PREMERA BLUE CROSS
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Payment Policy

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Title	**Multiple Deliveries/Births**		
Number	**CP.PP.140.v3.3**		
Last Approval Date	03/07/25	**Original Effective Date**	12/01/01
Cross Reference	• *Maternity Services Policy* • *Modifier 22- Increased Procedural Services* • *Modifier 59 – Distinct Procedural Service*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan limits billing for multiple birth maternity cases that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	The Plan reimburses multiple gestation deliveries following American College of Obstetrics and Gynecology (ACOG) coding guidelines for vaginal, cesarean section or a combination of vaginal and cesarean section deliveries. All multiple births are billed on the same claim with each birth billed on a separate line. The second and subsequent birth(s) must be appended with an appropriate modifier to indicate a **separate and distinct birth from the first/initial birth** (e.g., Modifier 59- *Distinct Procedural Service*). Examples of multiple births/deliveries include: (applicable codes in the Codes/Coding Guidelines section) **1. <u>All Vaginal Deliveries</u>:** a. First vaginal birth must be billed **either as a global maternity care code, a delivery and post-partum care code or delivery only code**; and b. Second and subsequent vaginal births: All billed as **vaginal delivery only codes** appended with the appropriate modifier to indicate they were separate vaginal deliveries (e.g., Modifier 59) **2. <u>At least one vaginal delivery with remaining births by cesarean section:</u>** a. First vaginal birth must be billed **either as a global maternity care code, a delivery and post-partum care code or a delivery only code**; and b. Second and subsequent cesarean births: All billed as **cesarean delivery only codes** appended with the appropriate modifier to indicate they were separate cesarean deliveries (e.g., Modifier 59) 3. **<u>All cesarean births</u>:** a. All cesarean births must be billed **either as one occurrence of a global maternity care code (cesarean only), a delivery and post-partum code (cesarean only) or a delivery only code (cesarean only).**

b. Second and subsequent cesarean births: No additional allowances for subsequent newborns delivered via the same incision as they are considered part of the initial cesarean delivery.

Modifier 59 must be appended to the second and subsequent newborn delivery only codes when it is necessary to distinguish separate and distinct multiple (e.g., twins, triplets).

A diagnosis code to indicate the **outcome of delivery for multiple births** is required and must be present at the claim level list of diagnosis codes to identify the type of multiple delivery. See the Codes/Coding Guidelines section of this policy for applicable multiple birth diagnosis codes for the outcome of delivery. Any other medical conditions and/or complications associated with the delivery should also be submitted on the claim.

Maternity Complications/High-Risk Pregnancies

In the event that maternity complications develop as part of the delivery of multiples that necessitate additional work **greater than typically required** to perform the delivery, whether vaginal or caesarean section, modifier 22- *Increased Procedural Services* **may be appended to the delivery code** (e.g., global maternity code, delivery only code or delivery and postpartum procedure codes). A diagnosis which reflects the related maternity complication or increased delivery services must be included in the claim to support the need for modifier 22.

Medical records, chart notes or operative report(s) **must document the need** for the additional services that are due to a maternity complication in order for the maternity claim to be processed correctly and support the potential increased reimbursement. The documentation should contain clear, concise statements indicating the substantial extra work rendered and the specific complication encountered during the pregnancy. Upon receipt of the records, the records will be reviewed to determine if additional reimbursement is appropriate.

Some examples of maternity complications where modifier 22 may be appended to the **delivery code**, when supported by the documentation, include but are not limited to the following:

- Gestational diabetes affecting delivery
- Placenta previa/placenta accreta
- Maternal sepsis
- Maternal severe hypertension/preeclampsia of pregnancy, including HELLP syndrome
- Cesarean-section delivery of twins/multiples when billed by a global cesarean maternity code
- Delivery of a single fetus which required **substantial additional work** and **delivery only code** was submitted

When the pregnancy complication exceeds the scope of licensure of the provider, the mother must be referred/transferred to an appropriate provider who can address the specific complication(s). Such a transfer of care may result in additional antepartum or postpartum services being rendered by the receiving provider. If the referring/transferring provider rendered less than the total global obstetrical care, the

	provider should submit the appropriate maternity code(s) for the specific obstetrical care rendered such as antepartum care only or postpartum care only. If any allowed amount indicated above exceeds the billed charge for the claim line, that line will allow at the billed charge.

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Codes/Coding Guidelines	The following code categories are referenced in this policy: **<u>Global Maternity Care Codes</u>**: • **59400** – Routine obstetric care including antepartum care, vaginal delivery (with/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/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 **<u>Delivery and Post-Partum Care Codes</u>**: • **59410** – Vaginal delivery only (with/without episiotomy and/or forceps) including postpartum care • **59515** – Cesarean delivery only including postpartum care • **59614** – Vaginal delivery only, after previous cesarean delivery (with/without episiotomy and/or forceps) including postpartum care • **59622** – Cesarean delivery only, following attempted vaginal delivery after pervious cesarean delivery including postpartum **<u>Delivery Only Codes</u>**: • **59409 –** Vaginal delivery only (with/without episiotomy and/or forceps) • **59514** – Cesarean delivery only • **59612** – Vaginal delivery only, after previous cesarean delivery (with/without episiotomy and/or forceps) • **59620** – Cesarean delivery only, following attempted vaginal delivery after pervious cesarean delivery **<u>Antepartum and Post-Partum Visit Codes:</u>** • **59425** – Antepartum care only; 4-6 visits • **59426** – Antepartum care only; 7 or more visits • **59430** – Postpartum care only (separate procedure) **<u>Multiple Birth Diagnosis Codes for Outcome of Delivery:</u>** • **Z37.2** – Twins, both liveborn • **Z37.3** – Twins, one liveborn and one stillborn • **Z37.4** – Twins, both stillborn • **Z37.50** – Multiple births, unspecified, all liveborn • **Z37.51** – Triplets, all liveborn • **Z37.52** – Quadruplets, all liveborn • **Z37.53 -** Quintuplets, all liveborn • **Z37.54** – Sextuplets, all liveborn • **Z37.59** – Other multiple births, all liveborn • **Z37.60** – Multiple births, unspecified, some liveborn • **Z37.61** – Triplets, some liveborn • **Z37.62** – Quadruplets, some liveborn • **Z37.63** – Quintuplets, some liveborn

	• **Z37.64** – Sextuplets, some liveborn • **Z37.69** – Other multiple births, some liveborn • **Z37.7** – Other multiple births, all stillborn • **Z37.9** – Outcome of delivery, unspecified

Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) Professional Edition codebook • The American College of Obstetricians and Gynecologists (ACOG) OB/GYN Coding Manual • International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codebook

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	03/07/25; 04/11/24; 05/19/23; 06/06/22; 08/02/21; 08/17/20; 10/11/19; 10/18/18; 11/06/17; 11/08/16; 11/15/15; 08/10/15; 08/10/14; 08/15/13; 08/19/12; 08/29/11; 09/03/10; 11/22/09; 12/19/08; 12/20/07; 12/10/06; 08/29/05; 10/08/04; 07/23/04; 08/04/03; 12/01/01	
Version History	10/18/18	Added new section "Codes/Coding Guidelines"
	10/11/19	In the examples discussing the second and subsequent deliveries, added a recommendation of the modifier to use when submitting these additional deliveries
	08/17/20	• Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms • In the Codes/Coding Guidelines section, added Antepartum and Postpartum codes
	08/02/21	• Added clarification in the Policy section that each multiple birth should be billed on a separate claim line with modifier 59. • Added the last paragraph in the Policy section to indicate that the diagnosis billed to indicate the outcome of the delivery should reflect a multiple birth diagnosis code. • Added Multiple Birth Diagnosis codes to the Codes/Coding Guideline section.

	06/06/22	Added clarification on the correct use of Modifier 22 to represent additional work required for additional deliveries.
	05/19/23	Removed single birth diagnosis codes from Diagnosis listing
	04/11/24	In the Policy section: • Revised the fourth and fifth paragraphs on the correct usage of modifier 59 and correct diagnosis code usage for the outcome of delivery of multiple births. • Added a new expanded section on *Maternity Complications/High-Risk Pregnancies* that addresses when to correctly append modifier 22 to the delivery procedure code to represent increased procedural services rendered for a high-risk pregnancy.
	03/07/25	Annual review; no changes

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