Definition: The obstetrical policy addresses routine antepartum (prenatal) care, delivery, postpartum care and global and non-global obstetric services.

Medical Necessity:

I. Antepartum (prenatal) care:

Antepartum (prenatal) services include: initial and subsequent patient history and physical examinations including, weight, blood pressure and fetal heart tone measurements; and routine urinalysis. The number of allowed visits:

- 0-28 weeks gestation – monthly visits
- 29-36 weeks gestation – biweekly visits
- 37 weeks gestation until delivery – weekly visits

If a woman presents to her obstetrician with amenorrhea or desires to confirm a self-administered pregnancy test, this visit may be coded as a normal office visit based on documentation of key elements of the evaluation and management service. If pregnancy is established, either an initial prenatal care visit (Category II Code 0500F) or a prenatal care at-risk assessment (HCPCS Code H1000) can be performed (if within the first 12 weeks of pregnancy) and separately billed and the global obstetrical care reimbursement period will begin with the following office visit.

If a woman with an already confirmed pregnancy presents to her obstetrician and routine antepartum care is performed within the first 12 weeks of pregnancy, either an initial prenatal care visit (Category II Code 0500F) or a prenatal care at-risk assessment (HCPCS Code H1000) can be separately billed and the global obstetrical care reimbursement period will begin at the subsequent visit.
A. Initial prenatal care visit (Category II Code 0500F):

The Company recognizes separate and distinct reimbursement for an initial prenatal care visit (Category II Code 0500F) at the first antepartum (prenatal) care visit. Category II Code 0500F is allowable once per physician, per pregnancy if a patient history, physical examination, pelvic exam and blood work are performed within the first 12 weeks of pregnancy. Category II Code 0500F is eligible for reimbursement after the first trimester if the individual has transferred care from one obstetrical provider to another.

B. Prenatal care at-risk assessment (HCPCS Code H1000):

The Company recognizes separate and distinct reimbursement for a prenatal care at-risk assessment (HCPCS Code H1000) at the first antepartum (prenatal) care visit. HCPCS Code H1000 is allowable once per physician, per pregnancy if a physical examination and maternal risk assessment is performed within the first 12 weeks of pregnancy. HCPCS Code H1000 is eligible for reimbursement after the first trimester if the individual has transferred care from one obstetrical provider to another.

C. Amniocentesis (CPT Code 59000):

Ultrasound guidance for amniocentesis (CPT Code 76946):

When determined to be medically necessary, amniocentesis (CPT Code 59000) is eligible for reimbursement at the allowed amount in addition to global obstetrical care reimbursement for the subsequent delivery. An office visit occurring on the same date of service by the same provider is considered to be included in reimbursement for the amniocentesis.

Ultrasound guidance for a medically necessary amniocentesis (CPT Code 76946) is eligible for payment at the allowed amount in addition to both amniocentesis and global obstetrical care reimbursement for the subsequent delivery.

The Company considers amniocentesis and ultrasound guidance for amniocentesis (CPT Codes 59000 and 76946) medically necessary and eligible for reimbursement providing that any of the following medical criteria is met:

- Age ≥35 years at expected time of delivery; or
- Previous pregnancy resulted in a child born with a chromosomal or genetic abnormality or major congenital malformation; or
- Fetus at increased risk for chromosomal or genetic abnormality or major congenital malformation; or
- Family history of a chromosomal or genetic abnormality; or
- Family history of three or more spontaneous abortions involving prior conceptions of either parent; or
• Family history of X-linked hereditary disorders; or
• Family history of a detectable hereditary error of metabolism; or
• Family history of neural tube defect or elevated maternal serum alpha-fetoprotein level; or
• Fetal lung maturity must be determined; or
• Polyhydramnios is present causing significant respiratory distress or preterm labor; or
• Chorioamnionitis is suspected;

**AND**

*At least one* of the following clinical conditions is present:

• Multiple gestation
• Abnormality of organs and soft tissues of pelvis
• Central nervous system malformation in fetus, antepartum condition or complication
• Chromosomal abnormality in fetus, antepartum condition or complication
• Hereditary disease in family possibly affecting fetus, antepartum condition or complication
• Suspected damage to fetus from viral disease in the mother, antepartum condition or complication
• Rhesus isoimmunization, antepartum condition or complication
• Isoimmunization from other and unspecified blood-group incompatibility, antepartum condition or complication
• Poor fetal growth, antepartum condition or complication
• Polyhydramnios
• Infection of amniotic cavity, antepartum condition or complication
• Elderly primigravida
• Elderly multigravida
• Down’s syndrome
• Autosomal deletion syndromes
• Balanced autosomal translocation in normal individual
• Klinefelter’s syndrome
• Chorioamnionitis
• Primary atelectasis
• Nonspecific abnormal findings in amniotic fluid
• Family history of mental retardation
• Supervision of high-risk pregnancy
• Screening for chromosomal anomalies by amniocentesis
• Screening for raised alpha-fetoprotein levels in amniotic fluid
Amniocentesis performed solely for sex determination in the absence of documented risk for X-linked hereditary disorders is considered not medically necessary and not eligible for reimbursement.

If amniocentesis is determined to be not medically necessary, ultrasound guidance for amniocentesis is also considered not medically necessary.

D. Chorionic villus sampling (CPT Codes 59015 and 76945):

The Company considers chorionic villus sampling (CPT Codes 59015 and 76945) medically necessary and eligible for reimbursement providing that at least one of the following clinical conditions is present:

- Central nervous system malformation in fetus
- Chromosomal abnormality in fetus
- Hereditary disease in family possibly affecting fetus
- Suspected damage to fetus from viral disease in the mother
- Suspected damage to fetus from other disease in the mother
- Suspected damage to fetus from drugs
- Suspected damage to fetus from radiation
- Other known or suspected fetal abnormality, not elsewhere classified
- Rhesus isoimmunization
- Isoimmunization from other and unspecified blood group incompatibility
- Elderly primigravida
- Elderly multigravida
- Chromosomal anomalies
- Other and unspecified congenital anomalies
- Primary atelectasis
- Hemolytic disease due to other and unspecified isoimmunization
- Congenital anomalies
- Pregnancy with history of abortion

If chorionic villus sampling is determined to be not medically necessary, ultrasound guidance for chorionic villus sampling is also considered not medically necessary.

E. Fetal non-stress test (CPT Code 59025):

Based upon medical necessity, the Company considers fetal non-stress testing eligible for reimbursement at the allowed amount at a frequency of every other day per fetus for unstable high-risk pregnancies. For stable high-risk pregnancies, outpatient fetal non-stress testing is subject to a frequency limit of two studies per fetus in any seven day period.
F. Cerclage of cervix (CPT Codes 59320 and 59325):

Based upon medical necessity, the Company considers cerclage of the cervix eligible for reimbursement at the allowed amount in addition to global obstetrical care reimbursement for the subsequent delivery.

G. Routine obstetric care (CPT Codes 59400, 59409, 59410, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620 and 59622):

Global obstetrical care services for routine antepartum (prenatal) obstetrical care include all of the following:

- First antepartum (prenatal) visit with initial history and physical examination; and
- Urinalysis as needed; and
- Periodic antepartum (prenatal) follow-up visits for pregnancy monitoring and screening (monthly visits up to 28 weeks gestation, biweekly visits between 29 and 36 weeks gestation and weekly visits thereafter until delivery with a maximum allowable of 14 antepartum [prenatal] office visits in addition to the initial prenatal care visit – Category II Code 0500F or prenatal care at-risk assessment HCPCS Code H1000).

H. External cephalic version (ECV) (CPT Code 59412):

Based upon medical necessity, the Company considers external cephalic version performed after 34 weeks gestation eligible for reimbursement at the allowed amount in addition to global obstetrical care reimbursement for the subsequent delivery.

I. Medical care:

Hospital visits for pregnancy-related complications arising during the antepartum (prenatal) period or for a non-pregnancy related problem are eligible for payment at the allowed amount in addition to global obstetrical care reimbursement for the subsequent delivery, if the inpatient stay is determined to be medically necessary by the Company.

NOTE: If the inpatient stay is determined to be medically necessary by the Company, claims for hospital visits submitted prior to delivery will be eligible for payment at the allowed amount in addition to global obstetrical care reimbursement for the subsequent delivery. Claims received for delivery services will edit to Care Authorizations. If the hospitalization was denied as not medically necessary and paid erroneously, the amount paid on history for hospital visits will be subtracted from the allowed global obstetrical care reimbursement.
II. Delivery:

Delivery services include inpatient admission history and physical examination, management of uncomplicated labor and vaginal or cesarean delivery. If the delivery is unusually complicated or inordinately protracted, or if significantly more work is required than usual, modifier 22 may be appended.

Services within the global obstetrical care allowance for routine delivery care include all of the following:

- Supervision of labor; and
- Episiotomy; and
- Delivery (vaginal or cesarean section); and
- Delivery of placenta.

A. Induction of labor (CPT Code 59899):

Based upon medical necessity, the Company considers induction of labor eligible for reimbursement at the allowed amount in addition to global obstetrical care reimbursement for the delivery, only if the induction is performed >24 hours prior to date of delivery. CPT Code 59899 should be used to indicate induction of labor. (This code will pend to Care Authorizations and documentation of services rendered will be requested as needed).

B. Insertion of cervical dilator (CPT Code 59200):

Insertion of any type of cervical dilator such as laminaria, prostaglandins or a foley bulb into the endocervix to stimulate the dilation of the cervical canal should be submitted with CPT Code 59200.

III. Postpartum care:

Postpartum services include all hospital and office visits related to follow-up of the pregnancy up to eight weeks after delivery.

*The Company recognizes separate and distinct reimbursement for one additional postpartum care visit in addition to the global payment. Category II Code 0503F is allowable once per physician, per pregnancy when a physical examination and pelvic exam are performed between delivery and eight weeks postpartum.

Services within the global obstetrical care allowance for routine postpartum care include all of the following:

- In-hospital postpartum care; and
Postpartum visits up to eight weeks after delivery *(Category II Code 0503F)* is reimbursed in addition to all postpartum visits through the first eight weeks after delivery.

IV. Global obstetrical care reimbursement:

Global obstetrical care reimbursement includes *all* of the following:

- Antepartum (prenatal) services up to fourteen (14) office visits; and
- Postpartum services (up to eight weeks after delivery); and
- Induction of labor one day prior to, or on the same date of service as delivery; and
- Interpretation of fetal non-stress tests; and
- Inpatient visits during the same admission as delivery; and
- Delivery-related laceration repair (episiotomy).

V. Multiple gestation:

The Company will reimburse 50 percent of the allowable amount of a delivery for each subsequent infant delivered in a multiple birth pregnancy. The physician should bill for the appropriate global delivery service (CPT Codes 59400, 59510, 59610 or 59618) for the first infant and then CPT Codes 59409, 59514, 59612 or 59620 with modifier 51 for each subsequent birth.

VI. High risk pregnancy:

Clinical conditions exist in which obstetrical care is significantly more complex than most pregnancies. These pregnancies may require more frequent and intensive involvement by the provider. Although the mother and fetus may be at increased risk for morbidity and mortality before and after delivery, increased **intensity of service and frequency of care** by the provider must be demonstrated to justify additional reimbursement.

In order to be eligible for additional reimbursement, the pregnancy must be high-risk and the physician must **provide documentation that additional medical care extending significantly beyond routine care was necessary and was provided.**

High-risk pregnancy includes, but is not limited to, the following medical conditions:

- Insulin dependent diabetes mellitus; or
- Intrauterine growth restriction (IUGR); or
- Pregnancy associated hypertension requiring treatment with antihypertensive medication before 35 weeks gestation; or
- Multiple gestation pregnancy; or
Renal impairment (serum creatinine > 2.0 mg/dl); or
 Functional Class II, III or IV† cardiac disease; or
 Transplant recipient on immunosuppressive medications; or
 Systemic lupus erythematosus.

If high-risk factors are present and the woman has required additional antepartum (prenatal) and postpartum office visits, physician reimbursement will be as follows:

<table>
<thead>
<tr>
<th>Number of total visits</th>
<th>Percentage of global obstetrical care reimbursement</th>
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<tbody>
<tr>
<td>Less than fourteen (&lt;14)</td>
<td>100%</td>
</tr>
<tr>
<td>Fifteen to eighteen (15-18)</td>
<td>110%</td>
</tr>
<tr>
<td>More than eighteen (&gt;18)</td>
<td>120%</td>
</tr>
</tbody>
</table>

Documentation of additional antepartum (prenatal) or postpartum office visits with CPT Code 59899 must be submitted for consideration of additional reimbursement.

VII. Midwife care (CPT Codes 59025, 59400, 59410, 59425, 59426 and 59430):

Nurse midwifery is the independent management of women’s health care, focusing on antepartum (prenatal) care, childbirth, postpartum care, family planning and gynecological care. Certified Nurse Midwife (CNM) and Certified Midwives (CM) practice within a health care system that makes obstetrician consultation available for collaborative management or referral as indicated, based upon the health status of the individual. Certified nurse midwives and certified midwives practice according to the Standards of the Practice of Nurse Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

†New York Heart Association Functional Classification of Patient with Heart Disease:

Class I Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.

Class II Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

Class III Patients with cardiac disease resulting in marked limitation of physical activity. They are
comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.

Class IV

Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Medical Mutual has adopted a modified version of InterQual® Procedures for fetal biophysical profile (CPT Codes 76818 and 76819) medical necessity guidelines (Corporate Medical Policy 201520-IQ Fetal Biophysical Profile). The criteria for these procedures are available via ReviewLink.

Source of Information:

- Centers for Medicare & Medicaid Services: national coverage determination for ultrasound diagnostic procedures (220.5). Effective date May 22, 2007.


<table>
<thead>
<tr>
<th>Applicable Code(s):</th>
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<tr>
<td><strong>CPT:</strong></td>
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<td><strong>HCPCS:</strong></td>
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0500F and 0503F