# SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

# 5.22 MATERNITY CARE AND DELIVERY

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

## MATERNITY CARE AND DELIVERY

Elective deliveries for pregnancies less than 39 weeks gestation can pose both short- and long-term risks for the newborn. The risks that newborns face after early delivery, even at 37 and 38 weeks' gestation include, but are not limited to, increased morbidity from respiratory distress, increased rates of pneumonia, ventilator use, hypoglycemia and NICU admission. The relative risk of neonatal mortality is 2.3 times greater at 37 weeks and 1.4 times greater at 38 weeks as compared to 39 weeks.

These guidelines are an extension of your network agreement. Use these guidelines to ensure proper reimbursement and avoid denied or returned claims. Always verify members' benefits prior to performing this or any other service as benefits may vary for some of our self-funded groups.

Blue Cross considers **elective deliveries**, whether vaginal or cesarean **prior to 39 weeks** to not be covered unless shown to be medically necessary. Elective deliveries that are deemed not medically necessary are not reimbursable. This includes claims for the delivering provider, anesthesiologist and facility. Claims denied as not medically necessary are NOT billable to the member. For global delivery claims (CPT codes 59400, 59410, 59510, 59610, 59614, 59515, 59618 or 59622) that have been denied as not medically necessary, the delivering provider may refile the ante-partum (59426) or post-partum (59430) care services for separate reimbursement consideration

The provider performing the delivery is required to include a modifier. Use one of the following modifiers when billing for a delivery of pregnancy (CPT codes 59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622):

| Modifier | Description |
|---|---|
| GB | Report when delivery is 39 weeks or more, whether spontaneous or elective. |
| AT | Report when delivery is less than 39 weeks and medically necessary. |
| GZ | Report when delivery is less than 39 weeks and NOT medically necessary. |
| *NO MODIFIER* | *Claim will DENY for incomplete information.* |

All other related claims (anesthesia, facility, etc.) will be subject to recoupment of payments should the delivery be determined to not be medically necessary. Labor inductions and elective cesarean deliveries for pregnancies less than 39 weeks gestational may be considered eligible for coverage when there is an established maternal or fetal risk in which the risk of continuing the pregnancy outweighs the risks of early birth. Management decisions should balance the risks of pregnancy prolongation with the neonatal and infant risks associated with early-term delivery. Maternal-fetal-medicine consultations are encouraged in the evaluation of pregnancies considered for early-term delivery and in the assessment of the risks/benefits from such delivery.

Please Note: The maternal patient should be provided with documentation that clearly explains the risks/benefits of early delivery.

Also, it is important to file ALL applicable diagnosis codes on a claim. It is equally important that providers code claims to the highest degree of specificity. Blue Cross discourages providers from filing not otherwise specified (NOS) diagnosis codes. Claims with NOS codes may pend for medical record review and more appropriate coding.

## Doula Services

The following codes should be used when billing for doula services:

- T1032: Doula services per 15 minutes.
- T1033: Doula services performed during labor and delivery, per diem.

T1032 is limited to 4 units per day and T1033 is limited to once per pregnancy.

## Global Billing for Maternity Care

When a sole obstetrician or obstetricians within the same group covering for each other, provide routine maternity care from the beginning of a member's pregnancy to delivery, our policy is to allow an initial evaluation and management service and a global delivery fee.

If a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level evaluation and management services code as a separately payable service, outside the global delivery package. Global obstetrical care begins after the initial visit when the obstetrical record is initiated as part of the physician's comprehensive obstetrics work-up which includes the comprehensive history and physical.

The global period for the obstetrical care, represented by CPT codes 59400, 59410, 59510, 59515, 59610, 59614, 59618 or 59622 includes all routine pregnancy-related evaluation and management office services, after the initial evaluation, and the delivery service.

If more than one obstetrician is involved in a patient's routine maternity care, Blue Cross would expect to see itemized services specific to the care delivered by the obstetrician for that patient. For example, a patient begins treatment in another state and then relocates to Louisiana and a Louisiana obstetrician begins routine care for that patient in the third trimester of pregnancy, the physician would bill the appropriate E&M code (99202-99215) or antepartum care CPT code (59425 or 59426) based on the number of visits, and the delivery code (with or without postpartum care) rather than a global delivery procedure.

Antepartum care for split providers should be billed as:

- 1 – 3 visits – bill evaluation and management codes (99202-99215)
- 4 – 6 visits – bill only CPT code 59425
- 7 or more visits – bill only CPT code 59426

For any post-partum visits on and after date of service December 1, 2017, we require obstetricians to submit a claim for the member's post-partum visit using the non-payable CPT code 0503F with a charge of $0.00. This visit should be performed no later than 60 days of the delivery date.

## Multiple Births

Physicians may receive additional reimbursement of $300 (subject to applicable network discounts) when filing for multiple births. The additional reimbursement applies to both vaginal deliveries and cesarean sections. To be eligible for the additional reimbursement, claims should be filed with the following CPT codes and Modifier 76:

| | | | |
|---|---|---|---|
| 59400 | 59510 | 59610 | 59618 |
| 59409 | 59514 | 59612 | 59620 |
| 59410 | 59515 | 59614 | 59622 |

Only one delivery code should be billed for a member. For example, if a patient with twins delivers the first baby vaginally and the second baby by cesarean section, only the cesarean section code should be billed. Modifier 76 should be added to the cesarean section code to indicate there was a multiple birth.

## For More Information

If you have any questions about the Elective Delivery of Pregnancy medical policy or if you would like a copy of another medical policy, please refer to the Medical Policy section of iLinkBlue.