UnitedHealthcare Community Plan

REIMBURSEMENT POLICY
CMS-1500
Policy Number 2024R0064F

Obstetrical Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services.

Unless otherwise specified, for the purposes of this policy, Same Group Physician and/or Other Qualified Health Care Professional includes all physicians and/or other qualified health care professionals of the same group reporting the same federal tax identification number.

Reimbursement Guidelines

Global OB Care

As defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Qualified Health Care Professional provides all components of the OB package, report the global OB package code.

The *Current Procedural Terminology* (CPT®) book identifies the global OB codes as: 59400, 59510, 59610, and 59618 UnitedHealthcare Community Plan reimburses for these global OB codes when all of the antepartum, delivery and postpartum care is provided by the Same Group Physician and/or Other Qualified Health Care Professional.

UnitedHealthcare Community Plan 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.

Please refer to the Itemization of OB Services section of this policy for guidance on coding services when a patient changes insurers or group practices during her pregnancy.

A. Services Included in the Global OB Package
Per CPT guidelines and the American College of Obstetricians and Gynecologists (ACOG), the following services are included in the global OB package (CPT codes 59400, 59510, 59610, 59618).

- Routine prenatal visits until delivery (up to 3 visits are allowed in addition to the global package depending on the state regulations)
- Recording of weight, blood pressures and fetal heart tones
- Routine chemical urinalysis
- 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

- Vaginal or cesarean section delivery (limited to single gestation; for further information, see Multiple Gestation section)
- Delivery of placenta
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- Repair of first or second degree lacerations
- Simple removal of cerclage (not under anesthesia)
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services provided within 60 days of delivery
- Postpartum care only
- Educational services e.g. breastfeeding, lactation, and basic newborn care

UnitedHealthcare Community Plan will not separately reimburse the above services when reported separately from the global OB code except as noted in the Non-Global OB Billing and State Exceptions Sections.

Per ACOG coding guidelines, 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). Claims submitted with modifier 22 must include medical record documentation that supports the use of the modifier; please refer to the Increased Procedural Services section of this policy and UnitedHealthcare Community Plan's "Increased Procedural Services Policy."

B. Services Excluded from the Global OB Package
Per CPT guidelines and ACOG, the following services are excluded from the global OB package (CPT codes 59400, 59510, 59610, 59618) and may be reported separately if warranted:

- First three antepartum E&M visits
- Laboratory tests
- Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76820, 76821, 76825, 76826, 76827 and 76828). For additional information, see E/M Service with an OB Ultrasound Procedure section.
- Amniocentesis, any method
- Amnioinfusion
- Chorionic villus sampling (CVS)
- Fetal contraction stress test
- Fetal non-stress test
- External cephalic version
- Insertion of cervical dilator more than 24 hours before delivery
- 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 OB Care section of this policy.
- Additional E/M visits for complications or high risk monitoring resulting in greater than the typical 13 antepartum visits; per 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.
- Inpatient E/M services provided more than 24 hours before delivery
- Critical care services that are unrelated to the specific anatomic injury or general surgical procedure performed, within global period (Use modifier FT)
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy)

C. Maternal-Fetal Medicine Specialists
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 has the same federal tax identification 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 is in a different group practice than the physician(s) and other qualified health care professionals supplying the routine antepartum care, modifier 25 is not necessary.

D. E/M Service with an OB Ultrasound Procedure
UnitedHealthcare Community Plan follows ACOG coding guidelines and considers an E/M service on the same date of service, by the Same Individual Physician or Other Qualified Health Care Professional to be separately reimbursed in addition to an OB ultrasound procedure (CPT codes 76801-76817 and 76820-76828) only if the E/M service is a separate and distinct service and is submitted with the appropriate modifier.

Non-Global OB Billing

There are some UnitedHealthcare Community Plan markets that require providers to bill in a method other than using the single most comprehensive, or global, CPT code. These markets are: **FL, KS FQHC's & RHC's**, **MD, MI, MO HealthNet FQHC's & RHC's, MS CAN, NJ, OH, PA and TX.** For additional information refer to the State Exceptions Sections for state specific requirements.

While **PA** providers are to bill global OB codes, they may also bill separately for antepartum services. Providers are to submit the appropriate level E&M codes. For **TX** the prenatal E/M codes must be appended with a TH modifier.

For **MD, MI, MS CAN, OH, and TX:** Global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum codes may be used.

For **NJ:** Global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery codes that include the postpartum visit are not covered. Delivery and Postpartum must be billed individually.

For **MS CAN** providers are to submit antepartum codes 59425/59426 per date of service.

Duplicate OB Services

Duplicate OB services are defined as any of the below listed CPT codes provided by the same or different physician on the same or different date of service. This follows the coding guidelines defined by the AMA.

CPT codes for global 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.
For additional information, refer to the Questions and Answers section, Q&A #5.

Itemization of OB Services

Global OB codes are utilized when the Same Group Physician and/or Other Qualified Health Care Professional provides all components provides all components of the OB package. However, physicians from different group practices may provide individual components of maternity care to a patient throughout a pregnancy. Although OB Related E/M Services should be billed as a global package, itemization of OB Related E/M Services may occur in the following situations:
- A patient transfers into or out of a physician or group practice
- A patient is referred to another physician during her pregnancy

- A patient has the delivery performed by another Physician or Other Qualified Health Care Professional not associated with her physician or group practice
- A patient terminates or miscarries her pregnancy
- A patient changes insurers during her pregnancy

A. Antepartum Care Only
The CPT Editorial Board created codes 59425 and 59426 to accommodate 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 by the Same Group Physician and/or Other Qualified Health Care Professional.

The antepartum care only CPT codes 59425 or 59426 should be reported by the Same Group Physician and/or Other Qualified Health Care Professional when:

- The antepartum care provided does not meet the routine antepartum care definition of the global OB package as defined by CPT ; or
- The antepartum care provided is less than the typical number of visits (usually 13) during the global OB package as defined by ACOG.

If the patient is treated for antepartum services only, the physician and/or other qualified health care professional should use CPT code 59426 if 7 or more visits are provided, CPT code 59425 if 4-6 visits are provided, or itemize each E/M visit if only providing 1-3 visits.

As described by ACOG and the AMA, the antepartum care only codes 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 qualified health care professional should report CPT code 59425 with the "from and to" dates for which the services occurred.
- **Exception**: **MS CAN** providers are to submit antepartum codes 59425/59426 per date of service.
- **Exception**: **California** providers are to submit antepartum codes 59425/59426 per date of service.

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

B. Delivery Services Only
Per the CPT book, "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: 59400, 59514, 59612, and 59620.
The delivery only codes should be reported by the Same Group Physician and/or Other Qualified Health Care Professional for a single gestation when:

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

If the same individual or Same Group Physician and/or Other Qualified 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.

For deliveries involving twin or triplet gestations, see the Multiple Gestation section of this policy.

Items Included in the Delivery Services
According to CPT and ACOG coding guidelines, the following services are included in the delivery 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
- Delivery of the placenta; any method
- Repair of first or second degree lacerations

UnitedHealthcare Community Plan will not separately reimburse for these services when one of the delivery only codes is reported.
UnitedHealthcare Community Plan considers insertion of a cervical dilator 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 global OB (59400, 59610) or delivery only (59409, 59410, 59612 and 59614) codes. Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier; please refer to the Increased Procedural Services section of this policy and UnitedHealthcare Community Plan's "Increased Procedural Services Policy."

C. Postpartum Care Only
The following is the CPT defined postpartum care only code: 59430

In order to accommodate various state regulations UnitedHealthcare Community Plan considers the postpartum period to be 60 day following the date of the cesarean or vaginal delivery. This is an increase to the ACOG guideline of six weeks.

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 Group Physician and/or Other Qualified Health Care Professional that provides the patient with services of postpartum care only. If a physician 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 only code..

D. Delivery Only including Postpartum Care
Sometimes a physician 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, 59515, 59614, and 59622.

The delivery only including postpartum care codes should be reported by the Same Group Physician and/or Other Qualified Health Care Professional for a single gestation when:

- The delivery and postpartum care services are the only services provided

- The delivery and postpartum care services are provided in addition to a limited amount 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

For reimbursement of inpatient E/M services unrelated to the routine OB care, please refer to UnitedHealthcare Community Plan's "Global Days Policy."

Non-OB Care

During Antepartum Stage:
Per ACOG guidelines, when a patient is seen for a condition unrelated to pregnancy (e.g., bronchitis, flu), these E/M visits are considered Non-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. UnitedHealthcare Community Plan 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.

During Postpartum Stage:
UnitedHealthcare Community Plan will reimburse non-OB related office E/M services rendered during the postpartum care when submitted with modifier 24. Please see UnitedHealthcare Community Plan's "Global Days Policy" for additional information.

Multiple Gestation

Twin Deliveries
UnitedHealthcare Community Plan's reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries. See table below for appropriate code submission regarding delivery of twin births.

Vaginal	Baby A	59400, 59410, or 59409
	Baby B	59409-59
Vaginal Birth After Cesarean	Baby A	59610, 59614, or 59612
	Baby B	59612-59
Cesarean Delivery	Baby A & Baby B	59510, 59515, or 59514
Repeat Cesarean Delivery	Baby A & Baby B	59618, 59622, or 59620
Vaginal Delivery + Cesarean Delivery	Baby A	59409-51
	Baby B	59510, 59515, or 59514
VBAC + repeat Cesarean Delivery	Baby A	59612-51
	Baby B	59618, 59622, or 59620

If there is increased physician work involvement for delivery of the second baby, modifier 22 is added to the global cesarean code (CPT codes 59510 or 59618). Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier; please refer to Increased Procedural Services section of this policy and UnitedHealthcare Community Plan's "Increased Procedural Services Policy."

Claim submissions for multiple gestation deliveries are reviewed by the UnitedHealthcare Community Plan Medical Claim Review unit.

Fetal Non-Stress Test

Per coding guidelines from the December 2008 *CPT Assistant*, multiple non-stress tests performed on a single fetus on the same day should be reported with CPT code 59025 for the initial test. Code 59025 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 modifier 77, to identify that the non-stress test was repeated by another physician.

Multiple Procedure Reductions

Multiple procedure reductions will be applied to OB codes having a delivery component for both vaginal and cesarean sections. Please refer to UnitedHealthcare Community Plan's "Multiple Procedure Policy."

Increased Procedural Services

The determination to allow additional reimbursement for OB services submitted with modifier 22 is based on individual review of clinical documentation that supports use of the modifier identifying an increased procedural service per CPT modifier guidelines.

Accordingly, physicians and other qualified health care professionals should submit supporting medical records whenever modifier 22 is utilized. UnitedHealthcare Community Plan's "Increased Procedural Services Policy" offers additional information surrounding the reimbursement of this modifier.

The following identifies some common OB situations that involve modifier 22; please note this is not an all-inclusive list.

- ACOG coding guidelines recommend reporting the repair of a third or fourth degree laceration at the time of delivery by appending modifier 22 to the global, delivery only or delivery only plus postpartum care code. UnitedHealthcare Community Plan's methodology for additional reimbursement in this circumstance is based on the allowable amount for the **delivery component** only of the OB code submitted.
- Per ACOG coding guidelines, modifier 22 can be used for increased services associated with delivery of twins; for further information, please refer to the Multiple Gestation section of this policy.

Assistant Surgeon and Cesarean Sections

Only a non-global cesarean section delivery code (CPT codes 59514 or 59620) is a reimbursable service when submitted with an appropriate assistant surgeon modifier. Refer to UnitedHealthcare Community Plan's "Assistant Surgeon Policy" for additional information regarding modifiers and reimbursement.

Prolonged Physician Services

Prolonged physician services for labor and delivery services are not separately reimbursable services. CPT codes for prolonged physician services (99415 – 99418,G0316–G0318,G0320–G0321,and G2212) are add-on codes used in

conjunction with the appropriate level E/M code. As described in ACOG coding guidelines, prolonged services are not reported for services involving indefinite periods of time such as labor and delivery management.
Home or Other Non-Facility Deliveries
Home delivery services are subject to this policy in the same manner as services performed by physicians and other qualified health care professionals who deliver in the hospital setting.

State Exceptions	
Arizona	Providers must bill the appropriate Global Delivery code if the patient is seen four or more times prior to delivery for prenatal care and physician performs the delivery, along with a prenatal service code that supports number of prenatal visits and the postpartum service code. There will be no additional compensation for the itemized OB service codes submitted along with the Global Deliver Code, as their value is already included in the Global Care.
California	Providers are to submit antepartum codes 59425/59426 per date of service.
Florida	• Global OB (three component) codes and Antepartum codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum (two component) codes may be used. • FL providers are to submit prenatal codes H1001 and/or H1000. • Prenatal care must be billed separately from the delivery and postpartum care. • An Evaluation and Management code cannot be reimbursed in addition to a prenatal visit on the same day, same recipient, same provider or provider group. • Up to 14 visits are allowed for prenatal care & up to 18 visits are allowed for high risk prenatal care. • Up to 3 postpartum only visits are allowed within 90 days following delivery, per recipient. This is in addition to delivery or delivery + postpartum codes billed. • Additional delivery codes are not reimbursed when delivery of two or more infants from a single pregnancy are delivered by the same delivery method.

Indiana	• Global codes 59400, 59510, 59610 and 59618 are not covered.
	• E/M procedure code may be used to accommodate the greater amount of work involved for the first prenatal visit. For subsequent visits, prenatal-care-only codes should be used
	• Prenatal care must be billed separately from the delivery and postpartum care
	• Delivery and postpartum care must be billed separately from prenatal care.
	• CPT 59425 and 59426 are used for all postpartum care.
	• Up to 14 visits are allowed for prenatal care during a normal pregnancy, as follows:
	  o Three visits in the first trimester
	  o Three visits in the second trimester
	  o Eight visits in the third trimester
	• To identify prenatal visits in each trimester, providers must bill the procedure code for the visit in conjunction with the appropriate U1, U2, or U3 modifier for each specific date of service:
	  o U1 – Trimester one – 0 through 14 weeks, 0 days
	  o U2 – Trimester two – 14 weeks, 1 day through 28 weeks, 0 days
	  o U3 – Trimester three – 28 weeks, 1 day through delivery

<table>
<tr><td>Kansas</td><td>Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) must bill using “unbundled” obstetrical (nonglobal) services separately on per encounter basis.

For multiple births, per State regulations, use the following table when billing multiple birth claims. Only one code for the first birth can be used in conjunction with another code for the consecutive birth(s). Codes must be billed on the same claim with one unit each regardless of the number delivered. Only one code from each column can be billed regardless of the number delivered. For coding combinations that require NCCI editing, it is recommended to add modifier 59.
<table>
<tr><td>Type of Delivery</td><td>Code for Frist Birth</td><td>Code for Consecutive Births</td></tr>
<tr><td>All Vaginal</td><td>59400, 59409, 59410, 59610, 59612, 59614</td><td>59409
59612</td></tr>
<tr><td>All Cesarean</td><td>59510, 59514, 59515, 59618, 59620, 59622</td><td>59514
59620</td></tr>
<tr><td>Mixed Delivery</td><td>59400, 59409, 59410, 59610, 59612, 59614</td><td>59514
59620</td></tr>
</table></td></tr>
<tr><td>Kentucky</td><td>Global OB codes will not be reimbursed for Kentucky, providers must unbundle the components and bill them separately. Delivery plus postpartum codes may be used.</td></tr>
<tr><td>Maryland</td><td>Global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum codes may be used.

Antepartum codes 59425 & 59426 will not be reimbursed; providers must submit E&M codes.

Per State regulations, Maryland requires claims for Birthing Centers (POS 25) and Providers to be submitted on Form 1500. Delivery codes are payable to both the Birthing Center and the Provider.</td></tr>
<tr><td>Michigan</td><td>Global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum codes may be used.</td></tr>
<tr><td>Mississippi CAN</td><td>Global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum codes may be used.

Multiple gestations delivered by C-Section: multiple deliveries are reimbursable, one delivery + postpartum (or delivery only if appropriate) and additional delivery only for additional babies.

Providers must bill CPT code 59425 or 59426 for antepartum visits. Only one code billed per visit, per date of service.</td></tr>
<tr><td>Missouri</td><td>Effective 08-01-2022, global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum codes may be used.

Prior to 08-01-2022, Missouri follows all the global billing requirements outlined in the Global OB Care section above.

The State of Missouri MO HealthNet requires Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHC) to bill using the non-global OB codes.

Doula services are separately reimbursable. Doula services must be billed with procedure codes S9445 with modifier TH/TS, or S9482, T1033, T1032, S9443.</td></tr>
<tr><td>Nebraska</td><td>Nebraska follows global OB billing; however when the primary physician does not participate in the total OB care, unbundling of services is allowed. Claim must be submitted with an explanation for the partial care. Providers will use one procedure code, i.e., for prenatal care only code, but shall provide individual dates of service on separate lines.</td></tr>
</table>

New Jersey	Due to State Requirements, Global OB codes will not be reimbursed, providers must unbundle the components and bill them separately. Delivery plus postpartum codes will not be reimbursed. Doula services are reimbursable. Doula services are available starting in the prenatal period and continuing up to 180 days postpartum (contingent on the member retaining NJFC eligibility). Doula services can be provided in the community, in clinicians' offices (if a Doula is accompanying the member to a clinician's visit), or in the hospital. Doulas may receive an incentive payment to encourage continuity of care during the postpartum period. In order for the Doula to receive the incentive payment: • The Doula must provide a postpartum service visit within 6 weeks of delivery • The Doula must also bill using 99199 HD U8 for the incentive payment • An obstetric clinician follow-up visit must occur within 6 weeks of delivery All Doula care claims should be billed with the diagnosis code Z32.2 and need to append the HD modifier. **Standard care** (8 perinatal visits-1 labor support visit, i.e. 8-1) • Up to 8 visits in the prenatal or postpartum period, including the option of 1 initial prenatal visit • Must use a U7 modifier for initial prenatal service visit • 99600 – allowing up to 6 units with units being defined as 15 minutes • 99199 – allowing up to 4 units with units being defined as 15 minutes Attendance at the delivery • **Delivery care** (1 labor – 1 unit, i.e. 1-1) • 59409 • 59514 **Enhanced care** (12 perinatal visits-1 labor support visit, i.e., 12-1) • Enhanced care delivery is available to members who are 19 years old or younger at the time of the first Doula service visit • Must use a 22 modifier • Up to 12 visits in the prenatal or postpartum period, including the option of 1 initial prenatal visit • 99600 – allowing up to 4 units with units being defined as 15 minutes • 99199 – allowing up to 4 units with units being defined as 15 minutes
New York	Modifier U7, U8 or U9 is required on delivery codes.

<table>
<tr><td>Ohio</td><td>Global OB codes will not be reimbursed. Providers must unbundle the components and bill the delivery charge and the prenatal visits on the same claim if the member has a primary carrier If the member does not have a primary the provider can bill the delivery and prenatal separately as services are rendered. Delivery plus postpartum codes may be used.

Antepartum codes 59425 & 59426 will not be reimbursed; providers must submit E&M codes.

For freestanding birthing centers, global OB code 59400 and antepartum codes 59425 and 59426 are allowed.

Claims for delivery will not be reimbursed unless delivery diagnosis codes that have the week of gestation in their description are used (Code list below).

Ohio Medicaid ICD-10 Gestational Week Diagnosis List

<table>
<tr><td>Z3A.01</td><td>Z3A.08</td><td>Z3A.09</td><td>Z3A.10</td><td>Z3A.11</td><td>Z3A.12</td><td>Z3A.13</td><td>Z3A.14</td></tr>
<tr><td>Z3A.15</td><td>Z3A.16</td><td>Z3A.17</td><td>Z3A.18</td><td>Z3A.19</td><td>Z3A.20</td><td>Z3A.21</td><td>Z3A.22</td></tr>
<tr><td>Z3A.23</td><td>Z3A.24</td><td>Z3A.25</td><td>Z3A.26</td><td>Z3A.27</td><td>Z3A.28</td><td>Z3A.29</td><td>Z3A.30</td></tr>
<tr><td>Z3A.31</td><td>Z3A.32</td><td>Z3A.33</td><td>Z3A.34</td><td>Z3A.35</td><td>Z3A.36</td><td>Z3A.37</td><td>Z3A.38</td></tr>
<tr><td>Z3A.39</td><td>Z3A.40</td><td>Z3A.41</td><td>Z3A.42</td><td>Z3A.49</td><td></td><td></td><td></td></tr>
</table>

Doula services are reimbursable beginning in the prenatal period and continuing up to 365 days postpartum (contingent on the member retaining UHC OH MCD eligibility).
• Providers must bill for doula services utilizing T1032 - services performed by a doula birth worker, per 15 minutes or T1033 - services performed by a doula birth worker, per diem
• Doula services are reimbursable without prior authorization up to 48 units/year (for T1032)
• T1033 is reimbursable for services provided on the date of delivery
• Doula services can be provided in the community, provider's office, acute care facilities, & via telehealth. Providers should add modifier GT for telehealth doula services
Doula service rendered at Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are also reimbursable in accordance with OAC Chapter 5160-28.</td></tr>
<tr><td>Pennsylvania</td><td>Antepartum visits are to be itemized. PA providers are to submit appropriate level E&M codes in addition to the global or most comprehensive code.

Per State regulations, Pennsylvania requires claims for Birthing Centers (POS 25) and Providers to be submitted on Form 1500. Delivery codes are payable to both the Birthing Center and the Provider.</td></tr>
<tr><td>Rhode Island</td><td>Doula services are separately reimbursable. Doula services must be billed with procedure codes S9445, S9446, 59510, 59400 and with modifier XU.</td></tr>
<tr><td>Tennessee</td><td>• TennCare will allow for a routine postpartum care visit (up to two visits) within the global period of 84 days. Allow 0503F to be reimbursed when billed with 59430.

• Allow 0500F to be reimbursed when billed with 99202-99205 & 99211-99215.

• Allow 96160 TH (any position) to be reimbursed in addition to any office or global service codes</td></tr>
</table>

Texas	Global OB codes will not be reimbursed, providers must bill an appropriate: • Antepartum - E/M procedure code for each visit (Home visit, New/Est. E/M or Preventive Med Serv.) appended with modifier TH. • Delivery and Postpartum - Non-global OB code for delivery and postpartum. Delivery plus postpartum codes may be billed. Services considered a part of OB service code (antepartum, delivery, postpartum) should not be billed separately – i.e. urinalysis, hemoglobin, hematocrit. These services are considered a component of the antepartum visit, delivery, and/or postpartum code. Modifier U1, U2 or U3 is required on delivery codes. Modifier U3 is not reimbursable. Code 59409 is allowed when billed by a Birthing Center on a CMS 1500 form on the same date of service as a professional provider claim billed for the delivery.
Virginia	CPT codes 59409, 59514 59425, 59430, 99600 and 99199 must be billed with HD modifier for Doula claims.
Washington	Washington Medicaid considers additional urinalysis codes 81001, 81003, and 81007 as part of the global OB and/or antepartum package; These codes are not separately reimbursed.

Definitions	
Non-Obstetric E/M Service	Visit(s) occurring outside the regularly scheduled antepartum period whereby the Same Group Physician and/or Other Qualified Health Care Professional providing maternity care provides services for a condition such as bronchitis, flu, or upper respiratory infection.
Obstetric (OB) Related E/M Service	Additional visit(s) provided in addition to routine antepartum care for a high-risk or complicated pregnancy.
Physician or Other Qualified Health Care Professional	Per the CPT book, a Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.

Questions and Answers	
1	**Q:** Will UnitedHealthcare Community Plan reimburse an attending physician for fetal monitoring during labor (CPT codes 59050 or 59051)? **A:** No, these codes are specifically for fetal monitoring during labor by a consulting physician.
2	**Q:** Why is CPT code 59200 considered part of the delivery service and not reimbursed separately? **A:** According to ACOG's coding guidelines, CPT code 59200 performed on the day of delivery is a component included in the delivery service. Therefore, UnitedHealthcare Community Plan considers this service included in the patient's delivery service and does not consider it a separately reimbursable service unless performed and reported on a date of service other than the date of delivery.

3	**Q:** If one physician performs the delivery only, and a physician in another practice (different federal tax identification number) provides all of the postpartum care, how should these services be reported? **A:** The physician who performs the delivery only should report the delivery only service without a postpartum component. The physician who performs the postpartum care should report the postpartum care only code.
4	**Q:** If one physician performs the delivery only, and a different physician in the same practice (same federal tax identification number) provides all of the postpartum care, how should these services be reported? **A:** Per the CPT book, the procedure code that most accurately reflects the services performed should be used. In this instance since these physicians are of the same physician group (same federal tax identification number), The appropriate CPT code that identifies both the delivery and postpartum care should be reported.
5	**Q:** How is an OB procedure reimbursed when reported by two different physicians with the same or different federal tax identification numbers reporting a component and a global OB care code during the same global OB period? **A:** When OB-services are eligible for reimbursement under this policy, only one provider will be reimbursed when multiple physicians bill duplicate OB services. UnitedHealthcare Community Plan follows a "first in, first out" claim payment methodology in determining which claim will be considered for reimbursement when claims for duplicate OB services are received that involve component and global OB care services.
6	**Q:** Should a postpartum visit be provided within the ACOG standard six-week period? **A:** The postpartum period includes routine office or outpatient postpartum visit(s) usually, but not necessarily, performed 6 weeks following delivery. If a physician routinely performs more than one postpartum outpatient visit in an uncomplicated case, the extra visit(s) is not billed separately. When a postpartum visit is scheduled, but the patient does not keep the appointment, the physician's documentation should reflect that the patient did not appear for the scheduled postpartum visit. This visit does not have to be refunded if a global OB code was previously submitted. If a patient returns to the office well after their scheduled postpartum visit (e.g., 6 months later) this visit may be reported separately since the global period would no longer apply. ******NOTE**: In order to accommodate various state regulations UnitedHealthcare Community Plan considers the postpartum period to be 60 day following the date of the cesarean or vaginal delivery. This is an increase to the ACOG guideline of six weeks.***
7	**Q:** Are contraceptive management services included in postpartum care? **A:** UnitedHealthcare Community Plan will consider separate reimbursement for the following contraceptive management services, when provided during the postpartum period. • Insertion, non-biodegradable drug delivery implant • Diaphragm or cervical cap fitting with instructions • Insertion of intrauterine device (IUD)
8	**Q:** What does the phrase "changes insurers" mean in relation to itemization of OB Related E/M Services? **A:** For the purposes of this policy, "insurer" means a third party payer. If a patient changed insurers during her OB care, the Physician or Other Qualified Health Care Professional would separate and submit the OB services that were provided in an itemized format to each insurer. For example, when reporting the antepartum care services, the code selection depends on how many visits were performed while covered under each insurer. The Physician or Other Qualified Health Care Professional should report CPT code 59426 when 7 or more visits are provided, CPT code 59425 when 4-6 visits are provided, or an E/M visit when only providing 1-3 visits. For purposes of this policy, "change insurers" could also mean that a patient continues to be covered under one insurer, but changes coverage for that insurer. The physician and/or other qualified health care professional should submit OB services in the same manner as if the patient had changed insurers.

9	**Q:** Can contraceptive educational consultations and/or classes for lactation, infant safety, birthing, and parenting be submitted separately within the global OB period? **A:** Contraceptive educational consultations and/or classes for lactation, infant safety, birthing, and parenting, are considered part of the global package and are not separately reimbursed when submitted by the Same Group Physician and/or Other Qualified Health Care Professional.
10	**Q:** Will critical care services be considered for separate reimbursement if performed within the global period? **A:** In those cases where a critical care visit is unrelated to the procedure with a global surgical period, critical care visits may be paid separately in addition to the procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed. When the critical care service is unrelated to the procedure, append the modifier FT.

Attachments

ICD-10 OB Related Diagnosis List	A list of ICD-10–CM diagnosis codes related to OB.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

MLN Matters Number: SE1408 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf

Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)

History

10/6/2024	Policy Version Change State Exceptions Section: Missouri Updated
10/4/2024	Policy Version Change State Exceptions Section: Ohio updated History Section: Entries prior to 10/4/2022 archived
9/15/2024	Policy Version Change State Exceptions Section: Kansas updated
7/12/2024	Policy Version Change State Exceptions Section: Pennsylvania updated
4/14/2024	Policy Version Change State Exceptions Section: Rhode Island added
1/14/2024	Policy Version Change State Exceptions Section: Mississippi CAN updated

11/5/2023	Policy Version Change State Exceptions Section: Virginia Added
10/20/2023	Policy Version Change State Exceptions Section: Ohio Updated
10/8/2023	Policy Version Change Attachments Section: OB-Related-ICD-10-CM-Diagnosis-Codes List updated
9/24/2023	Policy Version Change Attachments Section: OB-Related-ICD-10-CM-Diagnosis-Codes List updated
4/16/2023	Policy Version Change State Exceptions Section: Tennessee Added
1/27/2023	Policy Version Change State Exceptions Section: Updated Missouri History Section: Entries prior to 1/27/2021 archived
1/1/2023	Policy Version Change Policy Section: E/M Services with an OB Ultrasound Procedure; Prolonged Physician Service History Section: Entries prior to 1/1/2021 archived
11/13/2022	Policy Version Change State exceptions section: Changed FL exception language.
2/12/2012	Policy implemented by UnitedHealthcare Community & State