GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Global maternity care is usually reported with single all-inclusive service, which encompasses the antepartum care, the delivery service, and the postpartum care. It is not expected additional charges are reported when a global maternity service is reported.

Maternity care is defined as beginning with the initial visit, and ending with the release of care six weeks after delivery. There are four types of global delivery charges established by CPT:

1. Vaginal delivery (59400)
2. Cesarean delivery (59510)
3. Vaginal delivery after a previous Cesarean delivery (59610)
4. Cesarean delivery after failed vaginal delivery attempt after a previous Cesarean delivery (59618)

Antepartum (Prenatal) Care
In order to obtain correct reporting, a series of reporting only or Category II codes (0500F – 0503F) were developed by CPT in conjunction with HEDIS. A single Category II code can be reported each time an antepartum and postpartum visit occurs. These services can be reported after each visit occurs, or all at the time of delivery, or release from care at the end of the six-week postpartum period. While reporting of these services is not provider-mandated, it simply assists in mandated HEDIS reporting.

While CPT does not specify the number of expected antepartum visits, it is expected that at least 13 antepartum visits should occur and be reported (based on ACOG, HEDIS, and state reporting guidelines).

1. Initial visit using procedure code (0500F)
2. Second visit using procedure code (0501F)
3. 11 visits using procedure code (0502F)

It is expected that only one provider will provide antepartum, labor/delivery, and postpartum care, unless the care is transferred. During the initial visit, the pregnancy is diagnosed and reported with procedure code 0500F as a treatment indicator. The next visit encompasses a complete initial prenatal examination, as well as obtaining a complete medical history, which is reported with procedure code 0501F as a treatment indicator. All subsequent obstetrical visits are “determined by the individual needs of the woman and the assessment of her risks,” according to The American College of Obstetricians and Gynecologists (ACOG). These subsequent prenatal visits are reported with procedure code 0502F.

The routine antepartum visits include an educational plan with the following topics discussed: anesthesia, breast or bottle feeding, selection of a physician for the newborn, car seat and safety, tubal sterilization, circumcision, limitations, and restrictions. While this list is not all inclusive, it is an indicator of expected teaching performed during a routine pregnancy. This educational plan also includes discussions related to routine laboratory and radiological testing. This testing can include CBC, diabetes screening, glucose tolerance testing (if screening was abnormal), Rh antibody screening, Rhogam at 28 weeks (if indicated), as well as Syphilis IgG, GC, chlamydia screening, Group B strep screening, and ultrasounds. The laboratory and radiological testing are services reported separately, but the review of these services by the OB/GYN provider is considered a component of the routine obstetrical plan of care.

The documentation for supporting antepartum services are supported by ACOG, and their development of an antepartum flow sheet used to report the standard 13 antepartum visits. Subsequent antepartum visits include blood pressure, weight, urine for sugar and albumin, fundal height, and fetal heart tones beginning at 10-12 weeks by Doppler.
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, amniinfusion, forceps and/or vacuum-assisted delivery, episiotomy and/or laceration repair, as well as fetal and maternal testing, and induction of labor services.

Multiple Births
Paramount has adopted the billing guidelines for Multiple Birth reporting as set forth by The American College of Obstetricians and Gynecologists (ACOG).

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
- 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

Postpartum Care
Postpartum care includes hospital and office visits following any type of delivery, and can include any number of visits (usually extends 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. Each of these visits can be reported with procedure code 0503F.

POLICY
Global Maternity Care does not require prior authorization for HMO, PPO, Individual Marketplace, & Elite.
Global Maternity Care is non-covered for Advantage.

HMO, PPO, Individual Marketplace, Elite
Global service includes prenatal, delivery, and postpartum care. The service cannot be submitted separately, either by the same or by a different provider. Additional maternity services will be denied as part of the global service when submitted separately.

Any visits to the physician/nurse midwife 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.

There are a few specific examples in which obstetrical services 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 pregnancy does not result in a delivery
- The member switches physicians

A common example would occur when the nurse midwife has given all the antepartum care but must relinquish care when the member requires a cesarean delivery. In this case, the midwife bills for the prenatal care and the surgeon bills for the cesarean and postpartum care. No provider is to bill for global services.

Advantage
These members must follow non-global maternity care billing (PG0003 Non-Global Maternity Care).
CODING/BILLING INFORMATION
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</td>
</tr>
<tr>
<td>59409</td>
<td>Vaginal delivery only (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care</td>
</tr>
<tr>
<td>59610</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery</td>
</tr>
<tr>
<td>59612</td>
<td>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)</td>
</tr>
<tr>
<td>59618</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, after previous cesarean delivery</td>
</tr>
<tr>
<td>0500F</td>
<td>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)</td>
</tr>
<tr>
<td>0501F</td>
<td>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)</td>
</tr>
<tr>
<td>0502F</td>
<td>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])</td>
</tr>
<tr>
<td>0503F</td>
<td>Postpartum care visit</td>
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MODIFIERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Service requiring work substantially greater than typically required</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple surgeries performed on the same day, during the same surgical session</td>
</tr>
</tbody>
</table>

REVISION HISTORY EXPLANATION

11/01/06: No change
12/01/07: No change
10/01/08: Multi-gestational deliveries
03/01/10: Updated
04/13/12: No changes
09/09/14: Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
12/12/17: Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Industry Standard Review
Hayes, Inc.