Chapter 4 Section 18.1

Maternity Care

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1.0 CPT[1] PROCEDURE CODES

59000 - 59899, 82105, 82106, 82731, 84702

2.0 DESCRIPTION

Maternity care is the medical services related to conception, delivery and pregnancy loss, including prenatal and postpartum care (generally through the sixth post-delivery week), and treatment of complications of pregnancy.

3.0 POLICY

3.1 Services and supplies associated with antepartum care (including well-being of the fetus), childbirth, postpartum care, and complications of pregnancy may be cost-shared.

3.2 The maternity care benefit includes, but is not limited to, the following prenatal screening tests:

3.2.1 Anemia Screening.

3.2.2 Asymptomatic Bacteriuria, Urinary Tract, or Other Infection Screening. Screen with urine culture for women 12-16 weeks gestation, or at first prenatal visit, if later.

3.2.3 Gestational Diabetes Mellitus Screening. Screen women 24-28 weeks pregnant and those at high risk of developing gestational diabetes.

3.2.4 Hepatitis B Screening. Screen pregnant women for HBsAG during the prenatal period.

3.2.5 Human Immunodeficiency Virus (HIV) Infection Screening.

3.2.6 Rh Incompatibility Screening. Screen all pregnant women and provide follow-up testing for pregnant women at high risk.

3.2.7 Syphilis Infection Screening.

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3.2.8 Other screening tests as recommended by the United States Preventive Services Task Force.

3.3 Genetic testing is considered preventive rather than active medical treatment. However, under the family planning benefit, genetic testing, including testing done as part of routine prenatal care, is covered when performed in certain high risk situations. For the purpose of the TRICARE benefit, genetic testing may include specific tests to detect developmental abnormalities as well as tests for specific genetic defects.

3.4 The mother and child hospital length-of-stay (LOS) benefit may not be restricted to less than 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. The decision to discharge prior to those minimum LOSs must be made by the attending physician in consultation with the mother.

3.5 Maternity care for pregnancy resulting from noncoital reproductive procedures may be cost-shared. Where the contractual arrangements do not specify an amount for reimbursement for medical expenses, the full amount of all undesignated payments shall be deemed to be for medical expenses incurred by the surrogate mother. TRICARE will cost-share on the remaining balance of otherwise covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon arrangement has been exhausted.

3.6 For pregnancies in which the TRICARE beneficiary is a surrogate mother, services and supplies associated with antepartum care, childbirth, postpartum care, and complications of pregnancy may be cost-shared.

3.7 Tocolysis is a covered benefit. The off-label use of U.S. Food and Drug Administration (FDA) approved drugs are subject to requirements specified in Chapter 8, Section 9.1, paragraph 2.2.6. 17 alpha-hydroxyprogesterone caproate for prevention of preterm delivery is covered.

3.8 Progesterone therapy for the prevention of preterm birth is covered only when the following criteria are met:

3.8.1 Weekly injections of 17 alpha-hydroxyprogesterone caproate between 16 and 36 weeks of gestation for pregnant women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

3.8.2 Oral progesterone therapy or injections of 17 alpha-hydroxyprogesterone caproate are **NOT** covered for other high risk factors for preterm birth, including, but not limited to multiple gestations, short cervical length, or positive fetal tests for cervicovaginal fetal fibronectin.

4.0 EXCLUSIONS

4.1 Services and supplies related to noncoital reproductive procedures.

4.2 Home Uterine Activity Monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation for the purpose of monitoring suspected or confirmed pre-term labor is unproven.

4.3 Subcutaneous terbutaline pump and home use of maintenance subcutaneous terbutaline to suppress labor is unproven.

4.4 Lymphoctye or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss is unproven.

4.5 Salivary estriol test for preterm labor is unproven (CPT[2] procedure code 82677).

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