

Obstetrical Services Policy, Professional for Louisiana

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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Application

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.

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Policy

Overview

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical 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 Obstetrical 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 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care
- 59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

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 Obstetrical 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 Obstetrical 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 (CPT codes 81000 and 81002)
- 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 (CPT code 59414)
- Administration/induction of intravenous oxytocin (CPT codes 96365 - 96367)
- Insertion of cervical dilator on same date as delivery (CPT code 59200)
- 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 (CPT code 59430)
- 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."

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B. Services Excluded from the Global Obstetrical 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 Obstetrical Ultrasound Procedure](#) section.
- Amniocentesis, any method (CPT codes 59000 or 59001)
- Amnioinfusion (CPT code 59070)
- Chorionic villus sampling (CVS) (CPT code 59015)
- Fetal contraction stress test (CPT code 59020)
- Fetal non-stress test (CPT code 59025)
- External cephalic version (CPT code 59412)

- Insertion of cervical dilator (CPT code 59200) 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 Obstetric 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
- 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 Obstetrical (OB) Ultrasound Procedure

UnitedHealthcare Community Plan follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820-76828) only if the E/M service has modifier 25 appended to the E/M code.

If the patient is having an OB ultrasound and an E/M visit on the same date of service, by the Same Individual Physician or Other Qualified Health Care Professional, per ACOG coding guidelines the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure. Per CPT guidelines, modifier 25 should be appended to the E/M service to identify the service as separate and distinct.

Note: UnitedHealthcare Community Plan considers the review of a radiology service (identified by appending modifier 26 to the designated procedure code) to be included in the E/M service when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service for the same patient. Review of an ancillary test or x-ray, as contrasted with formal interpretation, is an integral part of the E/M service when both are provided by the same physician or other qualified health care professional on the same day. For more information, refer to UnitedHealthcare Community Plan's "Professional/Technical Component Policy" section titled "Professional Component with Evaluation and Management Services."

Duplicate Obstetrical 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 code descriptions refer to the [Code](#) section of the policy.

For additional information, refer to the [Questions and Answers](#) section, Q&A #6.

Itemization of Obstetrical Services

Global OB codes are utilized when the Same Group Physician and/or Other Qualified Health Care Professional 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 Obstetric (OB) Related E/M Services should be billed as a global package, itemization of Obstetric (OB) Related E/M Services may occur in the following situations:

- 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 (*Antepartum care only; 4-6 visits*) and 59426 (*Antepartum care only; 7 or more visits*) 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.

When date ranges span across the effective date of ICD-9-CM to ICD-10-CM for antepartum services see [Q&A #1](#).

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:

- 59409 - Vaginal delivery only (with or without episiotomy and/or forceps)
- 59514 - Cesarean delivery only

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

The delivery only codes should be reported by the Same 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 (CPT codes 96365 - 96367)
- 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 cervical dilator (CPT 59200) to be included if performed on the same date of delivery.

Per ACOG coding guidelines, reporting of third and fourth degree lacerations should be identified by appending modifier 22 to the 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 - Postpartum care only (separate procedure)

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 code (CPT code 59430).

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 - Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
- 59515 - Cesarean delivery only; including postpartum care
- 59614 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

The delivery 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."

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Non-Obstetric 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-Obstetric (OB) E/M Services and can be reported as they occur. The diagnosis code used in conjunction with the E/M service should support the non-OB condition being treated and/or evaluated. 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
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	Baby B	59409-59
VBAC*	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, 59620 or 59622
Vaginal Delivery + Cesarean Delivery	Baby B	59510, 59515 or 59514
	Baby A	59409-51
VBAC + repeat Cesarean Delivery	Baby B	59618, 59620 or 59622
	Baby A	59612-51

*VBAC=vaginal birth after cesarean

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 modifiers 59, XE, XP, XS or XU appended, to identify that a separate fetus is being evaluated. If subsequent testing is performed on the second fetus, CPT code 59025 with modifiers 59, XE, XP, XS or XU 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. Please refer to the Definitions section of this policy regarding modifiers 59, XE, XP, XS or XU.

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 (99354, 99355, 99356, 99357, 99358 and 99359) 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

Louisiana	<p>Louisiana Medicaid considers the recipient a 'new patient' for each pregnancy whether or not the recipient is a new or established patient to the provider/practice. The appropriate level E&M CPT procedure code from the range of codes 99201-99205 shall be billed for the initial prenatal visit and must include the TH modifier.</p> <p>Subsequent prenatal visits should be billed with the appropriate level E&M CPT code from the range of procedure codes used for an established patient: 99211-99215. The E&M CPT code for each of these visits must be modified with TH.</p> <p>The most appropriate "delivery only" CPT code should be billed. Delivery codes inclusive of the antepartum care and/or postpartum visit are not covered.</p> <p>CPT codes 59400-59699 can be billed with modifier 22 to signify multiple gestation deliveries, no supporting documentation required.</p> <p>Reimbursement for procedures billed with modifier 22 is 125% of the fee on file or billed charges, whichever is lower.</p>
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Modifiers

Modifier 22	<p>Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physician and mental effort required). Note: This modifier should not be appended to an E/M service.</p>
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Modifier 24	<p>Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period: The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.</p>
Modifier 25	<p>Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.</p>
Modifier 26	<p>Professional Component: Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.</p>
Modifier 59	<p>Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifiers 59, XE, XP, XS or XU are used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifiers 59, XE, XP, XS or XU. Only if no more descriptive modifier is available, and the use of modifiers 59, XE, XP, XS or XU best explains the circumstances, should modifiers 59, XE, XP, XS or XU be used. Note: Modifiers 59, XE, XP, XS or XU should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.</p>
Modifier 76	<p>Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.</p>

Modifier 77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
Modifier TH	Obstetrical treatment/services, prenatal or postpartum
Modifier U1	Delivery prior to 39 weeks of gestation and medically necessary
Modifier XE	A Service That Is Distinct Because It Occurred During A Separate Encounter
Modifier XP	A Service That Is Distinct Because It Was Performed By A Different Practitioner
Modifier XS	A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
Modifier XU	The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

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.
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.

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Questions and Answers

1	<p>Q: If a physician provides antepartum services when the “from” and “to” dates span across ICD-9-CM to ICD-10-CM code sets, and global maternity service codes are used, such as CPT 59425 or 59426, how should the services be reported?</p> <p>A: To facilitate correct payment and application of benefits in the UnitedHealthcare claims system, when the date span crosses ICD-9-CM to ICD-10-CM code sets, the “from date” of service should be reported with the correct ICD code from the applicable code set for that date of service. Example: Report the diagnosis using the ICD code set that is in effect for the date of service in the “from date” field. If the date in the “from date” field is on or before Sept. 30, 2015, use the ICD-9-CM code. If the date in the “from date” field is on or after Oct. 1, 2015, use the ICD-10-CM code.</p>
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	<p>Note: Global maternity care codes for services that span over the ICD-10 effective date do not need to be split on two lines to accommodate the implementation of ICD-10-CM. If an OB global code and/or antepartum services procedure code is reported on two or more claims by the Same Group Physician and/or Other Health Care Professional, only the first unit processed will be considered, all subsequent units will be rejected and not separately reimbursed.</p>
2	<p>Q: Will UnitedHealthcare Community Plan reimburse an attending physician for fetal monitoring during labor (CPT codes 59050 or 59051)?</p> <p>A: No, these codes are specifically for fetal monitoring during labor by a consulting physician.</p>
3	<p>Q: Why is insertion of cervical dilator (CPT code 59200) considered part of the delivery service and not reimbursed separately?</p> <p>A: According to ACOG’s coding guidelines, CPT code 59200 (insertion of a cervical dilator, e.g. laminaria, prostaglandin) performed on the day of delivery is a component included in the delivery service. Therefore, UnitedHealthcare 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.</p>
4	<p>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?</p> <p>A: The physician who performs the delivery only should report the delivery service without a postpartum component, e.g., CPT code 59409 (vaginal delivery only). The other physician should report the postpartum care only code (CPT code 59430).</p>
5	<p>Q: If one physician performs the delivery only (e.g. CPT code 59409), and a different physician in the same practice (same federal tax identification number) provides all of the postpartum care (i.e., CPT code 59430), how should these services be reported?</p> <p>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), CPT code 59410 would be reported as the code description identifies both the delivery and postpartum care.</p>
6	<p>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?</p> <p>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.</p>
7	<p>Q: Should a postpartum visit be provided within the ACOG standard six-week period?</p> <p>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.</p> <p>***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.***</p>

8	<p>Q: Are contraceptive management services included in postpartum care?</p> <p>A: UnitedHealthcare will consider separate reimbursement 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).</p>
9	<p>Q: What does the phrase “changes insurers” mean in relation to itemization of Obstetric (OB) Related E/M Services?</p> <p>A: For the purposes of this policy, “insurer” means a third party payer. If a patient changed insurers during her OB care, the physician and/or other 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 and/or other 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.</p> <p>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 health care professional should submit OB services in the same manner as if the patient had changed insurers.</p>
10	<p>Q: Can consultations and/or classes for lactation, infant safety, birthing, parenting, and contraceptive management be submitted separately within the global OB period?</p> <p>A: No, consultations and/or classes for lactation, infant safety, birthing, parenting, and contraceptive management are considered part of the global package and are not separately reimbursed.</p>

Codes	
CPT code section	
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only;
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care

59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Attachments: Please right click the icon to open the file

 UnitedHealthcare Community Plan ICD-10 OB Related Diagnosis List	A list of ICD-10 –CM diagnosis codes related to obstetrics to be used on or after date of service October 01, 2015.
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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)

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History

2/15/2021	Removed reference to other state exceptions
6/18/2019	State Exceptions: Updated FL
5/1/2019	State Exceptions: Updated TX
2/1/2019	Annual Anniversary Date and Policy Version Change Title Section Changed: Removed RPOC reference Updated Services Included in the Global Obstetrical Package Definitions: Updated verbiage and added “qualified” to other health professionals Q&A 10 added Attachments Section: Updated OB Related ICD-10-CM Diagnosis Codes list History Section: Entries prior to 1/1/2017 archived
9/30/2018	State Exceptions: Updated FL Attachments Section: OB Related DX Codes list updated
5/14/2018	State Exceptions: Updated MD
5/7/2018	State Exceptions: Updated TX

3/14/2018	Annual Approval Date Change (no version change)
3/4/2018	State Exceptions: Updated AZ, FL, MO, NE, NJ, NY, OH, PA, and TX. Removed WI Modifiers: Added 24, 26, TH, U7 and XE Attachments Section: Removed Ohio Medicaid Delivery CPT Code List Non Global Obstetrical Billing: Updated with additional information.
01/01/2018	Annual Version Change History Section: Entries prior to 1/1/2016 archived State Exceptions: Updated Texas verbiage that had been changed in error
11/10/2017	Attachments Section: OB Related DX Codes list updated
10/28/2017	Modifier sections updated: Added modifiers 76 and 77 Increased Procedural Services updated: Added addition modifier 22 verbiage Attachments Section: OB Related DX Codes list updated State Exceptions Section: FL & MO Updated
10/15/2017	State Exceptions: Information added to Florida
8/20/2017	Non Global Billing: MI added State Exceptions: Information added to Michigan and Louisiana
6/14/2017	State Exceptions: Missouri added
5/21/2017	References to Medicare removed State Exceptions: Florida added
3/8/2017	Annual Approval Date Change (no version change)
2/12/2017	Attachments Section: Gestational Week List added State Exceptions: Ohio Gestation Week exception added Reorganized information Resources Section: ACOG added
1/1/2017	Annual Version Change Attachment Section: ICD-9 List removed
2/12/2012	Policy implemented by UnitedHealthcare Community & State

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