Capital BLUE

PROFESSIONAL NETWORK REIMBURSEMENT POLICY

POLICY TITLE	Global Obstetrical Allowance and Concurrent Services
POLICY NUMBER	NR-05.601

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DESCRIPTION/BACKGROUND EXCLUSIONS | DEFINITIONS VARIATIONS - No | POLICY REFERENCES

I. DESCRIPTION/BACKGROUND TOP

This policy documents the methodology for the reimbursement of global obstetrical procedure codes and their individual components. The global obstetrical allowance refers to the antepartum, delivery and postpartum care that an obstetrical patient receives.

II. DEFINITIONS TOP

American Medical Association (AMA) - An organization whose mission is to promote the science and art of medicine and the betterment of public health. The AMA speaks out on issues important to patients and the nation's health and exercises a strong advocacy agenda on behalf of patients and provider. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research, and education.

Amniocentesis – Transabdominal puncture of the amniotic sac under ultrasound guidance using a needle and syringe in order to remove amniotic fluid.

Antepartum – Period of pregnancy between conception and onset of labor, used with reference to the mother.

Cesarean Section – Delivery of a fetus by means of surgical incision into the abdomen and uterus.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care

professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Episiotomy – Incision of the perineum at the end of the second stage of labor to avoid spontaneous laceration of the perineum and to facilitate delivery.
Postpartum – Occurring after childbirth.

Rh Factor – An antigenic substance present in the erythrocytes of eighty-five percent (85%) of the people. A person having the factor is Rh+ (Rh positive); a person lacking the factor is Rh- (Rh negative). If an Rh- person receives Rh+ blood, hemolysis and anemia occur.

RhoGAM ™ – A solution of gammaglobulins, which are proteins made by the immune system (antibodies). These special proteins will neutralize any blood from an Rh-positive fetus that gets inside an Rh-negative mother during normal delivery or miscarriage. This drug is given as an injection.

III. POLICY

TOP

All procedures and services included in the global obstetrical allowance (CPT Codes 59400, 59510, 59610, and 59618), including the antepartum, delivery and postpartum care, are subject to reimbursement consideration based on the Plan allowance in place for those procedure codes. To be considered eligible for separate reimbursement, procedures or services not included in the global obstetrical allowance should be reported using the procedure code that most accurately describes the service.

The services within the global obstetrical allowance may be performed by a medical doctor, doctor of osteopathy or a certified nurse midwife (CNM) who is licensed to practice as a registered nurse and meets the requirements set forth by the state of Pennsylvania regarding midwives.

The following services are included in the global obstetrical allowance:

Antepartum Care*:

- Initial and subsequent history
- Physical examination
- Blood pressure checks
- Fetal heart tones
- Weight checks

- Routine chemical urinalysis
- Urinalysis; bacteriuria screen
- Monthly visits to 28 weeks gestation
- Biweekly visits to 36 weeks gestation
- Weekly visits until delivery
- Insertion of cervical dilator *(when performed on the date of delivery)*

Intrapartum/Delivery*:

- Admission to hospital
- Admission history and physical
- Management of uncomplicated labor
- Preoperative counseling *(cesarean delivery)*
- Preparation of abdomen *(cesarean delivery)*
- Abdominal incision *(cesarean delivery)*
- Uterine incision *(cesarean delivery)*
- Uterine repair *(cesarean delivery)*
- Incision closure *(cesarean delivery)*
- Hemostasis *(cesarean delivery)*
- Fetal monitoring
- Placement of internal fetal and/or uterine monitors
- Catheterization or catheter insertion
- Preparation of perineum with antiseptic solution
- Vaginal delivery with or without forceps or vacuum extraction
- Cesarean section delivery

  Delivery of placenta, Episiotomy and the repair/suturing of the episiotomy or repair 1st and 2nd degree lacerations
- Injection of local anesthesia
- Administration of intravenous oxytocin

Postpartum*:

- Recovery room visit
- Uncomplicated inpatient hospital postpartum visits
- Uncomplicated outpatient visits up to six weeks postpartum
- Exploration of uterus
- Placement of hemostatic pack or agent
- Dictation of operative notes (cesarean delivery)

** Each procedure or service listed under the headings of antepartum, intrapartum/delivery and postpartum, may occur during several phases of pregnancy and delivery. Each procedure or service is listed under the phase during which it would most likely occur. If a procedure or service that falls inside the global obstetrical allowance is listed under Antepartum but actually occurs during the Delivery, the procedure or service would still be considered part of the global obstetrical allowance.*

In the case of multiple births, the primary birth is included as part of the global obstetrical allowance. Any subsequent births (twins, triplets, etc.) should be reported using the mode of delivery procedure code only (vaginal birth as 59409 or cesarean birth as 59514, using units to indicate the number of subsequent births).

If a provider other than the attending physician repairs an episiotomy or vaginal tear, the provider may bill separately for that service, using the appropriate repair procedure code. In addition, if either the attending physician or a provider other than the attending physician repairs third or fourth degree lacerations at the time of delivery, the laceration repair may be reported by appending modifier –22 to either the global obstetrical procedure code or the intrapartum/delivery and postpartum care procedure code.

There are several procedures/services that may be performed concurrent to services included in the global obstetrical allowance when medically necessary; these procedures/services may be eligible for separate or additional reimbursement in accordance with applicable reimbursement methodology (e.g. – Multiple Surgical Reductions, CCI, Bilateral Reductions, Bundled Procedure). They may include, but are not necessarily limited to:

Antepartum Care*:

- Office visit to diagnose pregnancy
- Management of medical problems not related to pregnancy
- Management of medical problems or complications related to pregnancy
- Laboratory tests excluding dipstick urinalysis
- Management of surgical problems arising during pregnancy
- Routine venipuncture
- Amniocentesis
- Cordocentesis
- Chorionic villus sampling
- Fetal contraction stress testing
- Fetal non-stress testing
- External cephalic version

- Obstetric ultrasounds
- Fetal biophysical profile
- Fetal echocardiography
- Administration of Rh immune globulin
- Cerclage of cervix
- Insertion of cervical dilator *(when performed prior to the date of delivery)*

Intrapartum/Delivery*:

- Fetal scalp blood sampling
- Administration of general or regional anesthesia
- Removal of cerclage sutures
- Any gynecological surgery
- Bowel repair
- Cystotomy, cystotomy drainage
- Bladder cystotomy to excise lesions
- Tubal ligation at the time of cesarean delivery
- Lysis of extensive, dense adnexal adhesions
- Hysterectomy at the time of cesarean delivery
- Injection of regional anesthesia

Postpartum*:

- Management of medical problems not related to pregnancy
- Management of medical problems or complications related to pregnancy
- Management of surgical problems arising in the postpartum period
- Tubal ligation
- Fetal invasive procedures
- Hysterorrhaphy of ruptured uterus

<u>Hysterectomy After Cesarean Delivery</u>

A hysterectomy performed at the time of a cesarean delivery should be reported using the appropriate procedure code (59525). This procedure code is an add-on code and is eligible for separate reimbursement only when reported with an appropriate primary procedure code.

<u>Change in Provider during the Global Period</u>

In the event a member decides during the course of pregnancy to use the services of a provider who is part of a different Provider Group for their maternity care, the services included in the global obstetrical allowance may be reported as separate and distinctive

services, i.e. antepartum care, postpartum care, delivery only or labor management only. Separate reimbursement considerations may also be made for services that are considered part of the global allowance when someone other than the patient's provider renders a particular part of the service. When billed separately, each service in the global obstetrical allowance should be reported using the most appropriate procedure code to describe the service. The total reimbursement for services rendered as separate procedures/services and not as part of the global obstetrical allowance will not exceed the global obstetrical Plan allowance.

If a member is seen for routine obstetrical care less than four (4) times, the provider should report each encounter using separate evaluation and management procedure codes instead of the antepartum procedure codes (59425 and 59426).

When there is more than one provider rendering obstetrical services to the patient, but the providers are part of the same provider group; the services listed as individual services within the global obstetrical package will not be eligible for separate reimbursement consideration. When different provider groups perform any of the individual services that comprise any of the global obstetrical groupings (i.e. Antepartum care only, Delivery only, Delivery and Postpartum care, Postpartum care only), those individual services may be reported separately by the group that performed each service.

Change in Insurance Coverage During the Global Period

If the member changes health insurance carriers anytime during pregnancy and delivery, the provider rendering the services should report the individual procedures and services contained within the global obstetrical package separately to the health insurance carrier providing coverage at the time the service(s) is rendered.

Please refer to the following Professional Network Reimbursement Policies for additional information:

NR-30.019 *Correct Coding and Reimbursement Methodology*

NR-30.020 *Payment Policy Indicators*

NR-30.003 *Reimbursement of Services Performed by Certified Nurse Midwives (CNM)*

In addition to the criteria and conditions contained in this policy, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

IV. EXCLUSIONS

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N/A

V. VARIATIONS TOP

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

VI. REFERENCES TOP

American Academy of Family Physicians
Coding for Intrapartum Care and Other Obstetrical Services

CPT 2020 Professional Edition
American Medical Association

EncoderPro for Payers
Optum™ 2020

OB/GYN Coding Manual: Components of Correct Procedural Coding
The American College of Obstetricians and Gynecologists Women's Health Care Physicians

Taber's Cyclopedic Medical Dictionary, Edition 21