Payment Policy: Reporting The Global Maternity Package

Reference Number: CC.PP.016
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 03/08/2024

Coding Implications
Revision Log

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

Policy Overview

According to CPT® guidelines and the American Congress of Obstetricians and Gynecologists (ACOG), the 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 code.

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

Code auditing software flags 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.

Services Included in the Global Obstetrical Package

- 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 (E/M)

Reporting Additional E/M Services during the Global Obstetrical Period

Any E/M 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 reported separately.

Delivery services include:

- Admission to L&D, history and physical, management of uncomplicated labor including fetal monitoring, vaginal delivery (with or without episiotomy, with or without forceps or vacuum extraction), or cesarean delivery or any E/M service on the calendar day prior to delivery and/or calendar day of delivery.
- Placement of internal fetal and/or uterine monitors
- Catheterization or catheter insertion
- Preparation of the perineum with antiseptic solution
- Delivery of the placenta, any method.
- 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 assure, etc.)

The afore mentioned services are not separately reimbursable when 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 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:

- Recovery room visit
- Uncomplicated inpatient hospital postpartum visits
- Uncomplicated outpatient visits
- Discussion of contraception (including writing a prescription)

Services that can be reported separately during the postpartum period in addition to the appropriate global OB code 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. (procedure is payable; E/M for discussion or consent 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
  - The patient transfers into or out of the practice
  - Referred to another physician at some point in the antepartum period
  - Delivery 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 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.

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, modifier -22 may be warranted. Providers should 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.

Pre-payment Clinical Claims Review

The Health Plan performs a prepay claim review when a provider submits a claim with services billed separately from the global service. The review includes prospective (prior to payment) claims history, and on appeal, medical records for adherence to correct coding principles.

Documentation Requirements

The claim (and on appeal, medical records) should include the following documentation.

- Other services performed indicate a diagnosis/condition unrelated to the maternity services. This may be separately reimbursable.
- Diagnoses that indicate a complication to maternity services, such as pregnancy-induced hypertension, abnormal cord conditions, gestational diabetes, or pre-term labor. These conditions must warrant treatment of a higher complexity than typical OB care, as well as require additional visits exceeding the normal allowed number of visits. 60 days of history are reviewed to determine what additional services were provided.
- Other diagnostic services performed that are not included in the typical maternity global package.

Clinical validation determines whether services have been reported appropriately, and the claim is then recommended for payment or denial.

Appeals/Reconsiderations
The provider has the right to request a reconsideration/appeal of denied services. Medical records must accompany the request 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 all-inclusive 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. *HCPCS Level II, 2024*
3. *ICD-10-CM 2024*
4. *Publications of the American Congress of Obstetricians and Gynecologists (ACOG)* *https://www.acog.org/-/media/project/acog/acogorg/files/creog/creog-coding-modules-slides.ppt*
5. *Medicaid NCCI 2023 Coding Policy Manual – Chapter 7* *https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-7.pdf*

Revision History	
02/27/2017	Converted to new template, corrected typos and removed duplicate wording, conducted review.
03/01/2018	Conducted review, updated policy
03/01/2019	Conducted Review, verified codes, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; no major updates required
12/01/2022	Annual Review completed; removed code tables as this information can be located in CPT resources
11/06/2023	Annual Review completed
03/08/2024	Annual Review completed

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. 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. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment 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. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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

 Providers, members, 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.