UnitedHealthcare Community Plan

REIMBURSEMENT POLICY
CMS-1500
Policy Number 2019R7122D

Cesarean Delivery Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

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Policy

Overview

This policy describes reimbursement for elective, non-medically indicated cesarean deliveries. For this policy, UnitedHealthcare Community Plan will use the ICD-10 diagnosis codes list defined by the Joint Commission National Quality Measures that supports cesarean deliveries along with additional diagnosis codes identified by UnitedHealthcare Community Plan medical directors.

Reimbursement Guidelines

Per the American College of Obstetricians and Gynecologists (ACOG) Committee, "Given the balance of risks and benefits, the Committee on Obstetric Practice believes that in the absence of maternal or fetal indications for cesarean delivery, a plan for vaginal delivery is safe and appropriate and should be recommended to patients."

Cesarean Obstetrical Care

A cesarean birth is the delivery of the baby through incisions in the mother's abdomen and uterus.

The American Medical Association (AMA), Current Procedural Terminology (CPT®) book defines cesarean delivery codes as:

- 59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care
- 59514 - Cesarean delivery only
- 59515 - Cesarean delivery only; including postpartum care
- 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.
- 59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- 59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

UnitedHealthcare Community Plan reimburses these cesarean delivery codes when submitted with an appropriate ICD-10 diagnosis code, from the defined list, in any position. Cesarean deliveries that are performed electively and do not include a high risk diagnosis will not be denied, but will not be reimbursed at the allowable amount. The ICD-10 diagnosis code list, within this policy, was defined by the Joint Commission National Quality Measures along with the addition of diagnosis codes determined by UnitedHealthcare Community Plan to support a cesarean delivery.

Obstetrical Care Services

Global obstetrical care, antepartum care only, delivery only and/or postpartum care only are reimbursable services.

Assistant Surgeon and Cesarean Sections

Only a non-global cesarean section delivery code (CPT codes 59514 or 59620) is a reimbursable service when submitted with an appropriate assistant surgeon modifier.

State Exceptions

Mississippi	Mississippi uses their own defined diagnosis list for Cesarean Deliveries.
New Mexico	New Mexico requires medically necessary cesarean section deliveries (CPT codes 59510, 59514 or 59615) to be billed with modifier U1 appended. New Mexico will not cover cesarean deliveries that are not considered medically necessary. In those cases, separate payment may be made for prenatal and postpartum care.
New York	Modifier U7, U8 or U9 is required on delivery codes.

Texas	Modifier U1, U2 or U3 is required on delivery codes. Modifier U3 is not reimbursable.

Modifiers	
Modifier U1	Delivery prior to 39 weeks of gestation and medically necessary
Modifier U2 (Texas)	Delivery at 39 weeks gestation or greater
Modifier U3 (Texas)	Delivery prior to 39 weeks of gestation and NOT medically necessary
Modifier U7 (New York)	Delivery less than 39 weeks of gestation for medical necessity
Modifier U8 (New York)	Delivery less than 39 weeks of gestation electively
Modifier U9 (New York)	Delivery at 39 weeks of gestation or greater

Definitions	
Elective Cesarean Delivery	A primary cesarean delivery in the absence of any maternal or fetal indications.

Questions and Answers	
1	**Q:** If one physician performs the cesarean delivery only, and a physician in another practice (different federal tax identification number) provides the antepartum and postpartum care, how should these services be reported? **A:** The physician who performs the cesarean delivery only should report the delivery service, without a postpartum component, e.g., CPT code 59514 (cesarean delivery only) with a medically indicated diagnosis code supporting reason for cesarean delivery. The other physician should report the antepartum care only code supporting the number of visits rendered (CPT code 59425 or 59426) and postpartum care only code (CPT code 59430).
2	**Q:** If a physician performs the total global obstetrical care that resulted in a cesarean delivery (CPT code 59510) that is planned because of a risk to the mother or fetus, will the global services be reduced if the supporting diagnoses for the delivery is within the list of the high risk diagnosis codes? **A:** No, reimbursement of the global obstetrical care services will not be reduced if billed with a high risk diagnosis code.
3	**Q:** If a physician requires the assistance of a physician assistant for a non-global cesarean delivery will the physician assistant's services be reduced if not supported by a high risk diagnosis code? **A:** Yes, the reimbursement for the Assistant at Surgery services will have the same requirements to support the cesarean services as the physicians. If not supported by a high risk diagnosis code, in any position, the procedure will be reimbursed at a reduction of the allowable amount.

Codes	
CPT code section	
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only;
59515	Cesarean delivery only; including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Attachments: Please right-click on the icon to open the file.	
ICD-10 OB C-Section Diagnosis List	A list of ICD-10-CM diagnosis codes that support Cesarean deliveries.
Mississippi ICD-10 OB C-Section Diagnosis List	A list of ICD-10-CM diagnosis codes that support Cesarean deliveries defined by Mississippi.

Resources

Individual state Medicaid regulations, manuals & fee schedules

Centers for Medicaid and CHIP, Early Elective Deliveries Resources

Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)

Joint Commission National Quality Measures

History

8/11/2019	Policy List Change: ICD-10 OB C-Section Diagnosis List updated
6/7/2019	Annual Anniversary Date and Version Change
3/21/2019	Word document version change Title section: Removed Annual Approval information & moved policy # to the header
1/1/2019	Annual Policy Version Change Policy List Change: ICD-10 OB C-Section Diagnosis List updated
10/08/2018	Attachments: Update to lists placing in alphanumeric order (no new version)
9/1/2018	Policy implemented by UnitedHealthcare Community & State
7/5/2018	Policy approved by the Reimbursement Policy Oversight Committee