# Obstetrics

Reimbursement Policy ID: RPC.0068.2400

Recent review date: 01/2024

Next review date: 01/2025

*Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.*

*In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.*

*This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.*

## Policy Overview

This policy describes the reimbursement guidelines for submitting claims for obstetrical services, including the initial visit, antepartum, delivery and postpartum services.

## Exceptions

N/A

## Reimbursement Guidelines

Select Health of South Carolina follows guidelines stated in the South Carolina Health and Human Services (SCDHHS) providers manual for submission of claims for the antepartum, delivery, and postpartum period.

For the initial pregnancy visit, providers have two options for submitting claims:

- A New patient Evaluation and Management (E/M) visit is billed, even if the patient is a patient of record at that practice and must contain a pregnancy diagnosis on the claim.

OR

- Providers may bill the appropriate E/M visit that meets the CPT description for the level of complexity for the initial visit and must contain a pregnancy diagnosis on the claim.

For visits billed after the initial visit during the antepartum period, providers should submit the appropriate CPT code depending on the complexity of care and the medical record documentation.

**Delivery**

Providers should bill the appropriate CPT code that describes the type of delivery (ex., vagina, cesarean section) along with the required modifier to indicate the gestational period the delivery occurs. Claims submitted without the associated modifier will not be reimbursed. When submitting claims, physicians must append a modifier to the delivery services.

**Modifier GB**

- 39 weeks gestation or more
    - Regardless of method (induction, cesarean section, or spontaneous labor)

**Modifier CG**

- Less than 39 weeks gestation
    - For deliveries resulting from patients presenting in labor or at risk of labor and subsequently delivering before 39 weeks gestation
    - For inductions or cesarean sections that meet the ACOG (American Academy of Gynecologists) guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained in the patient's medical record.
    - For inductions or cesarean sections that do not meet the ACOG guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the physician must obtain and document approval from the reginal perinatal center's maternal fetal medicine physician in the patient's file and hospital record.

**No Modifier**

- Claims that do not have the GB/CG modifiers indicated will be denied.
    - For elective deliveries less than 39 weeks gestation that do not meet ACOG approved guidelines or are not approved by the designated regional perinatal centers maternal fetal medicine physician

| CPT Code | Description |
|---|---|
| 59409 | Vaginal delivery only (with or without episiotomy and/or forceps |
| 59612 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) |
| 59514 | Cesarean delivery only |
| 59620 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean |

**Multiple births**

For multiple births of more than two, the claim should be sent hardcopy with operative notes attached. If the patient delivers multiple babies, all either vaginally or by C-section, the first birth should be billed with modifier GB (39 weeks or more) or CG (less than 39 weeks), and each consecutive birth should be billed using modifier 51. Example: Delivery of triplets, all vaginally at 39 weeks:

- Baby A= Vaginal Delivery with GB modifier,

- Baby B= Vaginal Delivery with 51 modifier,
- Baby C= Vaginal Delivery with modifier 51.

If the patient delivers multiple babies, the first vaginally and one (or more) via C-section, the first birth should be billed with modifier GB (39 weeks or more) or CG (less than 39 weeks), and the following birth, via C-section, should be billed using modifier 79. Example: Delivery of triplets, 1st birth vaginally, 2nd and 3rd via C-Section at 38 weeks:

- Baby A -Vaginal Delivery with modifier CG
- Baby B-C-section Delivery with modifier 79
- Baby C-C-section Delivery with modifier 51

**Delivery in cases of prolonged labor**

SCDHHS is modifying the delivery policy in cases of prolonged labor when a vaginal delivery with failure to progress converts to a cesarean section. For beneficiaries that have been admitted to the hospital and have been in active labor for at least six hours, the CPT code 59514 and modifier UA should be used when billing for the cesarean delivery. The patient records must indicate the time the patient was admitted to the hospital with active labor and the start time of the cesarean section. All claims and reimbursements are subject to an audit by the Division of Program Integrity.

**Licensed midwife**

Licensed Midwife A Licensed Midwife is defined as a person who is not a medical or nursing professional licensed by the South Carolina Department of Health and Environmental Control (SCDHEC), for the purpose of providing specifically defined prenatal, delivery and postpartum services to low-risk women. Reimbursement is 65% of the physician rate.

## Definitions

**Antepartum**

The period of time between conception and the onset of labor.

**Postpartum**

The period of time after the delivery of the baby lasting six to eight weeks.

## Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. The National Correct Coding Initiative (NCCI)
IV. https://www.selecthealthofsc.com/pdf/provider/provider-manual.
V. https://scdhec.gov/sites/default/files/Library/Regulations/R.61-24.pdf South Carolina Medicaid Fee Schedule(s).

## Attachments

N/A

## Associated Policies

RPC.0038.2400 Obstetric Ultrasound

## Policy History

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|---|---|
| 04/2024 | Revised preamble |
| 01/2024 | Reimbursement Policy Committee Approval |
| 08/2023 | Removal of policy implemented by Select Health of South Carolina from Policy History section |
| 01/2023 | Template revised<br>• Revised preamble<br>• Removal of Applicable Claim Types table<br>• Coding section renamed to Reimbursement Guidelines<br>• Added Associated Policies section |