

Obstetrical Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement 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 (QHP), including, but not limited to, non-network authorized and percent of charge contract physicians and other QHP.

United Healthcare Commercial

This Reimbursement Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Reimbursement Policy applies to all Individual Exchange benefit plans.

Policy

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.

Reimbursement Guidelines

Global 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, 59510, 59610 and 59618.

UnitedHealthcare 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.

UnitedHealthcare will adjudicate claims submitted with either a single date of service or a date span when submitting global OB codes. To facilitate claims processing, report one unit, whether submitted with a date span or a single date of

service.

Please refer to the [Itemization of OB Services](#) section of this policy for guidance on coding services when a patient changes insurers or group practices during her pregnancy.

A. Services Included in the Global OB 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
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- 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
- Educational services e.g., breastfeeding, lactation, and basic newborn care

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

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 UnitedHealthcare's "Increased Procedural Services Policy."

B. Services Excluded from the Global OB 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.
- 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 OB Ultrasound Procedure](#) section.
- Amniocentesis, any method

- Amnioinfusion
- Chorionic villus sampling (CVS)
- Fetal contraction stress test
- Fetal non-stress test
- External cephalic version
- Insertion of cervical dilator 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 the 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.
- Critical care services that are unrelated to the specific anatomic injury or general surgical procedure performed, within a global surgical period (Use modifier FT).
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).

C. 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. UnitedHealthcare 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 in the [Attachment Section](#)

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.

D. E/M Service with an OB Ultrasound Procedure

UnitedHealthcare follows ACOG coding guidelines and considers an E/M service on the same date of service, by the Same Individual Physician or Other QHP to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820-76828) only if the E/M service is a separate and distinct service and is submitted with the appropriate modifier.

OB Policy E/M Codes

| | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 | 99341 |
| 99342 | 99344 | 99345 | 99347 | 99348 | 99349 | 99350 | S0273 | S0274 | |

Duplicate OB 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 additional information, refer to the Questions and Answers section, Q&A #5.

Itemization of OB 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 Obstetric (OB) Related E/M Services should be billed as a global package, itemization of Obstetric (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 insurer during her pregnancy

A. 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 the Same Group Physician and/or Other Health Care Professional. The antepartum care only CPT codes 59425 or 59426 should be reported by the Same Group Physician and/or Other Health Care Professional 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.
- 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 UnitedHealthcare, then adjust the number of visits reported and the "from and to" dates to reflect when the patient became eligible under UnitedHealthcare coverage.

B. 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, 59514, 59612, and 59620.

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 QHP 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
- Delivery of the placenta; any method
- Repair of first or second-degree lacerations

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

UnitedHealthcare considers insertion of cervical dilator 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 UnitedHealthcare's "Increased Procedural Services Policy."

C. Postpartum Care Only

The following is the CPT defined postpartum care only code: 59430.

UnitedHealthcare 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 only code.

D. 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, 59515, and 59622.

The delivery only including postpartum care codes should be reported by the Same Group Physician 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 UnitedHealthcare's "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. UnitedHealthcare 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:

UnitedHealthcare will reimburse non-OB related office E/M services rendered during the postpartum care when submitted with modifier 24. Please see UnitedHealthcare's "Global Days Policy" for additional information.

Multiple Gestation

Twin Deliveries

UnitedHealthcare'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.

| | | |
|--------------------------------------|-----------------|----------|
| 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 | 59618 |
| 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 [Increased Procedural Services](#) section of this policy and UnitedHealthcare's "Increased Procedural Services Policy."

Claim submissions for multiple gestation deliveries are reviewed by the UnitedHealthcare Medical Claim Review unit.

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.

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 UnitedHealthcare's "Multiple Procedure 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. UnitedHealthcare'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. UnitedHealthcare's methodology for additional reimbursement in this circumstance is based on the allowable amount for the **delivery component** only of the OB 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

UnitedHealthcare 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 UnitedHealthcare's "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 (99415 – 99418, G0316 – G0318, G0320 – G0321, and G2212) 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.

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| 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 | |
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| 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. |
| Physician or Other Qualified Health Care Professional (QHP) | A "Physician or Other QHP" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. |
| Same Group Physician and/or Other Qualified Health Care Professional (QHP) | All physicians and/or other QHP of the same group reporting the same Federal Tax Identification number. |
| Same Individual Physician or Other Qualified Health Care Professional (QHP) | The same individual rendering health care services reporting the same Federal Tax Identification number. |

| Questions and Answers | |
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| 1 | <p>Q: Will UnitedHealthcare reimburse an attending physician for fetal monitoring during labor (CPT codes 59050 or 59051)?</p> <p>A: No, these codes are specifically for fetal monitoring during labor by a consulting physician.</p> |
| 2 | <p>Q: Why is CPT code 59200 considered part of the delivery service and not reimbursed separately?</p> <p>A: According to ACOG's coding guidelines, CPT code 59200 performed on the day of delivery is a component included in the delivery service. Therefore, UnitedHealthcare 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.</p> |
| 3 | <p>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?</p> <p>A: The physician who performs the delivery only should report the delivery only service without a postpartum component. The physician who performs all of the postpartum care should report the postpartum care only code.</p> |
| 4 | <p>Q: If one physician performs the delivery only and a different physician in the same practice (same federal tax identification number) provides all of the postpartum care, how should these services be reported?</p> <p>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), The appropriate CPT code that identifies both the delivery and postpartum care should be reported.</p> |

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| 5 | <p>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?</p> <p>A: When OB-services are eligible for reimbursement under this policy, only one provider will be reimbursed when multiple physicians bill duplicate OB services. UnitedHealthcare 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.</p> |
| 6 | <p>Q: Should a postpartum visit be provided within the ACOG standard six-week period?</p> <p>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.</p> |
| 7 | <p>Q: Are contraceptive management services included in postpartum care?</p> <p>A: UnitedHealthcare will consider separate reimbursement for the following contraceptive management services when provided during the postpartum period.</p> <ul style="list-style-type: none"> • Insertion, non-biodegradable drug delivery implant • Diaphragm or cervical cap fitting with instructions • Insertion of intrauterine device, (IUD) |
| 8 | <p>Q: How should the initial OB visit be reported?</p> <p>A: Per ACOG guidelines, if the OB record is not initiated, then the office place of service visit should be reported separately by using the appropriate E/M CPT code (99202 - 99215, 99242 - 99245 and 99341 - 99342, 99344 - 99345, 99347 - 99350) and ICD-10-CM diagnosis code of Z32.01. If the OB record is initiated during the confirmatory visit, then the confirmatory visit becomes part of the global OB package and is not reported separately.</p> |
| 9 | <p>Q: What does the phrase "changes insurers" mean in relation to itemization of Obstetric (OB) Related E/M Services?</p> <p>A: For the purposes of this policy, "insurer" means a third-party payer. If a patient changed insurers during her OB care, the Physician or Other QHP 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 or Other QHP 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.</p> <p>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 or Other QHP should submit OB services in the same manner as if the patient had changed insurers.</p> |
| 10 | <p>Q: How are OB services provided by Birthing Centers and reported on a CMS 1500 Claim Form or its electronic equivalent reimbursed?</p> <p>A: Services reported by a Birthing Center on a CMS 1500 Claim Form are not treated as a professional claim and are not subject to this reimbursement policy.</p> |
| 11 | <p>Q: Can contraceptive educational consultations and/or classes for lactation, infant safety, birthing, and parenting, be submitted separately within the global OB period?</p> |

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| | <p>A: Contraceptive educational consultations and/or classes for lactation, infant safety, birthing, and parenting, are considered part of the global package and are not separately reimbursed when submitted by the Same Group Physician and/or Other Health Care Professional.</p> |
| 12 | <p>Q: Will critical care services be considered for separate reimbursement if performed within a global surgical period?</p> <p>A: In those cases where a critical care visit is unrelated to the procedure with a global surgical period, critical care visits may be paid separately in addition to the procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed. When the critical care service is unrelated to the procedure, append the modifier FT.</p> |

| Attachments | |
|---|---|
| High-Risk-Complication-ICD-10-CM-Diagnosis-Codes-List | A list of ICD-10-CM diagnosis codes identifying complications or high-risk conditions |
| OB-Related-ICD-10-CM-Diagnosis-Codes | A list of ICD-10-CM diagnosis codes related to obstetrics |

| Resources |
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| <p>American Medical Association, <i>Current Procedural Terminology (CPT®)</i> and associated publications and services</p> <p>Centers for Disease Control and Prevention, <i>International Classification of Diseases, 10th Revision, Clinical Modification</i></p> <p>Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)</p> |

| History | |
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| 4/21/2024 | <p>Policy Version Change</p> <p>Policy List Update: High-Risk-Complication-ICD-10-CM-Diagnosis-Codes</p> |
| 4/1/2024 | <p>Template Update</p> <ul style="list-style-type: none"> Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans. Updated Application section to indicate this Reimbursement Policy applies to: <ul style="list-style-type: none"> All UnitedHealthcare Commercial benefit plans <p>All Individual Exchange benefit plans</p> |
| 3/31/2024 | <p>Policy Version Change</p> <p>Policy List Update: High-Risk-Complication-ICD-10-CM-Diagnosis-Codes</p> <p>History Section: Entries prior to 3/31/2022 archived</p> |
| 10/8/2023 | <p>Policy Version Change</p> <p>Logo Update</p> |



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| | Policy List Update: High Risk/Complication ICD-10-CM Diagnosis Codes and OB Related ICD-10-CM Diagnosis Codes History Section: Entries prior to 10/8/2021 archived |
| 1/1/2023 | Policy Version Change Policy Section: E/M Services with an OB Ultrasound Procedure; OB Policy E/M Code Table; Prolonged Physician Service History Section: Entries prior to 1/1/2021 archived |
| 1/1/2005 | Policy implemented by UnitedHealthcare Employer & Individual |
| 7/1/2001 | Policy approved by the Payment Policy Group |