Coding Policy Policy and Procedure		
SUBJECT: **TEMPORARY POLICY EMERGENCY PROVISIONS FOR** Global Payment for Obstetrical Care During COVID-19 Public Health Emergency	DEPARTMENT: **Coding Compliance**	
ORIGINAL EFFECTIVE DATE: **03/20**	DATE(S) REVIEWED/REVISED: 03/20, 06/20, 07/20, 10/20, 01/21, 05/21	
APPROVED BY: Administrative Council	NUMBER: **MC 07.0.PHE**	PAGE: **1 of 5**

NEED AND DURATION OF EMERGENCY PROVISIONS

1. **Need for the temporary provisions: Emergency provisions for global payment for obstetrical care to accommodate COVID-19.**
2. **Documents or source relied upon: CMS Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE).**
3. **Effective Date: February 4, 2020 for Medicare lines of business, March 6 for all other lines of business.**
4. **Termination Date: End of the public health emergency or until further notification.**
5. **Reassessment Date determined at Companies' sole discretion: December 31, 2021.**

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").

APPLIES TO:
All Providers
All Lines of Business

POLICY:
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. 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.

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. 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.

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.

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.

As long as 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.

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.

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. Effective for dates of service on or after June 1, 2014, 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. If postpartum care is also provided by the midwife, nurse midwife, or other provider, CPT code 59430 may be reported for postpartum care.

Except as stated in the paragraph 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.

PROCEDURE:

EFFECTIVE FEBRUARY 4, 2020, TELEPHONE VISITS (CODING POLICY 92.0) AND/OR TELEHEALTH VISITS (CODING POLICIES 67.0.A, 67.0.B, and 67.0.C) MAY BE USED IN LIEU OF FACE-TO-FACE SERVICES FOR GLOBAL OBSTETRICAL CARE. For the duration of this emergency provision, services performed by telephone and/or telehealth that meet all other requirements on this policy will be allowed as part of the global OB payment. No contract amendment or attestation is required**. THIS IS AN EMERGENCY PROVISION SUBJECT TO CANCELLATION AT THE SOLE DISCRETION OF COMPANY.**

Do not add modifier GT or 95 to 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 modifier GT or 95 only when billing individual Evaluation and Management (E&M) services

separately from the codes for global obstetrical care. **See Coding Policies 67.0.A, 67.0.B, 67.0.C, and 67.0.D for additional information about billing telehealth services.**

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
- Admission history and physical examination
- 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

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. **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.**

Minor complications such as urinary tract infections, blood pressure monitoring for hypertension, preterm contractions, breastfeeding issues, or care that would occur in the course of 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) 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

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.

For example:

- Global OB code reported is 59400 (Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care).
- During delivery, a fourth degree laceration occurs, requiring surgical repair.
- Modifier -22 may be added to CPT code 59400.
- Upon review of the medical records, an additional payment of 25% for the delivery may be approved. The additional payment will be 25% of the allowable for CPT code 59409 (Vaginal delivery only).

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.

REFERENCE:

Current Procedural Terminology (CPT)
Company Coding Edits
Company Coding Policies