Health Alliance™

Reimbursement Guide

Reimbursement Guide Name:	Reimbursement Guide- Obstetrical Global Services	Reimbursement Guide #:	RG-105

Reimbursement Guide Information	
Owner Department:	Risk Adjustment and Medical Economics
Owner:	Code Review Program Manager
Affected Departments:	
Reimbursement Guide Applies To:	All product lines
Electronic Signature/Date:	No Users

Purpose of the Reimbursement Guide

The purpose of this reimbursement guide is to establish clear guidelines for the reimbursement of medical services billed to Health Alliance. This guide aims to ensure that reimbursements are handled consistently, fairly, and in accordance with regulatory standards

Statement of the Reimbursement Guide

The obstetric package includes essential components such as antepartum care, delivery services, and postpartum care. When all maternity-related services are provided by the same physician or group, a global charge should be billed for maternity claims. Prenatal care is part of the global reimbursement and is not reimbursed separately when delivery services are provided by the same physician or group.

Procedure

Essential components of the obstetric package, covering antepartum care, delivery services, and postpartum care. A global charge should be billed for maternity claims when all maternity-related services are provided by the same physician or physicians within the same group. Prenatal care is considered part of the global reimbursement and is not reimbursed separately when delivery services are provided by the same physician or physicians within the same group.

1. **Antepartum Care:**
    - Antepartum care begins with conception and continues until delivery.
    - Inclusive services (part of the global OB package):
        - Obtaining patient history (initial and subsequent visits).
        - Physical examinations.
        - Recording weight, blood pressure, and fetal heart tones.
        - Routine chemical urinalysis.
        - Regular visits up to 28 weeks (monthly), 36 weeks (biweekly), and until delivery (weekly).
    - Services not included in the global OB package (report separately):
        - Complications related to pregnancy (e.g., cardiac, neurologic issues).
        - Evaluation and management (E/M) services unrelated to pregnancy.
        - Lab tests beyond routine urinalysis.
        - Surgical complications related to pregnancy.
        - Procedures like amniocentesis, cordocentesis, and fetal stress testing.

        - Ultrasounds, fetal biophysical profiles, and fetal echocardiography.
        - Administration of RH immune globulin.
        - Maternal-Fetal Medicine Specialists: A patient may consult a Maternal-Fetal Medicine (MFM) Specialist alongside their regular OB/GYN physician. MFM services are distinct from the routine global OB package and can be submitted for separate reimbursement using the appropriate E/M (evaluation and management) or procedure code
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2. **Intrapartum Care or Delivery Only:**
    - Services included in delivery (not an all-inclusive list):
        - Admission to the hospital.
        - Admission history and physical.
        - Management of uncomplicated labor (including fetal monitoring).
        - Integral components of delivery.
        - Placement of internal fetal and uterine monitors.
        - Catheterization.
        - Perineum preparation.
        - Vaginal delivery (with or without forceps/vacuum extraction).
        - Delivery of the placenta (integral part of vaginal or cesarean delivery).

Reporting codes for antepartum care only (without delivery or postpartum care) is necessary in specific circumstances, such as insurance changes, patient transfers, or miscarriages/abortions. The average number of antepartum visits for uncomplicated care is typically 13, but fewer visits can be reported separately using appropriate codes.

Antepartum care visits (CPT codes 59425 and 59426) and postpartum care (CPT code 59430):

1. Antepartum Care Visits (59425 and 59426):
    - 59425: Antepartum care only; 4-6 visits.
    - 59426: Antepartum care only; 7 or more visits.
    - Each code is reported only once.
    - When filling out the claim form, indicate “1” unit of service for either code 59425 or 59426.
    - If a physician provides 1-3 antepartum visits, report each visit using the appropriate evaluation and management (E/M) code (99201-99215).

    Examples of Reporting Antepartum Care Services:

    - Relocation of a patient:
        - Physician A provides 4 antepartum visits.
        - Patient relocates and begins seeing Physician B, who provides 8 antepartum visits, delivery, and postpartum care.
        - Physician A reports code 59425, and Physician B reports codes 59426 (antepartum care) and 59410 (delivery and postpartum care).
    - Termination of pregnancy:
        - If a patient receives 3 antepartum visits and experiences a miscarriage, report each visit with the appropriate E/M code.
        - Do not report code 59425 in this case, as the entire global maternity care was not provided.
2. Postpartum Care (59430):
    - Report code 59430 when the physician provides only postpartum care (separate procedure).
    - If a physician provides both antepartum and postpartum care but does not perform the delivery (due to referral), report codes 59426 (antepartum care) and 59430 (postpartum care).

References

- **American College of Obstetricians and Gynecologists (ACOG):** Coding Library | ACOG
- **American Medical Association.** *Current Procedural Terminology (CPT®) Professional Edition 2024*. American Medical Association; 2024.

History

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