Coding Policy

Global Payment for Obstetrical Care

CODING POLICY NUMBER: 7

Effective Date: 1/1/2025

Last Review Date: 1/2025

Next Annual Review: 2026

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

I. Reimbursement for obstetrical care is made on a global basis. The practitioner provides care to the member throughout the pregnancy and bills a single global fee after delivery for the prenatal (antepartum) visits, delivery services, and routine postpartum care.

   A. The global period for postpartum care lasts for 42 days (6 weeks) following delivery. Company considers all OB-related antepartum visits to be included in the global OB package or global antepartum care, including hospital visits prior to delivery that are within 48 hours of delivery. Note: Admission to the hospital is always included in the delivery charge based on CPT guidelines, even if performed more than 48 hours prior to delivery.

II. The comprehensive global obstetrical care codes (i.e., 59400, 59510, 59610, or 59618) may be used only if one provider group performs all the maternity care and the patient is seen for at least 10 prenatal visits while eligible with Company.

A. If the member is seen for fewer than 10 prenatal visits, or if the member begins obstetrical care with one provider and transfers care to a different provider group, the appropriate component codes (i.e., 59425 or 59426 for antepartum care only, depending on the number of antepartum visits, and the appropriate code for delivery with postpartum care only) for obstetrical care should be used instead of the comprehensive global obstetrical code.

III. If one provider group performs all maternity care, and the patient is seen by that provider group for at least 10 prenatal visits while eligible with Company, the provider is expected to report the appropriate comprehensive global obstetrical code. Otherwise, the provider should bill only the component OB codes for services performed during the time the patient is eligible with Company.

IV. If the patient begins obstetrical care with one provider and transfers care to another provider in a different group during her pregnancy, each provider should report the appropriate component codes for obstetrical care. Neither provider may use the comprehensive global obstetrical care codes if there is a transfer of care.

V. If there is no lapse in coverage with Company, the global OB code is paid on the plan that is in effect at the time of delivery. It is not appropriate to report partial OB services under different Company plans if the member has had continuous coverage with Company and all other criteria for billing the global codes are met.

VI. If a midwife or nurse midwife performs antepartum care, and delivery is performed by a physician within the same provider group, and all the other guidelines for using the comprehensive code for global obstetrical care are met, the comprehensive code for global obstetrical care should be billed by the physician.

VII. If a midwife, nurse midwife, or other provider performs labor management in the home or birthing center, and the patient is transferred to the hospital for delivery by a physician from a different group practice, the appropriate code for antepartum care (59425 or 59426, depending on the number of visits) may be reported by the first provider.

A. One additional Evaluation and Management code may be reported outside of the global codes for antepartum care (59425 or 59426, depending on the number of visits) for labor management services provided in the home or birthing center prior to transfer of care if the provider does not bill for delivery.
B. If postpartum care is also provided by the midwife, nurse midwife, or other provider, CPT code 59430 may be reported for postpartum care.

VIII. Except as stated in the above, labor management is included in payment for delivery and is not paid separately, even if labor management is performed by someone other than the delivering provider.

IX. Telephone visits (Coding Policy 92.0) and/or two-way video visits (Coding Policies 67.0.A and 67.0.E) may be used in lieu of face-to-face services for some of the antepartum visits included in payment for global obstetrical care. It is expected that the majority of the antepartum visits will be face-to-face.

PROCEDURE

GENERAL

Telemedicine visits

Do not add modifier GT or 95 or use location code 02 or 10 when billing codes for global obstetrical care, even when a portion of the service was performed by telephone or two-way video. Because the codes for global obstetrical care (including CPT codes 59425 and 59426) encompass multiple services that will include at least one face-to-face visit, the codes may be billed as if all visits were performed as face-to-face visits. Use location code 02 or 10 to identify telemedicine services only when billing individual Evaluation and Management (E/M) services separately from the codes for global obstetrical care. **See Coding Policies 67.0.A and 67.0.E for additional information about billing telemedicine services.**

Global Reimbursement for Obstetrical Care

Global reimbursement for obstetrical care includes the following:
Antepartum Care

- Initial and subsequent history (Note: Initial visit to confirm pregnancy is included in the global OB payment when performed by the physician who bills the global OB code.)
- Physical examinations
- Routine urinalysis
- Recording of weight
- Blood pressure monitoring
- Fetal heart tone monitoring
- All office and/or home visits related to the pregnancy

Delivery Services

- Admission to the hospital (even if more than 48 hours prior to delivery)
- Admission history and physical (H&P) examination (even if more than 48 hours prior to delivery)
- Hospital visits prior to delivery that are within 48 hours of delivery
- Management of uncomplicated labor
- Vaginal delivery (with or without episiotomy; with or without forceps)

- Cesarean delivery

Postpartum Care

- Hospital visits, all visits following delivery unless the patient is discharged and readmitted to the hospital
- Office and/or home visits for 6 weeks following delivery

Date of Service for Global OB Codes

- Global OB codes may not be reported until the delivery occurs. The date of delivery is the date of service to be used when billing the global OB codes, including the codes used for billing only antepartum visits and/or only postpartum visits.
- **EXCEPTION: An exception applies if the member's coverage with Company terminates prior to delivery, or if the member transfers care to a different provider group prior to delivery. The provider who is billing for antepartum care prior to the member's termination with Company or transfer of care to another provider group and who is using one of the component global codes for antepartum care may use the last date of service as the date of service for billing the global antepartum care codes.**

Complications

- Minor complications such as urinary tract infections, blood pressure monitoring for hypertension, preterm contractions, breastfeeding issues, or care that would occur during a routine prenatal or postpartum visit is considered inclusive to the global obstetrical package.
- Medical problems complicating the pregnancy, labor and delivery management, and/or postpartum period that require significant time, effort, and medical expertise may be billed if the documentation supports a service that is separately identifiable from a routine obstetrical visit.

External Cephalic Version (CPT 59412)

- This procedure requires specific training and experience and can be high risk with need for emergency C-section. It is not considered to be part of the global payment for obstetrical care.

Multiple Birth Reimbursement Policy

The Company multiple birth reimbursement policy is as follows:

Vaginal Delivery Only

- When multiple births occur by vaginal delivery only, they are eligible for reimbursement using the appropriate global obstetrical code for the primary procedure, and the vaginal delivery only

code(s) for the secondary procedure(s). Multiple surgery reduction will apply to secondary procedure(s) as described on Providence Health Plan Coding Policy 06.0. Use modifier -59 on the delivery-only code to indicate it is a distinct procedural service from the global OB code.

Cesarean Delivery Only

- When multiple births occur by cesarean delivery only, only the appropriate global obstetrical code for the primary procedure will be eligible for reimbursement. A second cesarean section delivery code is not eligible for separate reimbursement because only one cesarean incision is performed.

Vaginal and Cesarean Delivery

- When multiple births occur by both vaginal and cesarean delivery, they are eligible for reimbursement using the appropriate global cesarean obstetrical code for the primary procedure and the vaginal delivery only code(s) for the secondary procedure(s).
- Multiple surgery reduction will apply to secondary procedure(s) per Providence Health Plan Coding Policy 06.0. Use modifier -59 on the delivery-only code to indicate it is a distinct procedural service from the global OB code.

Modifier 22 (Increased Procedural Service)

- Additional reimbursement for maternity codes may be allowed if the documentation supports an increased procedural service as outlined in Coding Policy 10.0 (Increased Procedural Service).
- Modifier 22 may be appended only to global OB codes that include a delivery component or to the delivery-only codes.
- Modifier 22 may not be added to the code for Cesarean delivery simply because there are multiple births. Modifier 22 may be added to the code for Cesarean delivery if the documentation shows unusual circumstances leading to a more extensive, complex procedure than usual.
- Claims billed with modifier 22 must be accompanied by documentation (procedure note or chart notes) and a cover letter written by the physician explaining the unusual circumstances. The documentation is reviewed in Medical Management to determine medical necessity for additional payment. If additional payment is warranted, the additional payment will be based on the allowable amount for the delivery-only component of the obstetrical code submitted. Additional payment of 25% of the approved fee for the delivery component only may be allowed.

See Coding Policy 10.0 (Increased Procedural Services) for additional information.

Fetal Demise

The global OB codes may not be used for delivery when the fetus dies in utero prior to 20 weeks, zero days gestation. For fetal demise prior to 20 weeks gestation, report the code for antepartum visits

depending on the number of visits and the appropriate code for surgical management of incomplete or missed abortion.

CROSS REFERENCES

- Telemedicine Services, Coding Policies 67.0.A and 67.0.E
- Telephone Services, Coding Policy 92.0
- Modifier 22, Increased Procedural Services, Coding Policy 10.0
- Multiple Procedure Reductions, Coding Policy 06.0

REFERENCES

1. Current Procedural Terminology (CPT)
2. Providence Health Plan Clinical Coding Edits
3. Providence Health Plan Clinical Coding Policies

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 1/1999
6/2023	Added clarifying language to show that global OB codes always include hospital admission and admitting H&P based on CPT guidelines. Hospital visits more than 48 hours prior to delivery may be paid separately.
1/2024	Annual review. Removed references to CP 67.0.B and 67.0.D (retired) and added reference to CP 67.0.E, which replaced CP 67.0.B and 67.0.D.
1/2025	Annual review. Removed reference to PHE. Changes made for the PHE to allow some antepartum visits to be performed via telemedicine will be permanent.