



POLICY INFORMATION			
Policy Number:	POL-PP- 107	Original Effective Date:	7/1/2019
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NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

Maternal and newborn care encompasses the healthcare services provided to mothers and their babies before, during, and after pregnancy, focusing on promoting health and preventing complications. This care includes antenatal care, intrapartum care during labor and delivery, and postnatal care in the immediate postpartum period. The goal is to ensure the well-being of both the mother and the newborn.

Policy

Global Obstetrical Care

Blue KC accepts and prefers submission of the global obstetrical codes 59400, 59510, 59610 and 59618, which include antepartum care, delivery, and postpartum care.

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. Blue KC will not pay separately for emergency department services occurring the day before or on the same day as childbirth admission.

Antepartum

Antepartum care includes the subsequent history and physical examinations, recording of weight, height, blood pressures, fetal heart tones, chemical urinalysis, maternity counseling, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

The provider may choose to bill globally, visit-by-visit, or to use codes 59425 or 59426 for antepartum care. The date of service submitted for antepartum care should be the date of delivery. If antepartum care is not performed for the entire period, code each E/M service separately.

Pre-Delivery Inpatient Care required for treatment/stabilization

Inpatient care due to pregnancy complications should be coded separately using the CPT codes from the Medicine and the Evaluation and Management Service section of the CPT manual.

(Examples: cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes).

Delivery

Delivery includes admission, history and physical, management of uncomplicated labor and delivery (with or without episiotomy or forceps).

Vaginal delivery alone should be submitted with procedure code 59409 or 59612.

Cesarean (C-section) delivery alone should be submitted with code 59514 or 59620.

Subsequent Vaginal Birth after C-section (VBAC)

VBAC's should be coded using CPT codes 59618, 59620, and 59622, regardless of whether the vaginal birth is the first or



subsequent following the C- section.

Billing 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 with code 59400 or 59610 for twin A, and 59409 or 59612 with modifier 59, X [EPSU] appended for twin B.

If both twins are delivered via cesarean delivery, then report code 59510, routine obstetric care including antepartum care, cesarean delivery, and postpartum care, since only one cesarean delivery is performed. If the cesarean delivery is significantly more difficult, then append modifier -22 to code 59510.

If one twin is delivered vaginally and the other by cesarean delivery and the global obstetric care is provided by the same physician or same physician group, then report the global code 59510 or 59618, for the cesarean delivery, and 59409 or 59612, for the vaginal delivery with the -59, X [EPSU] modifier appended.

In all previously described different scenarios, the diagnosis code for multiple gestations should be indicated.

Postpartum

Postpartum care includes hospital visits and one to two office visits for usual, uncomplicated postpartum follow-up, urinalysis, and hemoglobin. The global codes (59400, 59510, 59610 or 59618) and delivery codes (59410, 59515, 59614 or 59622) include postpartum care.

Submit the postpartum care package (separate procedure) code 59430 only when another provider does the delivery. Submit this code one time with one unit of service. The date of service should be the delivery date.

Initial Visit and Itemized Services

The initial visit may be billed separately with an appropriate E/M code. An obstetrical profile (80055) and any laboratory procedure codes (other than urinalysis) should also be submitted separately.

Newborn Care

Submit procedure code 99460 or 99462 and Z76.2 (ICD-10-CM) to bill for routine services in the hospital for well newborns. If the newborn is ill, submit codes 99221-99223 or 99231-99233 for hospital visits.

Initial hospital care of neonates, 28 days of age or less, who require intensive observation, frequent interventions, and other intensive care services is reported with code 99477. Subsequent intensive care for extremely low birth weight infants is reported with codes 99478-99480, depending on the weight of the infant. For discharge day management submit E/M code 99238.

Pediatric standby should be submitted with code 99464. Another physician requests standby services. The physician may not be providing care or services to other patients during this period.

Code 99464 includes the initial stabilization of the newborn; thus, services may be denied as incidental to 99464. When billing a newborn circumcision (54150 or 54160) on the day of discharge, add modifier -25 to code 99238. A diagnosis indicating the circumcision (ICD-10- CM diagnosis Z41.2) must be linked as the primary diagnosis to the circumcision procedure (54150 or 54160).



For neonatal critical care services see codes 99468-99476.

Complications or Unusual Circumstances

Submit modifier –22 with specific documentation to justify additional reimbursement along with the delivery or operative report for complications during delivery. Unusual circumstances resulting in extensive antepartum or postpartum care should be coded separately. A narrative/operative report should be sent with the claim.

Lactation Education

If done as part of the delivery, lactation education should be billed on the 837I, on the mother’s claim. If this is done after discharge, it should be incorporated into the E/M for postpartum care.

Collection of Umbilical Cord Blood

Collection of umbilical cord blood may be done at the time of a delivery either for donation to organizations such as the Red Cross or per the patient’s request to bank the blood for potential future need.

Regardless of intent, cord blood collection is not a reimbursable service. If billing for the collection per the request of the patient, the patient must be notified that this charge will be their liability. The charge should be submitted using an unlisted procedure code, such as 59899, with a description and will be denied as subscriber liability.

Obstetrical Care Coding Alternatives

Different options are available for billing obstetrical care. Global billing is preferred. Antepartum care only and post-partum care only may be billed using the appropriate Evaluation and Management code.

Coding

CPT	Definition
Global Billing	
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
Antepartum Care Only	
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
Delivery Only	
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59514	Cesarean delivery only;
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
Delivery and post-partum only	



59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59515	Cesarean delivery only; including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
Post-partum Care Only	
59430	Postpartum care only (separate procedure)

References and Resources

American Medical Association CPT Manual
Blue KC Provider Reference Guide

Related Documents

Payment Policy POL-PP-200 Newborn and Neonatal Critical and Intensive Care Services

Revision History

Date	Summary of Revisions
7/1/2019	New Policy
7/1/2020	Annual review, no updates or changes were made
7/1/2021	Annual review, no updates or changes were made
10/07/2021	Removed modifier 51 and added modifier 59
8/6/2022	Annual review, removed modifier 22 option for multiple births
5/11/2023	Added information on (procedures and E/M services) occurring within one (1) calendar day of delivery is inclusive to global maternity reimbursement
7/1/2023	Annual Review, no updates or changes were made
1/29/2024	Modifiers X[EPSU] were added in addition to modifier 59 for twin delivery.
7/1/2024	Annual review, no updates or changes were made
7/1/2025	Annual review, no updates or changes were made