

# OBSTETRICAL POLICY

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## Related Policies

- Refer to the [Reimbursement Guidelines](#) section of the policy

## INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

## APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

## APPLICATION

This 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.

## 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. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services.

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

Oxford may allow a newly enrolled woman to continue maternity care on an in plan basis with a non-participating provider. This is referred to as Transitional Care. This will most likely result in a prorated claim.

## REIMBURSEMENT GUIDELINES

### **Global Obstetrical (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 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

Oxford 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 Health Care Professional.

Oxford will adjudicate claims submitted with either a single date of service or a date span when submitting global OB codes. To facilitate claims processing, a single date of service may be utilized.

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.

### **Services Included in the Global Obstetrical Package**

Per CPT guidelines and the American Congress of Obstetricians and Gynecologists (ACOG), the following services are **included** in the *Global OB* package (CPT codes 59400, 59510, 59610, 59618):

- All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)
- Initial and subsequent history and physical exams
- 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 6 weeks of delivery
- Postpartum care only (CPT code 59430)

Oxford will not separately reimburse the above services when reported separately from the global OB code.

### **Exceptions:**

- Participating and non-participating New Jersey providers may elect to be reimbursed for maternity services rendered to a covered person enrolled with a New Jersey line of business on either a global (one payment for all services rendered during the term of the pregnancy for antepartum care, delivery and postpartum care) or on an installment basis (3 equal payments that when combined are the equivalent of the global payment for services rendered during the term of the pregnancy).
- If a non-participating provider in New York is eligible for a global payment and payment is requested before delivery, two dates of service prior to delivery may be reimbursed.

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 Oxford's *Increased Procedural Services* policy.

### **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:

- Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of ICD-10-CM diagnosis code Z32.01 (Encounter for pregnancy test, result positive).
- Laboratory tests (excluding routine chemical urinalysis)
- 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 \(OB\) 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. For further information, please refer to [High Risk/Complications](#) section of this policy.
- Inpatient E/M services provided **more than 24 hours before** delivery
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).

### **High Risk/Complications**

A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global OB CPT codes of 59400, 59510, 59610 or 59618. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. Per ACOG coding guidelines, if a patient sees an obstetrician for extra visits to monitor a potential problem and no problem actually develops, the physician is **not** to report the additional visits; only E/M visits related to a current complication can be reported separately. Oxford will separately reimburse for E/M services associated with high risk and/or complications when Modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

Refer to the [High Risk/Complication Diagnosis Code List](#).

### **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 health care professionals supplying the routine antepartum care, Modifier 25 is not necessary.

### **Evaluation and Management (E/M) Service with an Obstetrical Ultrasound Procedure**

Oxford 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 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.

### **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 [Applicable Codes](#) section of the policy.

For additional information, refer to [Q&A #5](#).

### **Itemization of Obstetrical Services**

Global OB codes are utilized when the Same Group Physician and/or Other 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 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 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

### **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 Same Group Physician and/or Other Health Care Professional.

The *Antepartum Care Only* CPT codes 59425 or 59426 should be reported by Same Group Physician and/or Other Health Care Professionals 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 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 (1).
- 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 health care professional should report CPT code 59425 with the "from and to" dates for which the services occurred.

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

### **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 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 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

Oxford will not separately reimburse for these services when one of the delivery codes is reported.

Oxford 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 Oxford's *Increased Procedural Services* policy.

### **Postpartum Care Only**

The following is the CPT defined *Postpartum Care Only* code:

- 59430 - Postpartum care only (separate procedure)

Oxford follows ACOG guidelines and considers the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.

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 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).

## **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 Physicians and/or Other 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 the *Global Days* policy.

## **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. Oxford 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**

Oxford will reimburse non-OB related office E/M services rendered during the postpartum care when submitted with Modifier 24. Please see Oxford's *Global Days* policy for additional information.

## **Multiple Gestation**

### **Twin Deliveries**

Oxford'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.

Type of Delivery	Baby A/B	CPT Code(s)
Vaginal	Baby A	59400
	Baby B	59409-59
VBAC*	Baby A	59610
	Baby B	59612-59
Cesarean Delivery	Baby A & Baby B	59510
Repeat Cesarean Delivery	Baby A & Baby B	59518
Vaginal Delivery + Cesarean Delivery	Baby B	59510
	Baby A	59409-51
VBAC + repeat Cesarean Delivery	Baby B	59618
	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 the [Increased Procedural Services](#) section of this policy and the *Increased Procedural Services* policy.



### **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. Please refer to the Definitions section of this policy regarding Modifier 59.

### **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 the *Multiple Procedures* 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 health care professionals should submit supporting medical records whenever Modifier 22 is utilized. Oxford'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. Oxford's methodology for additional reimbursement in this circumstance is based on the allowable amount for the **delivery component** only of the obstetrical 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.

Per ACOG coding guidelines, it is **not** appropriate to append Modifier 22 to the global OB code when additional E/M services result in greater than the typical 13 routine antepartum visits. For information regarding additional payment of E/M services that go beyond the typical number encountered in an average pregnancy, please refer to the [High Risk/Complications](#) section of this policy.

### **Laboratory Tests**

Oxford follows ACOG coding guidelines and considers CPT laboratory codes 81000 and 81002 as included in the global antepartum or global OB service when submitted with an OB diagnosis code in an office setting.

### **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 the *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, 99359, 99415, and 99416) 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 health care professionals who deliver in the hospital setting.

## DEFINITIONS

**Modifier 22 (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, and physician and mental effort required).

**Note:** This Modifier should not be appended to an E/M service.

**Modifier 25 (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.

**Modifier 59 (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. Modifier 59 is 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 Modifier 59. Only if no more descriptive modifier is available, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used. **Note:** Modifier 59 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.

**Modifier 76 (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.

**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.

**Non-Obstetric (OB) E/M Service:** Visit(s) occurring outside the regularly scheduled antepartum period whereby the Same Group Physician and/or Other 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 Health Care Professional:** All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.

**Same Individual Physician or Other Health Care Professional:** The same individual rendering health care services reporting the same Federal Tax Identification number.

## APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan



document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

CPT Code	Description
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
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
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
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
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

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## QUESTIONS AND ANSWERS

1	Q:	Will Oxford 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 insertion of cervical dilator (CPT code 59200) considered part of the delivery service and not reimbursed separately?
	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, Oxford 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 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).

4	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?
	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.
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 providers bill duplicate obstetrical services. Oxford 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.
7	Q:	Are contraceptive management services included in postpartum care?
	A:	Oxford 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).
8	Q:	How should the initial OB visit be reported?
	A:	Per ACOG guidelines, if the obstetrical record is not initiated, then the office place of service visit should be reported separately by using the appropriate E/M CPT code (99201-99215, 99241-99245 and 99341-99350) and ICD-10-CM diagnosis code of Z32.01. If the obstetrical record is initiated during the confirmatory visit, then the confirmatory visit becomes part of the global obstetric package and is not reported separately.
9	Q:	What does the phrase "changes insurers" mean in relation to itemization of Obstetric (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 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.  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.

## ATTACHMENTS

### Obstetrical Evaluation & Management (E/M) Codes

A list of obstetrical evaluation and management (E/M) codes



Obstetrical Policy  
E&M Codes.xls

## High Risk/Complication ICD-10-CM Diagnosis Codes

A list of ICD-10-CM diagnosis codes identifying complications or high risk



High Risk  
Complicated ICD-10 C

## Obstetrical Related ICD-10-CM Diagnosis Codes

A list of ICD-10-CM diagnosis codes related to obstetrics



OB Related ICD-10  
CM Diagnosis Codes

## REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [2018R0064A]

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

Centers for Disease Control and Prevention, International Classification of Diseases, 9th Revision, Clinical Modification.

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

## POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
11/12/2018	<ul style="list-style-type: none"><li>Updated list of <i>High Risk/Complication ICD-10-CM Diagnosis Codes</i> (attachment file) to reflect quarterly code edits:<ul style="list-style-type: none"><li>Added F12.23, F12.93, F53.0, F53.1, N35.82, N35.92, O30.131, O30.132, O30.133, O30.139, O30.231, O30.232, O30.233, O30.239, O30.831, O30.832, O30.833, O30.839, O86.00, O86.01, O86.02, O86.03, O86.04, O86.09, and Z20.821</li><li>Removed N88.3, O00.0, O00.1, O00.2, O00.8, O00.9, O33.7, O34.21, O70.2, O86.0, R93.8, and Z36</li></ul></li><li>Updated list of <i>Obstetrical Related ICD-10-CM Diagnosis Codes</i> (attachment file) to reflect quarterly code edits:<ul style="list-style-type: none"><li>Added F53.0, F53.1, O30.131, O30.132, O30.133, O30.139, O30.231, O30.232, O30.233, O30.239, O30.831, O30.832, O30.833, O30.839, O86.00, O86.01, O86.02, O86.03, O86.04, and O86.09</li><li>Removed O00.10, O00.11, O00.2, O00.20, O00.21, O00.8, O00.9, O33.7, O34.21, O70.2, O86.0, and Z36</li></ul></li><li>Archived previous policy version ADMINISTRATIVE 200.18 TO</li></ul>