GUIDELINES FOR GLOBAL MATERNITY REIMBURSEMENT

File Name: guidelines_for_global_maternity_reimbursement
Origination: 10/2003
Last Review 1/2024

Description

The global obstetrical professional package includes all services (antepartum care, delivery, and postpartum care) normally provided within routine maternity care.

Routine antepartum care consists of periodic evaluation and management of pregnancy, including prenatal history and physical examinations following the initial diagnosis of pregnancy; obtaining and recording of weight, blood pressures, fetal heart tones; and routine chemical urinalysis. Routine visits occur every four weeks until 28 weeks, biweekly until 36 weeks, then weekly until delivery. These visits typically result in approximately 13 office visits.

Delivery services include admission to the hospital, admission history and physical, management of labor, and delivery, whether vaginal (with or without episiotomy, with or without forceps), cesarean, or vaginal birth after cesarean.

Postpartum services include initial inpatient postpartum care, and subsequent office or other outpatient visits following vaginal or cesarean section delivery. There may be more than one postpartum visit for routine evaluation and care.

Same practice is defined as a physician and/or other qualified health care professional of the same group and same specialty with the same Federal Tax ID number.

This policy applies only to professional maternity services. For facility maternity services, see Provider Blue Book.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will provide reimbursement for maternity related services according to the criteria outlined in this policy.

Reimbursement Guidelines

Section I. Global vs Individual Maternity Services:

Global maternity service codes should be filed when the same physician and/or other qualified health care professional or the same practice performs all the prenatal, delivery, and post-partum services during the global period.

Global maternity codes are reported for all routes of delivery. See Billing and Coding section for complete listing.

There are several circumstances when performing prenatal, delivery, and postpartum services does not result in global billing. In these situations, the maternity services may be separately billable with individual maternity service codes. The most common scenarios occur 1) when more than one provider or practice performs maternity services during the global period; 2) when more than one payer provides maternity benefits during the global period; 3) when prenatal care is initiated late; and 4) when the pregnancy ends early.

Individual maternity service codes are reported for antepartum only, and delivery and/or postpartum care only services. See Billing and Coding section for complete listing. There are also circumstances where reporting individual Evaluation and Management (E/M) (CPT® 99202-99215) is required.

The tables below illustrate when to report global maternity, individual maternity service, and/or E/M service codes:

Prenatal Care, Delivery, and Postpartum Services by More Than One Provider	Global Code	Individual Maternity Service Code(s)	Individual E/M Code
1. When more than one provider or practice performs maternity services during the global period			
All antepartum, delivery, and postpartum care provided by same provider or same practice (*Requires a minimum of 4 antepartum visits*)	**X**		
Provider “A” or same practice provides 4 or more antepartum visits, delivery, and postpartum care **But** Separate provider “B” or their practice provides 3 or fewer antepartum visits	**A**		**B**
Provider “A” or same practice provides 4 or more antepartum visits without delivery or postpartum care **But** Separate provider “B” or their practice provides 4 or more antepartum visits, delivery, and postpartum care		**A and B**	
Provider or same practice provides 4 or more antepartum visits without delivery and/or postpartum care		**X**	
Provider or same practice provides 3 or fewer antepartum visits			**X**
2. When more than one payer covers maternity benefits during the global period			

Prenatal Care, Delivery, and Postpartum Services by More Than One Provider	Global Code	Individual Maternity Service Code(s)	Individual E/M Code
Prenatal Care, Delivery, and Postpartum Benefits Provided by More than One Insurer		X	
Prenatal Care, Delivery, and Postpartum Benefits Provided by More than One Member ID with same insurer		X	
The coverage terminates prior to delivery		X	
3. When prenatal care is initiated late			
Prenatal care starts late (after first trimester OR after 42 days of plan enrollment)		X	
4. When the pregnancy ends early			
The pregnancy results in premature delivery with 4 or more antepartum visits	X		
The pregnancy results in premature delivery with 3 or fewer antepartum visits		X	
The pregnancy results in miscarriage, or other loss of pregnancy prior to viability		X	

Section II. Multiple Births

Delivery of more than one gestation requires specific billing and coding to accurately capture the work performed.

1) Vaginal deliveries only

- Physician or same practice filing as global, per above
  - **Baby A: File appropriate "global vaginal delivery" code**
    - Reimbursed at 100% of allowable
  - **Babies B and beyond: File appropriate vaginal "delivery only" code with Modifier 59**
    - Indicate total # of "Babies B and beyond" in units field
    - Reimbursed at 50% of allowable for all "Babies B and beyond"

- Physician or same practice unable to file as global, per above
  - Postpartum care following hospital discharge not provided
    - **File appropriate vaginal "delivery only" code**
      - Indicate total # of babies in units field
      - Reimbursed at 50% of allowable for all "Babies B and beyond"

- Provided postpartum care following hospital discharge
  - **Baby A: File appropriate vaginal "delivery only, including postpartum care" code**
  - **Babies B and beyond: File appropriate vaginal "delivery only" code with Modifier 59**
    - Indicate total # of "Babies B and beyond" in units field
    - Reimbursed at 50% of allowable for all "Babies B and beyond"

2) Cesarean delivery only

- Physician or same practice filing as global, per above
  - **File appropriate "global Cesarean delivery" code with 1 unit**
    - Reimbursed at 100% of allowable

- Physician or same practice unable to file as global, per above
  - Postpartum care following hospital discharge not provided
    - **File appropriate Cesarean "delivery only" code with 1 unit**
  - Provided postpartum care following hospital discharge
    - **File appropriate Cesarean "delivery only, including postpartum care" code with 1 unit**

Only one (1) unit of a single "Cesarean" code (59510, 59618, 59514, 59515, 59620, 59622) should be reported regardless of the number of babies delivered via Cesarean incision (AMA, 2002). Modifiers will not override the edit.

3) Vaginal delivery, followed by Cesarean delivery

- **Baby A: File appropriate vaginal "delivery only" code with Modifier 59**
  - Reimbursed at 50% of allowable
- **Babies B and beyond:**
  - Physician or same practice filing as global, per above
    - **File appropriate "global Cesarean delivery" code with 1 unit**
      - Reimbursed at 100% of allowable

  - Physician or same practice unable to file as global, per above
    - Postpartum care following hospital discharge not provided
      - **File appropriate Cesarean "delivery only" code with 1 unit**
        - Reimbursed at 100% of allowable

    - Provided postpartum care following hospital discharge
      - **File appropriate Cesarean "delivery only, including postpartum care" code with 1 unit**
        - Reimbursed at 100% of allowable

Only one (1) unit of a single "Cesarean" code (59510, 59618, 59514, 59515, 59620, 59622) should be reported regardless of the number of babies delivered via Cesarean incision (AMA, 2002). Modifiers will not override the edit.

Section III. Services Excluded from Global Billing.

Some services, when medically necessary, are not included in the global obstetric package.

Examples of antepartum services (not an all-inclusive list) that may be reimbursed outside the global allowance include:

- Initial office visit for confirmation of pregnancy
- Pregnancy test
- Prenatal laboratory profile
- Initial and repeat blood glucose testing
- Urine culture and/or sensitivity for urinary tract infection (excludes dipstick urinalysis)
- Wet prep
- Cervical cytology/HPV testing
- Amniocentesis
- Cordocentesis
- Prenatal Screening for Fetal Aneuploidy
- Screening for Group B beta strep
- Screening for HIV
- Chorionic villus sampling
- Care of miscarriage/covered termination of pregnancy
- Pregnancy-associated plasma protein A in the first trimester along with nuchal translucency to assess risk of aneuploidy
- Fetal stress test and fetal non-stress test
- Biophysical profile
- Medically necessary diagnostic fetal ultrasound tests

Examples of services related to delivery that may be reimbursed outside the global allowance include:

- External cephalic version
- Insertion of cervical dilator by physician on the calendar day prior to delivery

Examples of diagnoses for postpartum services that may be reimbursed outside the global allowance when filed with Modifier 24 include:

- Delayed and secondary postpartum hemorrhage
- Contraceptive management and placement of Long-Acting Reversible Contraception (LARC)
- Infection of obstetric surgical wound
- Local infection of the perineal skin and subcutaneous tissue
- Thromboembolic events

- Endometritis
- Mastitis
- Conditions requiring additional outpatient observation and/or inpatient care, such as:
    - Septic pelvic thrombophlebitis
    - Pre-eclampsia with/without severe features

Section IV. Services in Addition to Routine Prenatal, Delivery, and Postpartum Care

These scenarios apply to providers submitting global maternity service codes. For scenarios where more than one provider performs antenatal services or consultations, see Section I.

Antenatal Care

The standard antepartum schedule consists of approximately 13 antepartum visits at these intervals:

- One visit every 4 weeks up to 28 weeks
- One visit every 2 weeks up to 36 weeks
- One visit every week from 36 weeks until delivery

Visits that occur on the standard antepartum schedule are included in global maternity billing, regardless of the reason for the visit. ICD-10 diagnosis codes indicating screening or supervision of normal or high risk pregnancy are required as the primary diagnosis for all office visits occurring on the standard antepartum schedule. E/M services submitted with a routine maternity diagnosis on the claim are considered part of the global allowance and not separately reimbursable. See Routine Maternity Diagnoses chart in Billing and Coding section.

Problem Visits Related to Pregnancy. Due to confirmed complications of pregnancy, a member may require more than the 13 antepartum office visits. In these situations, a separate E/M service code may be submitted. Append Modifier 25 to the relevant **antepartum** E/M service code when services occur outside the standard antepartum schedule **and** when the 13th visit is exceeded. Submit the claim without a routine maternity diagnosis when the 14th or subsequent antepartum visit has occurred.

Visits occurring on the standard antepartum schedule plus additional pregnancy related problem visits both count toward the 13 visit total.

Problem Visits Unrelated to Pregnancy. For problem visits unrelated to the pregnancy, submit the claim at the time of service. A separate E/M service code may be submitted with Modifier 25 appended to the relevant E&M service code. These visits would be appropriately coded with ICD-10 diagnosis codes found **outside** of Chapter 15: Pregnancy, Childbirth, and Puerperium codes (*O00-O9A*).

Problem visits unrelated to pregnancy do not count toward the 13 visit total. A problem visit unrelated to pregnancy that occurs on the same day as a scheduled standard antepartum visit is filed at the time of service for the unrelated problem, but the antepartum visit is also counted toward the 13 visit total since standard antepartum care is performed.

Surveillance Visits. Additional antenatal visits that occur for surveillance due to a past history of a high risk pregnancy are not eligible for reimbursement outside the global maternity unless the current pregnancy becomes high risk. These visits would be appropriately coded with ICD-10 diagnosis codes indicating

screening or supervision of a high risk pregnancy as the primary diagnosis, even though they may occur outside the standard antepartum schedule. See Routine Maternity Diagnoses chart in Billing and Coding section.

Labor and Delivery

Outpatient and inpatient antenatal care (procedures and E/M services) occurring within one (1) calendar day of delivery is inclusive to global maternity reimbursement.

Following CPT® manual guidelines, prolonged service codes are not eligible for reimbursement related to services that do not have a time component, such as labor and delivery.

The removal of any cerclage within one (1) calendar day of the delivery and in the same place of service as the delivery is included in global maternity reimbursement.

Postpartum Care

The standard postpartum schedule typically consists of 1-3 visits up to 12 weeks postpartum. (ACOG, 2018)

When postpartum complications or conditions unrelated to postpartum care occur, the member may require additional visits. Append Modifier 24 to the **postpartum** E/M service unrelated to the pregnancy **or** not considered part of routine, uncomplicated postpartum care.

General Procedural and Diagnosis Coding

The level of E&M service is determined by the extent of Medical Decision Making (MDM) and other coding criteria as outlined in current CPT® guidelines. Blue Cross NC may monitor and verify the number of antepartum visits and documentation of required elements for E/M services that occur during the global period.

In accordance with ICD-10 guidance, Chapter 15: Pregnancy, Childbirth, and Puerperium codes (*O00-O9A*) have sequencing priority over codes from other chapters. Additional codes from other chapters may be used secondarily for disease and condition specificity.

For providers credentialed to render prenatal, delivery, and postpartum services, coding for antenatal problem visits outside the standard antepartum schedule should follow ICD-10-CM Chapter 15 guidelines when selecting a diagnosis code. Providers not rendering prenatal, delivery, or postpartum care services should follow standard ICD-10-CM guidelines and indicate pregnancy as an incidental secondary diagnosis.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Global Maternity Service Codes	
CPT® code	**Description**
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Individual Maternity Service Codes	
CPT® code	**Description**
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Routine Maternity Diagnoses	
ICD-10 code	**Description**
*O09.**	Supervision of high risk pregnancy
O80	Encounter for full-term uncomplicated delivery
O82	Encounter for cesarean delivery without indication
*Z34.**	Encounter for supervision of normal pregnancy
Z36.*	Encounter for antenatal screening of mother
Z39.*	Encounter for maternal postpartum care and examination

Quality Reporting:

In support of quality tracking and in accordance with HEDIS guidelines, we require that separate claims be submitted for the following:

Date of first prenatal visit.

Submit a claim reflecting the actual date of the first visit for prenatal care in first trimester OR within 42 days of plan enrollment.

First Prenatal Visit	
CPT® / Diagnosis code	**Description**
0500F	*Initial prenatal care visit*
0501F	*Prenatal flow sheet documented in medical record by first prenatal visit*
***AND** any of the following applicable diagnosis codes*	
*Z34.**	Encounter for supervision of normal pregnancy
*O09.**	Supervision of high risk pregnancy
*O36.8**	Maternal care for other specified fetal problems

Date of postpartum visit(s).

In accordance with HEDIS reporting requirements, the postpartum visit(s) should occur 1-12 weeks after delivery. Submit a claim with the actual date the postpartum service was rendered.

Postpartum Visit	
CPT® / Diagnosis code	**Description**
0503F	*Postpartum care visit*
AND	
*Z39.2**	Encounter for routine postpartum follow-up

FAQ

Q1. Provider sees patient for missed periods and confirms pregnancy. Is this visit separately reimbursable?

A1. Yes, the visit to confirm pregnancy is not included in the global maternity payment regardless of whether the prenatal flow chart is started.

Q2. Patient develops a viral illness while pregnant and seeks care from her provider on a day that is not part of the scheduled prenatal care, will this appointment be counted towards the visits included in the global payment?

A2. No, as this service was unrelated to the pregnancy, the E/M service to treat the viral illness will be reimbursed separately. 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 with the E/M service should support the condition being treated and/or evaluated was unrelated to the pregnancy. Since this visit was off schedule, it would not be counted towards the 13 global visit total.

Q3. My patient is considered high risk due to previous pregnancy complications, thus the provider scheduled more frequent visits starting at 18 weeks and saw the patient 3 additional times. The patient did not experience any complications. Are these 3 additional visits separately reimbursable?

A3. No, as the patient did not experience any complications, these visits are included in the global payment. According to ACOG coding guidelines, if a member sees an obstetrician for potential complications and no complication develops, the provider is not to report the additional E&M visits. However, if the patient had experienced complications, these visits may be separately reimbursable (see Q6. And Q9.).

Q4. What primary diagnosis code should be reported during the antepartum routine schedule (every 4 weeks until 28 weeks, biweekly until 36 weeks, and weekly until delivery)? Does this differ for routine visits versus pregnancy complication visits?

A4. Antepartum visits occurring on the routine schedule, both routine and non-routine (pregnancy complication) in nature must be reported with a pregnancy supervision primary diagnosis code (O09.X; Z34.X). See Routine Maternity Diagnoses in the Billing and Coding section. Non-routine/pregnancy complication condition must be reported in the secondary diagnosis field.

Q5. Are antepartum visits occurring on the routine schedule (every 4 weeks until 28 weeks, biweekly until 36 weeks, and weekly until delivery) separately reimbursable from the global payment? What if the Modifier 25 is reported with the visit?

A5. No, routine antepartum visits are considered part of the global maternity payment even when reported with a Modifier 25.

Q6. My patient has developed a complication during pregnancy, and I scheduled additional visits. Are these additional antepartum visits separately reimbursable?

A6. It depends. If the total number of antepartum visits exceeds 13, and the visits are outside the standard antenatal schedule, then these complication related visits are separately reimbursable outside of the global payment as long as the baby was not delivered within 24 hours of the visit. These visits must be reported with a Modifier 25. However, if the total antepartum visits are less than or equal to thirteen, the visits are included in the global maternity payment.

Q7. Are educational programs such as child safety or parenting classes separately reimbursable?

A7. No, these educational programs are considered to be a component of the global maternity payment.

Q8. Are contraceptive management services, such as IUD or implant insertion and diaphragm fitting, provided post-delivery considered to be separately reimbursable?

A8. Yes, these services are separately reimbursable to the qualified professional healthcare provider.

Q9. The provider sees the member for a complication the day prior to the actual delivery. Is this visit separately reimbursable?

A9. No, as the baby was delivered the day after the visit for complication, this visit is not separately reimbursable and considered part of the global maternity payment.

Q10. Due to a change in insurance coverage, the patient received her initial prenatal care from another provider. Does the provider that delivered the baby receive the global payment?

A10. If the initial provider has performed 4 or more antepartum visits, then the delivering provider should file with individual maternity service codes for antenatal care, delivery, and postpartum care. Neither provider would bill the maternity global.

Q11. The patient did not schedule a post-partum visit until 8-weeks post-delivery. Will this visit still be considered part of the global maternity payment?

A11. Routine and scheduled post-partum visit(s) are included in the global. Timing may vary, but typically falls within 1-12 weeks post-delivery. Append modifier 24 to the E/M service when that service is unrelated to the pregnancy or not considered part of routine, uncomplicated postpartum care.

Q12. How should services be reported if a different doctor from a different practice delivered the baby from the physician that provided all of the post-partum care?

A12. As the providers are from different practices, each provider should report the individual maternity service code that represents the portion of care that they provided.

Q13. Can the attending physician performing the delivery be reimbursed for fetal monitoring (59050 or 59051) during labor?

A13. No, fetal monitoring during labor is only reimbursable when billed by a consulting physician.

Q14. Is insertion of cervical dilator (CPT® 59200) separately reimbursable from the delivery?

A14. No, it is not separately reimbursable. Since CPT® 59200 is typically performed within the day of the delivery, it is considered to be a component of the delivery. Thus, this service would be included in the global payment.

Q15. How should E&M services with a maternity diagnosis be reported if the member transfers to a different practice prior to delivery?

A15. Since the providers are from different practices, then the E&M visits should be reported with Modifier 25.

Related policy

Carrier Screening for Genetic Disease

Consistency Guidelines

Maternal and Fetal Diagnostics

Prenatal Screening AHS - G2035

Prenatal Screening for Fetal Aneuploidy AHS –G2055

References

Policy entitled: Maternity Reimbursement

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

Policy renamed: Guidelines for Global Maternity Reimbursement

Medical Policy Advisory Group - 03/24/2006

Senior Medical review – 10/2012

Senior Medical Director review – 11/2013

Senior Medical Director review – 5/2015

American College of Obstetricians and Gynecologists (ACOG). Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50.

American Medical Association, *Current Procedural Terminology* (CPT®)

American Medical Association (AMA). “Maternity Care – Conception to Delivery”. CPT Assistant. Chicago: AMA Press, August 2002.

American Congress of Obstetricians and Gynecologists (ACOG). (2021, August 18th). *Coding for postpartum services (the fourth trimester)* https://www.acog.org/practice-management/coding/coding-library/coding-for-postpartum-services-the-4th-trimester

American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). 2017. *Guidelines for Perinatal Care* (8th ed.).

The American College of Obstetricians and Gynecologists (ACOG). 2020. *OB/GYN Coding Manual: Components of Correct Procedural Coding*.

History

10/03	Original policy issued.
10/03	Medical Policy Advisory Group review. Reaffirm.
04/07/05	Medical Policy Advisory Group reviewed policy on 03/10/2005. Corrected a typo.
7/21/05	Titled changed from “Maternity Reimbursement” to “Guidelines for Global Maternity Reimbursement”. For clarity, added the following statement to the Benefits Application section “In the absence of maternity benefits, elective cesarean delivery (primary or repeat) is not eligible for coverage.”
5/08/06	Medical Policy Advisory Group review 3/24/06. Policy number added to the Key Words Section. The following added to the Multiple Birth section of the Policy: 3. a. i. "(100%)", 3.

	b. i. " -51 modifier and (50%)", 4 a. i. "(100%)", 4. b. i. "-51 modifier and (50%)". 4. b. i Changed CPT code 59650 to 59620.
3/26/07	In the section, "Benefits Application" added the word "and" before "episiotomy" in the third paragraph. Added the following to the Multiple Birth section of the Policy: 2. c. "If antepartum and/or postpartum care were not provided, then procedure code 59409 should be reported reflecting the appropriate number of deliveries in the units fields." 3.c. " If antepartum and/or postpartum care were not provided, then procedure code 59610 should be reported reflecting the appropriate number of deliveries in the units fields." 4.c. "If antepartum and/or postpartum care were not provided, then procedure code 59618 should be reported reflecting the appropriate number of deliveries in the units fields. Medical Policy reviewed by Senior Medical Director of Network Support.
05/05/08	Policy reviewed 4/4/2008 by Vice President and Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy. No changes to policy criteria.
6/22/10	Policy Number(s) removed (amw)
10/16/12	Description section revised. In the "Billing for Maternity Care" section, modifier 51 was changed to modifier 59. (adn)
10/16/12	Item C in the "Billing for Maternity Care" section dealing with multiple births has been extensively revised. Added Item D. Notification 10/16/12 for effective date 12/28/12. (adn)
12/10/13	Routine policy review. No change to current policy. (adn)
5/13/14	Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)
5/26/15	Corrected typo removed the word "only" from section "Billing for Maternity Care" Item C.1.a. ("vaginal delivery only" should read "vaginal delivery"). Added quality reporting guidelines to the Billing/Coding section. "In support of quality tracking and in accordance with HEDIS guidelines, we require that claims (outside of the global billing claim) be submitted with the following: date of first prenatal visit and date of postpartum visit." Notification given 5/26/2015 for effective date of 7/28/2015. (adn)
7/26/16	In the section "Billing for Maternity Care" Item C.1.a. "Baby A: File the appropriate "vaginal delivery" code" was revised to read "Baby A: File the appropriate "global vaginal delivery" code". (an)
9/30/16	In the Billing for Maternity Care section, Item B.4. revised to read: another provider in a different practice assumes care of the member prior to completion of global services. Added Item 5. Separate billing for pre/post-natal and delivery services is allowed when "during the member's pregnancy, there was a change in the member's benefit package or certificate number due to an employer change only." Codes O09.A0, O09.A1, O09.A2, O09.A3 added to Billing/Coding section. (an)
12/29/17	Routine review. Removed ICD-9 codes. ICD-10 codes added. Code range for O36.83xx was expanded for 2018. No change to policy statement. (an)
12/14/18	Routine annual policy review. No change to policy statement or criteria. (an)
1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
12/31/20	Routine policy review. Medical Director approved 12/2020. No changes to policy statement. (eel)
8/19/21	Policy format update. Extensive revisions throughout policy. **Notification given 8/19/2021 for effective date of 10/19/2021.** (eel)
12/30/21	Routine policy review. Grammatical corrections. Medical Director approved. (eel)
6/1/22	O82 added to Routine Maternity Diagnosis table. "The removal of any cerclage within one (1) calendar day of the delivery and in the same place of service will not be eligible for separate reimbursement as it is incorporated into the delivery reimbursement." Added to Reimbursement Guidelines section. Clarified Antenatal Care "E/M services submitted with a

	routine maternity diagnosis on the claim are considered part of the global allowance and not separately reimbursable." Medical Director approved. **Notification given 3/31/2022 for effective date of 6/1/2022.** (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
7/18/2023	Removed lactation training from FAQ. Updated application section regarding abortion. No change to policy intent – verbiage update only. (ss)
1/19/2024	In the FAQ section, Q & A #15 was added: How should E&M services with a maternity diagnosis be reported if the member transfers to a different practice prior to delivery? No change to policy intent, clarification only. (tlc)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

In the absence of maternity benefits, prenatal, delivery, and postpartum services are only reimbursed for complications of pregnancy. Complications of pregnancy per member certificate language are medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of pregnancy. In the case of abortion services, in the absence of elective abortion coverage, abortion services will be reimbursed only when a qualified physician determines there exists a medical emergency in the mother.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.