive involvement by the provider, increased intensity of service and frequency of care. The medical record must support the additional medical care extending significantly beyond routine care was necessary and was provided. Additional antenatal visits that occur for surveillance due to a past history of a high-risk pregnancy are not eligible for reimbursement outside the global maternity unless the current pregnancy becomes high risk. These visits would be appropriately coded with ICD-10 diagnosis codes indicating screening or supervision of a high-risk pregnancy as the primary diagnosis, even though they may occur outside the standard antepartum schedule. High risk pregnancy should be the first listed diagnosis for prenatal outpatient visits and from the category O09 supervision of high-risk pregnancy.
A high-risk pregnancy includes, but is not limited to, the following medical conditions:

- Insulin dependent diabetes mellitus; or
- Intrauterine growth restriction (IUGR); or
- Pregnancy associated hypertension requiring treatment with antihypertensive medication before 35 weeks gestation; or
- Multiple gestation pregnancy; or
- Renal impairment (serum creatinine>2.0mg/dl); or

- Functional Class II, III or IV cardiac disease; or
- Transplant recipient on immunosuppressive medications; or
- Systemic lupus erythematosus.

Delivery
Labor and delivery services are based on the need of each individual patient and can include, but not limited to, the following types of services, fetal monitoring of any type of method, rupture of membranes, amnioinfusion, forceps and/or vacuum-assisted delivery, episiotomy and/or laceration repair, as well as fetal and maternal testing, and induction of labor services.

The following services are included in the labor and delivery global services:
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Management of uncomplicated labor
- Any internal or external fetal monitoring performed
- Management of uncomplicated labor, vaginal or cesarean section delivery
- Induction of labor (e.g., PEGGELL insertion, use of pitocin)
- Exploration of uterus
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.
- Delivery of placenta
- Episiotomy and/or vaginal repair of first- or second-degree lacerations
- Attendance at labor by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable

Outpatient and inpatient antenatal care (procedures and E/M services) occurring within one (1) calendar day of delivery is inclusive to global maternity reimbursement.

Postpartum Care
Postpartum care includes hospital and office visits following any type of delivery and can include any number of visits (typically consists of 1-3 visits, usually extending over a six-week period). It is expected that the member will have postpartum care related to their medical needs, with the final postpartum visit at the conclusion of the postpartum period.
The following services are included in the postpartum care global services:
- Recovery room services
- All uncomplicated inpatient hospital postpartum care
- All routine in hospital postpartum care and outpatient postpartum visits through six weeks, including suture removal and pap smears
- Discussion of contraception [Note: separate reimbursement is supported for contraceptive management services when provided during the postpartum period only when submitted with CPT codes 11981 (insertion, non-biodegradable drug delivery implant), 57170 (diaphragm or cervical cap fitting with instructions), or 58300 (insertion of intrauterine device, IUD).]

When billing an antepartum/delivery/postpartum global obstetric code providers must bill Paramount using the date of delivery as the date of service. All claims must be billed to Paramount after the date of delivery, or the claim will deny.

When billing the Global codes, the primary provider or an associated coverage provider must render at minimum 6 prenatal visits, the delivery, and one postpartum visit. The first prenatal visit must occur on or before the 28th week of gestation.

When the number of visits that will occur is less than the number required to bill a global code (at least 6 visits, the delivery, and a postpartum visit), the provider must bill using the non-global fee-for-service reimbursement method.

Reporting of third- and fourth-degree lacerations should be identified by appending Modifier 22 to the global OB code (CPT codes 59400 and 59610) or delivery only code (CPT codes 59409, 59410, 59612 and 59614).

When a provider renders only antepartum care one of the antepartum only codes should be billed in accordance with CPT guidelines. One unit of service is billed on one line of service with the date of service as last antepartum visit. This code is allowed once per member per pregnancy episode and is only reimbursed when not billed with the Global Fee Reimbursement.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

Multiple Births (Global)
Paramount has adopted the billing guidelines for Multiple Birth reporting as set forth by The American College of Obstetricians and Gynecologists (ACOG).
When billing for multiple vaginal births providers should bill the global delivery code on one claim line and bill a second claim line that includes the delivery only code for a vaginal delivery, with the modifier 51 appended. Report multiple gestations with the applicable diagnosis code.

Vaginal Delivery Reporting

- Primary delivery service code: 59400 or 59610
- Each additional delivery code: 59409-51 or 59612-51
- If the additional service becomes a cesarean delivery, then report the primary delivery service as a cesarean delivery: 59510 or 59618

Cesarean Delivery Reporting

- Primary delivery service code: 59510 or 59618
- No additional procedural delivery code warranted, since only one incision is made
- Only a single cesarean delivery service is to be reported no matter how many live births
- Modifier 22 should be added to support substantial additional work for complicated deliveries involving multiple births

Multiple Providers and Global Coding
When more than one provider participates in prenatal, delivery, and postpartum services for the same member, the following conditions apply:

- The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and a minimum of one postpartum visit) are provided directly by the primary provider, or a coverage provider.
- If the primary provider bills for the global fee, non-participating providers may claim payment from Paramount. Payment of the global fee constitutes payment in full both to the primary provider and to all participating providers who provided components of the obstetric global service.
- If the primary provider bills for the global fee, any non-participating provider who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no non-participating provider may claim payment for the delivery.
- If the primary provider bills on a fee-for-service basis and does not bill a global fee, any other participating or non-participating provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services they provided to the same member.

Separately Billable Services from Global Fee Reimbursement
Providers may be reimbursed separately from the global fee for the following services, which includes but is not limited to:

- Fetal non-stress (CPT Code 59025), cerclage of cervix (CPT Codes 59320, and 59325), external cephalic version (CPT Code 59412), amniocentesis (CPT Codes 59000, 59001, and 76946), chorionic villus sampling (CPT Code 59015), ultrasound guidance for chorionic villus sampling (CPT Code 76945), maternal or fetal ultrasound procedures (CPT Codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, and 76828), and hospital visits for pregnancy- or nonpregnancy-related indications during the antepartum period may be eligible for payment at the allowed amount in addition to global obstetrical care reimbursement for the subsequent delivery.
- Payment for non-obstetrical services provided by an obstetrician, a participating Provider, or the Primary Provider during the pregnancy (e.g., bronchitis, asthma, urinary tract infection, during antepartum or postpartum care)
- Pregnancy test – When the pregnancy is confirmed during a problem visit or preventative visit, these services are not included in global OB package and are reported separately using the appropriate evaluation and management codes 99201-99205, 99211-99215, 99241-99245, 99281-99285 and 99384-99385.
- Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of ICD-10-CM diagnosis code Z32.01 (Encounter for pregnancy test, result positive).
- Laboratory tests (excluding routine chemical/dipstick urinalysis)
    - Cervical cytology/HPV testing
    - Screening for Group B beta strep
    - Screening for HIV
- Anesthesia services according to the guidelines established in the Paramount's payment policy
- Counseling specific to high-risk members (e.g., antepartum genetic counseling, see Paramount's medical policy on genetic counseling)
- Evaluation and testing, not all-inclusive:
    - Amniocentesis, any method
    - Amnioinfusion
    - Cerclage of cervix
    - Chorionic villus sampling (CVS)
    - External cephalic version
    - Fetal contraction stress test
    - Fetal non-stress test
    - Induction of labor, only if the induction id performed > 24 hours prior to date of delivery
    - Insertion of cervical dilator more than 24 hours before delivery
    - Maternal or fetal ultrasound procedures
- Special screening tests for genetic disorders (for specific guidelines see Paramount's medical policies on genetic testing)
- Specialized care (for example, treatment of premature labor)
- Childbirth classes
- Postpartum skilled nursing home visit(s)
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy)
- Examples of diagnoses for postpartum services that may be reimbursed outside the global allowance when filed with Modifier 24 include:
    - Delayed and secondary postpartum hemorrhage
    - Contraceptive management and placement of Long-Acting Reversible Contraception (LARC)
    - Infection of obstetric surgical wound
    - Local infection of the perineal skin and subcutaneous tissue
    - Thromboembolic events
    - Endometritis

- Mastitis
- Conditions requiring additional outpatient observation and/or inpatient care, such as:
  - Septic pelvic thrombophlebitis
  - Pre-eclampsia with/without severe features

When Global Billing/Coding is not applied
There are several circumstances in which obstetrical services, antepartum, delivery, and postpartum, cannot be billed globally and must be billed as separate services such as when:

- The member's coverage starts after the onset of the pregnancy
- The member's coverage terminates prior to the delivery
- The member changes insurers during the pregnancy
- The pregnancy does not result in a delivery, the pregnancy is terminated or miscarries
- The member transfers into or out of a physician or group practice
- When a certified nurse midwife is the primary provider and a physician performs a cesarean section, the certified nurse midwife may claim payment for the prenatal visits only on a fee-for-service basis. The operating physician may claim payment for the cesarean section only on a fee-for-service basis.

Non-Global Maternity Care
Providers may bill for antepartum, the delivery, and postnatal services separately when a global code is not applicable. Non-global maternity care is reported with each individual service on each date of service. A routine OB antepartum E/M service should be reported as 99213 –TH, based on ACOG and CPT criteria, and level of service expected. Each antepartum visit should have the modifier -TH appended to the service, along with the correct diagnosis.

Antepartum Only Services – 4-6 Visits (CPT Code 59425)
If only one to six antepartum care visits have been performed, bill the appropriate evaluation and management code and the appropriate diagnosis. Each claim billed should identify the actual date(s) of service rendered.

Antepartum Only Services – Greater than 6 Visits (CPT Code 59426)
When a provider renders more than 7 antepartum visits but not the delivery or postpartum care the antepartum only codes should be used in accordance with CPT guidelines. One unit of service is billed. Bill one line of service and identify the last date of service rendered. This code is allowed once per member, per pregnancy episode.

Delivery and Postpartum Care Only Coding (CPT Codes 59410, 59515, 59614, 59622)
If a physician performs both the delivery and postpartum care, but not the prenatal care, claims should be submitted using the delivery and postpartum care only codes. Only one unit of service is billed. All claims must be submitted with the date of delivery as the date of service.

Delivery Only Services (CPT Codes 59409, 59514, 59612, 59620)
If a physician performs only the delivery, submit claims using the actual delivery date of service.

Postpartum Care Only Services (CPT Code 59430).
When a physician renders only postpartum care CPT code 59430 should be used, irrespective of the type of delivery. The actual date of service of the postpartum office visit should be billed on the claim form.

The –TH modifier is used to identify prenatal or postpartum obstetrical (OB) treatment services for non-global reporting of evaluation and management (E/M) services. This modifier is to be appended to only the prenatal E/M services. Documentation must not only support the level of service reported, but also the diagnosis code must support the medical necessity of the service provided. The purpose of appending this modifier is to follow state guidelines and assist in HEDIS reporting.

At no time should fee-for-service services for a routine pregnancy be billed in combinations that result in reimbursement that is higher than the global reimbursement amount.

Multiple Births (Delivery Only)
When billing for multiple vaginal births, the first delivery should be billed with the delivery only code applicable to the form of delivery. Second and subsequent vaginal deliveries should be billed on separate lines using the same delivery code used for the primary birth, with modifier 51 appended, supporting no additional procedural delivery. Providers may not submit additional coding for the second or subsequent cesarean deliveries, since only one incision is made.
All deliveries must be billed on the same claim form and contain the same date of service.

- Example: Twins
  - Line 1: 59409 with 1 unit
  - Line 2: 59409-51 with 1 unit

If the case requires additional services, the provider should submit modifier 22 with the delivery only code applicable to the delivery type and submit supporting documentation substantiating any additional reimbursement sought by the provider. Increased intensity of service and frequency of care by the provider must be demonstrated to justify additional reimbursement.

Note: When two different delivery methods are used bill the first line with the delivery only code applicable to the form of delivery, bill the second line with the delivery only CPT code with modifier 59 (Distinct procedural service) appended.

Caesarean section, labor induction, or any delivery following labor induction is subject to the following criteria:

- Gestational age of the fetus must be determined to be at least thirty-nine weeks or
- If a delivery occurs prior to thirty-nine weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery.

CODING/BILLING INFORMATION:
It is the responsibility of the submitting provider to submit the most accurate and appropriate Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/International Classification of Disease-10(ICD-10) code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply a right to reimbursement or guarantee claims payment.

- This list of codes may not be all-inclusive
- The inclusion or exclusion of a code in this section does not necessarily indicate coverage. Codes referenced in this policy are for informational purposes only.
- Deleted codes and codes which are not effective at the time of the service is rendered may not be eligible for reimbursement.
- Payment for supplies may be included in payment for other services rendered.

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
59000	Amniocentesis; diagnostic
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
59015	Chorionic villus sampling, any method
59025	Fetal non-stress test
59200	Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)
59320	Cerclage of cervix, during pregnancy; vaginal
59325	Cerclage of cervix, during pregnancy; abdominal

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care [Antepartum, Delivery and Postpartum Global Coding]
59409	Vaginal delivery only (with or without episiotomy and/or forceps) [Delivery Only Fee-For-Service Coding]
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care [Delivery and Postpartum Care Only Fee-For-Service Coding]
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
59425	Antepartum care only; between 4 and 6 visits [Antepartum Care Only Fee-For-Service Coding]
59426	Antepartum care only; 7 or more visits [Antepartum Care Only Fee-For-Service Coding]
59430	Postpartum care only (separate procedure) [Postpartum Care Only Fee-For-Service Coding]
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care [Antepartum, Delivery and Postpartum Global Coding]
59514	Cesarean delivery only [Delivery Only Fee-For-Service Coding]
59515	Cesarean delivery only; including postpartum care [Delivery and Postpartum Care Only Fee-For-Service Coding]
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery [Antepartum, Delivery and Postpartum Global Coding]
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) [Delivery Only Fee-For-Service Coding]
59614	Vaginal delivery after previous cesarean (with or without episiotomy and/or forceps); including postpartum care. [Delivery and Postpartum Care Only Fee-For-Service Coding]
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery [Antepartum, Delivery and Postpartum Global Coding]
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery [Delivery Only Fee-For-Service Coding]
59622	Cesarean delivery following attempted vaginal delivery after previous cesarean delivery; including postpartum care [Delivery and Postpartum Care Only Fee-For-Service Coding]
59898	Unlisted laparoscopy procedure, maternity care and delivery
59899	Unlisted procedure, maternity care and delivery
99202	Office or other outpatient visit for the evaluation and management of a new patient; expanded history, exam, straightforward decision-making; 20 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99203	Office or other outpatient visit for the evaluation and management of a new patient; detailed history, exam, straightforward decision-making; 30 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99204	Office or other outpatient visit for the evaluation and management of a new patient; comprehensive history, exam, moderate complexity decision-making; 45 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99205	Office or other outpatient visit for the evaluation and management of a new patient; comprehensive history, exam, high complexity decision-making; 60 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99211	Office or other outpatient visit for the evaluation and management of an established patient; evaluation and management, may not require presence of physician; 5 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99212	Office or other outpatient visit for the evaluation and management of an established patient; history, exam, straightforward decision-making; 10 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99213	Office or other outpatient visit for the evaluation and management of an established patient; expanded history, exam, straightforward decision-making; 15 minutes [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]

99214	Office or other outpatient visit for the evaluation and management of an established patient; office visit (25 minutes face to face) [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
99215	Office or other outpatient visit for the evaluation and management of an established patient; office visit (25 minutes face to face) [Antepartum/Postpartum Care Fee-For-Service Coding, when applicable, with modifier TH]
Quality Reporting - In support of quality tracking and in accordance with HEDIS guidelines	
0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care, report also date of visit and in a separate field, the last date of menstrual period LMP)
0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period – LMP (Note: If reporting 0501F prenatal flow sheet, it is not necessary to report 0500F initial prenatal care visit)
0502F	Subsequent prenatal care visit (excludes patients who are seen for a condition unrelated to pregnancy or prenatal care [e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care])
0503F	Postpartum care visit
MODIFIERS	
22	Increased Procedural Service; requiring work greater than typically required
25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of a procedure or other service
51	Multiple Procedures; performed on the same day, during the same surgical session
59	Distinct Procedure Service; a procedure or service was distinct or independent from other non-E/M services performed on the same day
TH	Obstetrical treatment/services, prenatal or postpartum

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 10/30/2005

Date	Explanation & Changes
11/01/2006	• No change
12/01/2007	• No change
10/01/2008	• Multi-gestational deliveries
03/01/2010	• Updated
04/13/2018	• No change
09/09/2014	• Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
12/17/2017	• Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
12/11/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/01/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
09/01/2023	• Changed the title from Global Maternity Care to Maternity Care • Combined medical policies PG0001-Global Maternity Care, PG0002-Non-Global Maternity Care and PG0083 Obstetrical Treatment Services into one medical policy • No changes to the policies content
02/01/2024	• Medical Policy placed on the new Paramount Medical Policy format
12/01/2024	• Medical Policy changed to a Reimbursement Policy, and updated to align with Medical Mutual RP-202002 Obstetrical Care.

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

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