Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Maternity Services		
Effective Date: **08/07/20**	Committee Approval Obtained: **08/07/20**	Section: **Surgery**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.amerigroup.com.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage 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 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. Amerigroup Medicare Advantage 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 to be recouped for overlapping services. **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 to be recouped for overlapping services. **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 6 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 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 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. Amerigroup Medicare Advantage reserves 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.
History	• Biennial review approved and effective 08/07/20 • Biennial review approved 06/27/18: policy template updated • Review approved 09/15/16 and effective 11/15/17: Outcome of delivery/weeks of gestation section added • Review approved 02/29/16: policy template updated • Initial review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • Current Procedural Terminology, 2018
Definitions	• **General Reimbursement Policy Definitions**

Related Policies	• Claims Requiring Additional Documentation • Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) • Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service • Maternity Ultrasound in the Outpatient Setting (CG-Med-42)
Related Materials	• None