03-59000-04

Original Effective Date: 01/27/00

Reviewed: 08/22/24

Revised: 09/15/24

Subject: Complications of Pregnancy

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

Complications of pregnancy are medical conditions experienced during pregnancy, which may seriously jeopardize the health of the pregnant mother or unborn (fetus, infant).

POSITION STATEMENT:

NOTE: Review member's contract language in making a coverage decision about coverage for complications of pregnancy.

Complications of pregnancy **meet the definition of medical necessity** when the condition is diagnosed as a separate condition from the pregnancy. Coverage for complications of pregnancy is limited to covered services to treat the condition caused by the complication.

BILLING/CODING INFORMATION:

CPT Coding:

Vaginal Delivery, Antepartum and Postpartum Care	
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
Cesarean Delivery	

59510	Routine obstetric care including antepartum care cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care

HCPCS Coding:

G9361	Medical indication for induction for delivery by Cesarean birth or induction of labor (< 39 weeks of gestation [documentation of reason(s) for elective delivery (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes (premature or prolonged), maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, late pregnancy, prior uterine surgery, or participation in clinical trial)]

REIMBURSEMENT INFORMATION:

Reimbursement for a vaginal delivery (59400, 59409, 59410, 59414, 59610, 59612, and 59614) performed on the same day as a cesarean section (59510, 59515, 59618, 59620, and 59622) is based on medical review of documentation of the medical indications and physician's operative report.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline reviewed date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

None applicable.

RELATED GUIDELINES:

None applicable.

OTHER:

The following information may be required documentation to support medical necessity: physician history and physical, physician operative report, physician procedure notes, antepartum, and, postpartum records, and plan of treatment.

LOINC Codes:

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physician operative note	28573-4	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physician procedure note	11505-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Attending physician visit note (i.e., ante partum and postpartum records)	18733-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Labor and Delivery records	15508-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Plan of treatment	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

REFERENCES:

1. American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, Society for Maternal-Fetal Medicine. Medically Indicated Late-Preterm and Early-Term Deliveries: ACOG Committee Opinion, Number 831. Obstet Gynecol. 2021 Jul 1;138 (1):e35-e39.
2. Center for Disease Control and Prevention. Pregnancy Complications, May 14, 2024.
3. Nisenblat V, Barak S, Griness OB, et al. Maternal complications associated with multiple cesarean deliveries. Obstet Gynecol. 2006 Jul;108(1):21-6. [Abstract]
4. Office on Women's Health Pregnancy Complications, Dec 29, 2022.
5. Preeclampsia and High Blood Pressure During Pregnancy. American College of Obstetricians and Gynecologists FAQ034, April 2022.

COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 08/22/24.

GUIDELINE UPDATE INFORMATION:

01/27/00	Medical Coverage Guideline developed.
03/15/02	Bi-annual review of MCG; no changes.
10/01/02	Revised ICD-9 code range for ectopic pregnancy.
03/15/04	Annual review. Deleted bed rest from the "when services are covered". Deleted diagnoses code range 669.22 – 669.44 from the medically necessity list and added to the list of diagnoses that require medical review.
08/15/06	Clarified coding for other complications of labor and delivery. Updated references.
01/01/07	Added "Medical" and "Reimbursement Guideline" to title. Updated description section. Updated ICD-9 diagnoses that do not require medical review and diagnoses that require medical review. Added diagnosis codes: 649.10 – 649.14, 649.20 – 649.24, 649.30 – 649.34, 649.40 – 649.44, 649.50 – 649.53, and 649.30 – 649.64. Revised other section. Updated references.
02/15/07	Revised ICD-9 diagnoses codes. Under the section for diagnoses that do not require medical review: Deleted 634.11 – 634.91, 641.80, 674.40, 674.42, and 674.44. Corrected typo for 659.32 (change 5th digit to 1 [659.31]). Under the section for diagnoses that require medical review: Deleted 634.00 – 634.92, 637.00 – 637.92, 638.0 – 638.9. Added 643.20, 643.21, 643.23, 651.23, and 665.44. Deleted extra 652.03.
06/15/07	Reformatted guideline.
08/15/07	Annual review, coverage statement maintained, references updated.
04/15/09	Annual review. Revised description section and position statement. Updated ICD-9 diagnoses codes and descriptors. Updated references.
03/15/10	ICD-9 code update, deleted 651.13 from diagnoses that do not require medical review. Added 651.13 to diagnoses that require medical review.
08/15/10	ICD-9 code updates; added 640.90, 640.91, 640.93, 678.00, 678.01, 678.03, 678.10, 678.11, 678.13, 679.00, 679.01, 679.02, 679.03, 679.04, 679.10, 679.11, 679.12, 679.13, 679.14, 641.00, 641.01, 641.03, 641.80, 641.81, 641.83, 641.90, 641.91, 641.93, 646.12, 646.22, 647.02, 647.12, 647.22, 647.32, 647.42, 647.52, 647.62, 647.82, 647.92, 648.71, 649.71, 649.72, 656.20, 656.21, 656.23, 664.60, 664.61, 664.64, 665.74, 671.04, 671.10 – 671.14, 671.20 – 671.24, 671.30, 671.31, 671.33, 671.40, 671.42, 674.44, 671.50 – 671.54, 671.80, 671.84, 671.90, 671.91, 671.93, 675.04,675.10 – 675.14, 675.20 – 675.24, 675.80 – 675.84, 675.90 – 675.93, and 676.00 – 676.94.
02/15/11	Revision; related ICD-10 codes added.
07/15/11	Revision; formatting changes.
10/01/11	Revision; related ICD-9 code added 649.81 and 649.82, and deleted 631.
04/01/12	ICD-9 code updates; deleted ICD-9 codes that do not require medical review.
05/11/14	Revision: Program Exceptions section updated.
05/15/14	Code update; added 654.23.
07/01/14	Quarterly HCPCS update; added G9361.

07/30/15	Revised O36 1st digit; changed 0 to O.
11/01/15	Revision: ICD-9 Codes deleted.
10/01/16	Revision; updated billing/coding information section.
01/01/17	Annual HCPCS code update. Revised G9361 code descriptor.
07/15/18	Review; no change in position statement. Updated references
07/15/20	Review/upate. No change in position statement. Updated references.
09/15/22	Review; no change in position statement.
08/21/23	Update to Program Exceptions section.
01/01/24	Position statement maintained.
09/15/24	Review; no change in position statement. Updated references.