Payment Policy: Reporting The Global Maternity Package

Reference Number: LA.PP.016
~~Product Types: ALL~~
Effective Date: 08/2020 Coding Implications
Date of Last Revision: ~~07/2023~~06/2024 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
According to the CPT® manual guidelines and the American Congress of Obstetricians and Gynecologists (ACOG); CPT's global obstetrical package includes all the services (antepartum care, delivery and postpartum care) normally provided in an *uncomplicated* maternity case. These services are considered bundled and therefore are not reported or reimbursed separately. The global obstetric package includes approximately 13 antepartum visits and traditionally extends to 6 weeks following delivery. The global obstetrical package procedure code includes antepartum, delivery and postpartum care.
When pregnancy is confirmed during a problem-oriented visit or preventative visit, these services are not included in the global OB package and are reported separately using the appropriate evaluation and management codes 99201-99205, 99211-99215, 99241-99245, 99281-99285 and 99384-99385.

The purpose of this policy is to define payment criteria for the global obstetrical package procedure code to be used in making payment decisions and administering benefits.

Reimbursement
Louisiana Healthcare Connections code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures.
Payments to providers are subject to post payment review and recovery of overpayments.
~~Louisiana Healthcare Connections clinical code auditing software will flag provider claims billed with a maternity service that was previously reimbursed by the global OB code or billed with the global OB code for clinical validation. Clinical validation occurs *prior to* claims payment. Once a claim has been clinically validated, it is either released for payment or denied for unbundling~~.[WK1]

The MCO shall accept global maternity procedure codes for claims billed for secondary payment. Global maternity codes shall be recognized and considered for reimbursement only when billed to the MCO as secondary payer. The MCO shall deny claims billed to the MCO as primary payer. *Refer to the Professional Services Fee Schedule for the global maternity procedure codes and rates.*

The MCO shall calculate reimbursement based upon LDH TPL payment policy as defined in the Contract or this Manual.

- LDH, or is contracted actuary, will consider maternity global codes in rate development. Global maternity codes shall only be payable when billed to the MCO as secondary payer; therefore, these codes will not be included in encounter kick payment logic.
- The provider should bill prenatal, delivery, and/or postpartum services separately when the enrollee's coverage terminates prior to delivery.
- Add-on codes for maternity-related anesthesia will not apply. The MCO should bypass add-on rates when modifiers 47 and 52 are reported.
- Interest applies when a payable clean claim remains unpaid beyond the 30 day claims processing deadline. Refer to the Contract for detailed information.
- Maternity claims where the enrollee's primary carrier does not cover maternity services should be billed to the MCO as primary payer. The MCO should accept global maternity procedure codes for claims billed only as secondary payer.

Services Included in the Global Obstetrical Package
Antepartum care includes:

- Initial and subsequent history and physical examinations
- Physical examinations
- Recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis
- Monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks, and weekly visits until delivery
- Labor evaluation and management

Reporting Additional Evaluation and Management Services during the Global Obstetrical Period

Any evaluation and management services, inpatient or outpatient, performed that are related to the pregnancy are included in the provision of the antepartum care and are not reported separately. However, any other visits or services provided within the antepartum period should be coded and reported separately.

Global Maternity Care for Third Party Liability
Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care. Other antepartum services are not considered part of global maternity services—they are reimbursed separately. An initial visit, confirming the pregnancy, is not a part of global maternity care services.

Delivery services include:

- Admission to L&D, update of history and physical, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery or any E/M service on the calendar day prior to delivery and/or calendar day of delivery.

- Management of uncomplicated labor including fetal monitoring
- Placement of internal fetal and/or uterine monitors
- Catheterization or catheter insertion
- Preparation of the perineum with antiseptic solution
- Vaginal delivery with or without forceps or vacuum extraction
- Delivery of the placenta, any method.
- Episiotomy and repair/suturing of lacerations
- Injection of local anesthesia
- Administration of intravenous oxytocin (96365-96367)
- Exploration of uterus
- Placement of a hemostatic pack or agent
- Simple removal of Cerclage (not under anesthesia)
- Discussion and consent for contraception (includes Rx for birth control, consent for IUD, consent for tubal, consent for essure, etc.)

The health plan will not separately reimburse the aforementioned services when they are reported independently from the global OB code unless there is a state, contractual or health plan policy exception.

Reporting Third or Fourth Degree Laceration Tear at Time of Delivery
The ACOG 2015 Coding Manual instructs providers to report the appropriate CPT integumentary section code (e.g., 12041-12047 or 13131-13133) OR add modifier 22 to the delivery code reported.

Postpartum care includes:

- The recovery room visit
- Any uncomplicated inpatient hospital postpartum visits
- Uncomplicated outpatient visits
- Discussion of contraception (including writing a prescription)

Services that can also be performed during the postpartum period and are reported separately in addition to the appropriate code for the maternity delivery services include the following:

- Management of inpatient or outpatient medical problems not related to pregnancy
- Management of inpatient or outpatient medical problems or complications related to pregnancy
- Management of surgical problems arising in the postpartum period.
- Tubal ligation procedure, IUD procedure, etc. (The procedure is payable, the E/M to discuss, consent, or decision for is not – this is included in the global service)

Rationale for Edit
CPT Assistant defines the following guidelines for billing of the global obstetrical package. "The global obstetrical package is reported when a physician from a solo practice or the same physician group practice provides the global routine obstetric care. Global services are reported based upon the type of delivery. It is not appropriate to report the antepartum, delivery, and postpartum care separately when a single physician or the physicians of the same group practice

provide the total obstetrical care. However, there are circumstances when the antepartum care or postpartum care is reported separately and not as a global maternity package."

- More than one obstetrician provides care for a patient:
  - If the patient transfers into or out of the practice
  - Is referred to another physician at some point in the antepartum period
  - Is delivered by another physician not associated with or covering for the obstetrician
- Only one obstetrician provides care for the patient but the services are less than the usual obstetric package. Coding depends on the age of the gestational age of the fetus.
  - After 20 weeks 0 days, the physician reports the global obstetric code.
  - Prior to 20 weeks 0 days, the physician reports an abortion code and/or E/M service codes as appropriate for antepartum care.
- The patient changes insurers during her pregnancy. The physician reports an antepartum code only to the first insurer and the appropriate antepartum only and delivery plus postpartum care codes to the second insurer.

Utilization

Coding for Delivery of Multiple Gestations
Per CPT Assistant, regarding the appropriate coding of maternity services for multiple gestation pregnancies, "The preferred method of reporting a vaginal delivery of twins, when the global obstetrical care is provided by the same physician or physician group, is by appending modifier -22 to the global maternity package."

Both vaginal deliveries - report 59400 for twin A and 59409-51 for twin B.
One vaginal and one cesarean - report 59510 for Twin A and 59409-51 for Twin B.
Both delivered via cesarean - report only 59510 or 59514 (because only one cesarean was performed). If the cesarean is significantly more difficult, add modifier -22 to this code.
Physicians need to submit an operative note with the claim. Routine obstetric care, including antepartum care, cesarean delivery, and postpartum care are included since only one cesarean delivery is performed.
Documentation Requirements

~~*Pre-payment Clinical Claims Review*~~
~~*Clinical Review Guidelines used to determine whether or not maternity services and/or additional E/M services are appropriately billed separately.*~~
~~Louisiana Healthcare Connection will perform a prepayment clinical claims review when the provider submits a claim with services and/or procedures billed separately from the global service. This review is performed by a registered nurse who will review the prospective (prior to claims payment) claims history, and on appeal, medical records for adherence to correct coding principles.~~

~~*Claim Documentation Requirements*~~
~~The claim (and on appeal, medical records) should include the following documentation.~~

- ~~Other services and/or procedures performed indicate a diagnosis or condition unrelated to the maternity services. This may be separately reimbursable.~~

- ~~Diagnoses reported that indicate a complication to maternity services. (e.g.; pregnancy-induced hypertension, abnormal cord conditions, gestational diabetes, and pre-term labor). It is possible for these diagnoses to be separately reimbursable, however if no treatment was done they would not be reimbursed. These conditions must warrant care or treatment of a higher complexity than typical OB care, as well as require additional visits that exceed the normal allowed number of visits. The Clinical Review team reviews 60 days of history to determine what additional services were provided.~~
- ~~Other diagnostic procedures or services are performed that are not considered inclusive in the typical maternity global package.~~

~~If the nurse reviewer concludes that services have been reported appropriately, the claim will be recommended for payment. If the nurse reviewer concludes that services have been reported incorrectly, the claim will be denied.~~

Appeals/Reconsiderations
The provider has the right to request a reconsideration/appeal of denied services. Medical records must accompany the request in order for the services/procedures to be reconsidered for payment. *Medical records should not be submitted upon first time claims submission*, as first time claim review consists only of a review of the information documented on the claim and in the member/provider history. Medical records should only be submitted if the claim is denied after first time claim review and the provider wishes to request a reconsideration or appeal.

Coding and Modifier Information This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be allinclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References

1. *Current Procedural Terminology (CPT®)*, 2024~~2~~2
2. *HCPCS Level II*, 2022~~3~~4
3. Publications of the American Congress of Obstetricians and Gynecologists (ACOG) https://www.acog.org/-/media/project/acog/acogorg/files/creog/creog-coding-modulesslides.ppt
~~3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2021~~
4. *ICD-10-CM ~~Official Draft Code Set,~~* 2022~~3~~4
5. Medicaid NCCI 2023 Coding Policy Manual – Chapter 7 https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-7.pdf
~~5. *Publications and Services of the American Congress of Obstetricians and Gynecologists* (ACOG)~~

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/26/2022	
Annual Review; removed code tables as this information can be located in CPT resources. Changed member to member/enrollee. Added Global Maternity Care for TPL	07/03/2023	10/30/23
Annual Review; added Coding and modifier information, updated dates and reference links. Pre-payment language has been removed	11/2024	

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

~~POLICY AND PROCEDURE APPROVAL~~

~~The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.~~