Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

Reimbursement Policy

Subject: **Maternity Services**	
Policy Number: **G-14001**	Policy Section: **Surgery**
Last Approval Date: **07/07/2023**	Effective Date: **07/07/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/nv**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

NVBCBS-CD-RP-036803-23-CPN36618 February 2024

Anthem allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN) unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on all aspects of the global obstetric care package (antepartum, delivery, and postpartum) being provided by the provider or provider group reporting under the same TIN. If a provider or provider group reporting under the same TIN does not provide all antepartum, delivery, and postpartum services, global obstetrical codes may not be used, and providers are to submit for reimbursement only the elements of the obstetric package that were provided.

Anthem will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

Global services
If global, delivery only, delivery/postpartum, antepartum only, or postpartum only services have been paid for the same pregnancy, a claim for global services may be denied or may cause a previously paid claim for overlapping services to be recouped.

Delivery only
If global, delivery only, or delivery/postpartum services have been paid for the same pregnancy, a claim for delivery only services may be denied. Delivery only services will be separately reimbursed to assistant surgeons only for cesarean deliveries if appended with the appropriate modifier.

Delivery/postpartum
If global, delivery only, delivery/postpartum, or postpartum only services have been paid during the same pregnancy, a claim for delivery/postpartum services may be denied or may cause a previously paid claim for overlapping services to be recouped.

Antepartum only
If global or antepartum only services have been paid during the same pregnancy, a claim for antepartum only services may be denied.

Postpartum only
Postpartum only claims may be denied if global, delivery/postpartum, or postpartum only services have already been paid during the same pregnancy.

Included in the global package
The following elements of the global package are not separately reimbursable when any CPT code for global services is billed:

- Initial and subsequent history and physical exams when pregnancy diagnosis has already been established

- All routine prenatal visits until delivery (typically monthly through 28 weeks, then biweekly until 36 weeks and weekly until delivery) — usually 13 visits
- Additional visits for a high-risk pregnancy, potential problems, or history of problems that do not actually develop or are inactive in the current pregnancy
- Collection of weight, blood pressure, and fetal heart tones
- Routine urinalysis
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) services that occur within 24 hours of delivery
- Management of uncomplicated labor (including administration of labor inducing agents)
- Insertion of cervical dilators on the same date of the delivery
- Simple removal of cerclage
- Vaginal (including forceps or vacuum assisted delivery) or cesarean delivery of single gestation
- Delivery of placenta
- Repair of first- or second-degree lacerations
- Uncomplicated inpatient visits following delivery
- Routine outpatient E/M services within six weeks of delivery
- Discussion of contraception
- Postpartum care only
- Education on breastfeeding, lactation, exercise, or nutrition

Not included in the global package

The following services may be billed separately from the global obstetrical package:

- Initial E/M visit to diagnose pregnancy when the activities in the antepartum record are not initiated
- Laboratory testing (excluding routine urinalysis)
- Additional antepartum E/M visits (in excess of 13) for a high-risk complication that is active in the current pregnancy, these additional visits are to be submitted for payment only at the time of delivery; these visits must be submitted with a Modifier 25 and an appropriate high-risk diagnosis
- Additional E/M visits for conditions unrelated to pregnancy; these visits may be reported as they occur and must clearly not be related to pregnancy
- Maternal or fetal echocardiography procedures
- Amniocentesis
- Chorionic villus sampling
- Fetal contraction stress testing and nonstress testing
- Biophysical profile
- Amnioinfusion
- Insertion of cervical dilator that occurs more than 24 hours before delivery
- Inpatient E/M encounters that occur more than 24 hours before delivery
- Management of surgical problems arising during pregnancy
- Care provided by maternal fetal medicine specialists
- Ultrasound — refer to the Maternity Ultrasound in the Outpatient Setting Medical Policy

- External cephalic version

Antepartum/postpartum care
Providers should use the appropriate E/M codes for antepartum and postpartum care. We reserve the right to request medical documentation to perform post-pay review of paid claims.

Outcome of delivery/weeks of gestation
Providers are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims.

Failure to report the appropriate diagnosis code will result in denial of the claim.

Policy History	
07/07/2023	Review approved: policy template updated
08/07/2020	Review approved
06/27/2018	Review approved: policy template updated
09/15/2016	Review approved 09/15/2016 and effective 11/01/2017: outcome of delivery/weeks of gestation section added
02/29/2016	Review approved: policy template updated
04/14/2014	Initial approval 04/14/2014 and effective 02/01/2015

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • State Medicaid • Current Procedural Terminology

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Claims Requiring Additional Documentation
Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)
Maternity Ultrasound in the Outpatient Setting (CG-Med-42)
Modifiers 25 and 57