Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	March 3, 2025	**Revised Date:**	March 2025
Date Reviewed:	February 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

REIMBURSEMENT GUIDELINES:

Newborn Care and Associated Services

The Plan will provide reimbursement for routine in-patient care of a newborn. If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services.

When reported for provider attendance at a high-risk neonatal delivery, reimbursement may be made to a provider other than the provider who performed the delivery:

- For attendance at a cesarean section or attendance at a vaginal delivery, use code 99464.
- Payment may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
- Any specific procedures necessary to care for the sick infant(s) should be reported under the appropriate procedure code (e.g., intubation - 31500, resuscitation - 99465).
- When attendance at delivery (99464) and resuscitation (99465) are reported by the same doctor, the charges should be combined and processed under code 99465. The allowance for the resuscitation includes the allowance for the attendance at the delivery. *Modifier 25 may be reported with medical care, such as evaluation and management (E/M) services, etc., to identify it as significant and separately identifiable from the other service(s) provided on the same day.
- If a doctor other than the doctor performing the delivery reports both attendance at the delivery and daily medical care of the newborn, payment may be made for both services.

***Note:** When modifier 25 is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: The above guidelines apply to claims reporting a maternity diagnosis (i.e., twin gestation, cesarean section).

Applicable codes:

31500	99221	99222	99223	99231	99232	99233	99238	99239
99460	99462	99463	99464	99465				

Obstetrical Delivery and Associated Services

The following are the Plan's reimbursement policies for obstetrical delivery and associated services:

- For the delivery of a viable infant at any time, regardless of the period of gestation, may be paid as a delivery; **or**
- Interruption of pregnancy after 24 weeks may be processed as a delivery; **or**
- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When re-suturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

The following guidelines apply to payment for multiple births:

- If the infants are delivered by the same or different methods (vaginal or cesarean section), payment should be made for one delivery for each newborn.
- Antepartum and postpartum care should be included with only one delivery code e.g., reimbursement will be made only for a single antepartum and postpartum period, regardless of the number of newborns delivered).

Applicable codes:

59400	59409	59410	59414	59510	59514

Note: Report modifier 59 to identify the delivery only code for multiple births as distinct from the global delivery codes reported on the same day. When modifier 59 is reported the patient's records must support its use in accordance with CPT guidelines.

Payment for the obstetrical delivery performed on the same date of service includes the allowance for the services listed above. If any of those services are reported on the same day by the same provider or physician group, as obstetrical delivery and the charges are itemized, the Plan will combine the charges and pay only the delivery.

The following services are considered included in a vaginal delivery or a cesarean section, or delivery after previous cesarean delivery and therefore, are not reimbursement eligible as distinct and separate services:

- Induction of labor (e.g., PEGGELL insertion, use of Pitocin); **or**
- Augmentation of labor (e.g., use of Pitocin); **or**

- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Note: Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local).

Note: Separate reimbursement may occur for external cephalic version (59412).

If the services listed above are performed independently, payment can be made under the appropriate code(s) below.

59030	59400	59409	59410	59412	59510	59514	59515
59610	59612	59614	59618	59620	59622	59871	59899

Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability.

The Plan will allow reimbursement for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

Fetal Monitoring

Payment for the delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate reimbursement may be made for fetal monitoring to a physician other than the attending physician when ANY of the following criteria are met (all separately billed procedures must be clearly and separately documented in the medical record):

- For any high-risk pregnancy; **or**
- For multiple gestations with complications; **or**
- For any unusual or abnormal fetal heart rate findings; **or**
- When there is a need for scalp pH; **or**
- For fetal decelerations which are recurrent and of unknown etiology; **or**
- When there are atypical fetal responses with maternal medical diseases; **or**
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Note: When fetal monitoring is provided on the same day as an E/M service by the same health care professional, the fetal monitoring is not eligible for separate reimbursement. When fetal monitoring is a benefit, the fetal monitoring is included in the allowance for the E/M service, and therefore, is not separately reimbursed.

When a global obstetrical care service provided exceeds normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual [e.g., as in obstetrical care for high-risk pregnancies]), the service may be given individual consideration. Additional payment for such care may be made when warranted by the patient's medical condition, based on documentation in the medical record. In order to facilitate the processing of claims for high-risk

obstetrical care, the appropriate global obstetrical care code should be reported in conjunction with modifier 22. The charge for additional payment above the global obstetrical fee should reflect the additional medical care provided. Additional medical visits should not be itemized on the claim; however, the additional visits should be documented within the patient's medical record. All pertinent records should be submitted with the claim form.

Applicable codes: 59050 59051

Antepartum and Postpartum Care

If the provider or physician group who performs a delivery submits itemized charges for antepartum and/or postpartum care and the delivery, the Plan will provide reimbursement for only the procedure code for a delivery (including antepartum and/or postpartum care).

The Plan will consider antepartum care (59425, 59426) for reimbursement if the pregnancy is terminated by abortion, provided the delivery would have been reimbursement eligible.

Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of the normal prenatal care. When used as a method of treatment, these injections may be paid under the appropriate injection/drug codes in accordance with the member's benefits.

Applicable codes:

59400	59409	59410	59412	59414	59425	59426	59430	59510
59514	59515	59525	59610	59612	59614	59618	59620	59622

DEFINITIONS:

Modifier	Definition
22	Unusual services.
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
59	Distinct procedural service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
6 / 2022	Removed MP X-17 Reference
7 / 2023	Administrative policy review with no changes in policy direction
3 / 2025	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP- 023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	July 24, 2023	**Revised Date:**	July 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

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REIMBURSEMENT GUIDELINES:

Newborn Care and Associated Services

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If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services.

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- For attendance at a cesarean section or attendance at a vaginal delivery, use code 99464.
- Payment may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
- Any specific procedures necessary to care for the sick infant(s) should be reported under the appropriate procedure code (e.g., intubation - 31500, resuscitation - 99465).
- When attendance at delivery (99464) and resuscitation (99465) are reported by the same doctor, the charges should be combined and processed under code 99465. The allowance for the resuscitation includes the allowance for the attendance at the delivery. *Modifier 25 may be reported with medical care (i.e. visits, consults, etc.) to identify it as significant and separately identifiable from the other service(s) provided on the same day.
- If a doctor other than the doctor performing the delivery reports both attendance at the delivery and daily medical care of the newborn, payment may be made for both services.

***Note:** When modifier 25 is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: The above guidelines apply to claims reporting a maternity diagnosis (i.e., twin gestation, cesarean section).

Applicable codes:

31500	99221	99222	99223	99231	99232	99233	99238	99239
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Obstetrical Delivery and Associated Services

The following are the Plan's reimbursement policies for obstetrical delivery and associated services:

- For the delivery of a viable infant at any time, regardless of the period of gestation, may be paid as a delivery; **or**
- Interruption of pregnancy after 24 weeks may be processed as a delivery; **or**
- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When resuturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

The following guidelines apply to payment for multiple births:

- If the infants are delivered by the same or different methods (vaginal or cesarean section), payment should be made for one delivery for each newborn.
- Antepartum and postpartum care should be included with only one delivery code e.g. reimbursement will be made only for a single antepartum and postpartum period, regardless of the number of newborns delivered).

Applicable codes:

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Note: Report modifier 59 to identify the delivery only code for multiple births as distinct from the global delivery codes reported on the same day. When modifier 59 is reported the patient's records must support its use in accordance with CPT guidelines.

Payment for the obstetrical delivery performed on the same date of service includes the allowance for the services listed above. If any of those services are reported on the same day by the same provider or physician group, as obstetrical delivery and the charges are itemized, the Plan will combine the charges and pay only the delivery.

The following services are considered included in a vaginal delivery or a cesarean section, or delivery after previous cesarean delivery and therefore, are not reimbursement eligible as distinct and separate services:

- Induction of labor (e.g., PEGGELL insertion, use of pitocin); **or**
- Augmentation of labor (e.g., use of pitocin); **or**
- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Note: Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local).

Note: Separate reimbursement may occur for external cephalic version (59412).

If the services listed above are performed independently, payment can be made under the appropriate code(s) below.

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Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability.

The Plan will allow reimbursement for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

Fetal Monitoring

Payment for the delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate reimbursement may be made for fetal monitoring to a physician other than the attending physician when ANY of the following criteria are met (all separately billed procedures must be clearly and separately documented in the medical record):

- For any high risk pregnancy; **or**
- For multiple gestations with complications; **or**
- For any unusual or abnormal fetal heart rate findings; **or**
- When there is a need for scalp pH; **or**
- For fetal decelerations which are recurrent and of unknown etiology; **or**
- When there are atypical fetal responses with maternal medical diseases; **or**
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Note: When fetal monitoring is provided on the same day as a consultation by the same health care professional, the fetal monitoring is not eligible for separate reimbursement. When fetal monitoring is a benefit, the fetal monitoring is included in the allowance for the consultation, and therefore, is not separately reimbursed.

When a global obstetrical care service provided exceeds normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual [e.g. as in obstetrical care for high risk pregnancies]), the service may be given individual consideration. Additional payment for such care may be made when warranted by the patient's medical condition, based on

documentation in the medical record. In order to facilitate the processing of claims for high risk obstetrical care, the appropriate global obstetrical care code should be reported in conjunction with modifier 22. The charge for additional payment above the global obstetrical fee should reflect the additional medical care provided. Additional medical visits should not be itemized on the claim, however the additional visits should be documented within the patient's medical record. All pertinent records should be submitted with the claim form.

Applicable codes: 59050 59051

Antepartum and Postpartum Care

If the provider or physician group who performs a delivery submits itemized charges for antepartum and/or postpartum care and the delivery, the Plan will provide reimbursement for only the procedure code for a delivery (including antepartum and/or postpartum care).

The Plan will consider antepartum care (59425, 59426) for reimbursement if the pregnancy is terminated by abortion, provided the delivery would have been reimbursement eligible.

Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of the normal prenatal care. When used as a method of treatment, these injections may be paid under the appropriate injection/drug codes in accordance with the member's benefits.

Applicable codes:

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POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
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Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	July 11, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

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Newborn Care and Associated Services

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If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services.

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- Payment may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
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Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
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- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When resuturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

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- Induction of labor (e.g., PEGGELL insertion, use of pitocin); **or**
- Augmentation of labor (e.g., use of pitocin); **or**
- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Note: Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local).

Note: Separate reimbursement may occur for external cephalic version (59412).

If the services listed above are performed independently, payment can be made under the appropriate code(s) below.

59030	59400	59409	59410	59412	59510	59514	59515
59610	59612	59614	59618	59620	59622	59871	59899

Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability.

The Plan will allow reimbursement for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

Fetal Monitoring

Payment for the delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate reimbursement may be made for fetal monitoring to a physician other than the attending physician when ANY of the following criteria are met (all separately billed procedures must be clearly and separately documented in the medical record):

- For any high risk pregnancy; **or**
- For multiple gestations with complications; **or**
- For any unusual or abnormal fetal heart rate findings; **or**
- When there is a need for scalp pH; **or**
- For fetal decelerations which are recurrent and of unknown etiology; **or**
- When there are atypical fetal responses with maternal medical diseases; **or**
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Note: When fetal monitoring is provided on the same day as a consultation by the same health care professional, the fetal monitoring is not eligible for separate reimbursement. When fetal monitoring is a benefit, the fetal monitoring is included in the allowance for the consultation, and therefore, is not separately reimbursed.

When a global obstetrical care service provided exceeds normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual [e.g. as in obstetrical care for high risk pregnancies]), the service may be given individual consideration. Additional payment for such care may be made when warranted by the patient's medical condition, based on documentation in the medical record. In order to facilitate the processing of claims for high risk obstetrical care, the appropriate global obstetrical care code should be reported in conjunction with modifier 22. The charge for additional payment above the global obstetrical fee should reflect the additional medical care provided. Additional medical visits should not be itemized on the claim, however the additional visits should be documented within the patient's medical record. All pertinent records should be submitted with the claim form.

Applicable codes: 59050 59051

Antepartum and Postpartum Care

If the provider or physician group who performs a delivery submits itemized charges for antepartum and/or postpartum care and the delivery, the Plan will provide reimbursement for only the procedure code for a delivery (including antepartum and/or postpartum care).

The Plan will consider antepartum care (59425, 59426) for reimbursement if the pregnancy is terminated by abortion, provided the delivery would have been reimbursement eligible.

Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of the normal prenatal care. When used as a method of treatment, these injections may be paid under the appropriate injection/drug codes in accordance with the member's benefits.

Applicable codes:

59400	59409	59410	59412	59414	59425	59426	59430	59510
59514	59515	59525	59610	59612	59614	59618	59620	59622

RELATED MEDICAL POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- X-17: Obstetrical Ultrasound

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy