Multiple Gestation Delivery

Description:

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy and/or forceps), or Cesarean delivery.\(^1\)

The incidence of multiple gestation pregnancy is increasing steadily largely due to the availability of assisted reproductive technologies.\(^2\)

Medical Criteria:

Not applicable as this is a reimbursement policy

Policy:

Coding/reimbursement of multiple gestation deliveries depend upon the method of delivery. Multiple surgery reduction rules will apply. Note: If global maternity services were not provided, please code for delivery only services when applicable.

For both Vaginal Deliveries:  
Report either 59400 or 59610 for twin A, and either 59409-59 or 59612-59 for twin B (and subsequent multiples).

For one Vaginal and one Cesarean delivery:  
Report either 59510 or 59618 for twin B, and 59409-59 or 59612-59 for twin A (and subsequent multiples).

Cesarean Sections:  
Report either 59510 or 59618. A modifier-22 to the global code can be added if the Cesarean was significantly more difficult.

Coverage:

Benefits may vary by groups/contracts. Please refer to the appropriate member certificate/subscriber agreement/Rite Care contract for applicable pregnancy services and nursery care benefits/coverage.

Coding:

59400  
59409  
59510  
59610  
59612  
59618

References:


Published:

Policy Update, June 2006
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This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgement in the treatment of your patients. Benefits and eligibility are determined by the member’s subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions.

This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.

Back to Previous Page