Professional Pricing Policy

Subject: **Maternity Services (HMO Only)**	
Policy Number: HLSP-0004	Policy Section: **Surgery**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

HealthLink allows for global obstetrical codes once per period of a pregnancy when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN) unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Allowance is based on all aspects of the global obstetric care package (antepartum, delivery and postpartum) being provided by the provider or provider group reporting under the same TIN. If a provider or provider group reporting under the same TIN does not provide all Antepartum, Delivery and Postpartum services, global obstetrical codes may not be used and providers are to submit for only the elements of the obstetric package that were provided.

HealthLink will not allow duplicate or otherwise overlapping services during the course of the pregnancy.

Global Services

If Global, Delivery Only, Delivery/Postpartum, Antepartum Only or Postpartum Only services have been allowed for the same pregnancy, a claim for Global services may be denied or may cause a previously-paid claim for overlapping services to be adjusted/recouped.

Delivery Only

If Global, Delivery Only, or Delivery/Postpartum services have been allowed for the same pregnancy, a claim for Delivery Only services may be denied. Delivery Only services will be separately allowed for assistant surgeons only for cesarean deliveries if appended with the appropriate modifier.

Delivery/Postpartum

If Global, Delivery Only, Delivery/Postpartum or Postpartum Only services have been allowed during the same pregnancy, a claim for Delivery/Postpartum services may be denied or may cause a previously paid

claim for overlapping services to be adjusted/recouped.

Antepartum Only

If Global or Antepartum Only services have been allowed during the same pregnancy, a claim for Antepartum Only services may be denied.

Postpartum Only

Postpartum Only claims may be denied if Global, Delivery/Postpartum, or Postpartum Only services have already been allowed during the same pregnancy.

Included in the Global Package

The following elements of the global package are not separately allowed when any CPT code for global services is billed:

- Initial and subsequent history and physical exams when pregnancy diagnosis has already been established
- All routine prenatal visits until delivery (typically monthly through 28 weeks, then biweekly until 36 weeks and weekly until delivery) – usually 13 visits
- Additional visits for a high risk pregnancy, potential problems, or history of problems that do not actually develop or are inactive in the current pregnancy
- Collection of weight, blood pressure and fetal heart tones
- Routine urinalysis
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E&M) services that occur within 24 hours of delivery
- Management of uncomplicated labor (including administration of labor inducing agents)
- Insertion of cervical dilators on the same date of the delivery
- Simple removal of cerclage
- Vaginal (including forceps or vacuum assisted delivery) or cesarean delivery of single gestation
- Delivery of placenta
- Repair of first- or second-degree lacerations
- Uncomplicated inpatient visits following delivery
- Routine outpatient E&M services within 6 weeks of delivery
- Discussion of contraception
- Postpartum care only
- Education on breastfeeding, lactation, exercise, or nutrition
- Augmentation of labor, amniotomy, and vacuum extraction are not eligible for separate reimbursement; (these services are included in the global reimbursement for labor and delivery.)

Not Included in the Global Package

The following services may be billed separately from the global obstetrical package:

- Initial E&M visit to diagnose pregnancy when the activities in the antepartum record are not initiated
- Laboratory testing (excluding routine urinalysis)
- Additional antepartum E&M visits (in excess of 13) for a high risk complication that is active in the current pregnancy. These additional visits are to be submitted for payment only at the time of delivery. These visits must be submitted with a Modifier 25 and an appropriate high risk diagnosis.
- Additional E&M visits for conditions unrelated to pregnancy. These visits may be reported as they occur and must clearly not be related to pregnancy
- Maternal or fetal echocardiography procedures
- Amniocentesis

- Chorionic villus sampling
- Fetal contraction stress testing and nonstress testing
- Biophysical profile
- Amnioinfusion
- Insertion of cervical dilator that occurs more than 24 hours before delivery
- Inpatient E&M encounters that occur more than 24 hours before delivery
- Management of surgical problems arising during pregnancy
- Care provided by maternal fetal medicine specialists
- Ultrasound – refer to the Maternity Ultrasound in the Outpatient Setting Medical Policy
- External cephalic version

Antepartum/Postpartum Care

Providers should use the appropriate E&M codes for Antepartum and Postpartum care. We reserve the right to request medical documentation to perform post-pay review of paid claims.

Related Coding

Code	Description	Comments
59430	Postpartum care only (separate procedure)	90 day postpartum period applies.

Exemptions

Definitions

General Professional Pricing Policy Definitions

Related Policies and Materials

Global Surgical Package
Modifier 59 and XE, XP, XS and XU (Distinct Procedural/Separate/Unusual Service)
Modifier 22 (Increased Procedural Services)

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- The American College of Obstetrics and Gynecologists
- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.