

## CHAMPVA POLICY MANUAL

CHAPTER: 2  
SECTION: 14.4  
TITLE: CESAREAN SECTIONS

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**AUTHORITY:** 38 USC 1713; 38 CFR 17.270(a) and 17.272(a)

**RELATED AUTHORITY:** 32 CFR 199.4(c)(2)(i)

**TRICARE POLICY MANUAL:** Chapter 3, Section 13.4

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### I. EFFECTIVE DATE

July 27, 1993

### II. PROCEDURE CODE(S)

- A. CPT codes: 59400, 59410, 59510 and 59515
- B. ICD-9-CM codes: 74.00-74.99, 650, and 669.7
- C. DRG codes: 370, 371, 372, 373, 374, and 375

### III. POLICY

Cesarean sections (C-sections) are authorized when determined medically necessary. Cost sharing for services and supplies related to elective cesarean section, that is, those done at the request or convenience of the beneficiary is limited to what would have been provided for a vaginal delivery. In those cases where the procedure is not medically indicated and the patient chooses to proceed with the C-section, CHAMPVA will reimburse at the Diagnosis Related Group (DRG) rate payable for a vaginal delivery. The primary diagnosis must be changed to a vaginal delivery (ICD-9-CM 650). The related professional claims will be reimbursed at the vaginal delivery rate as well using either CPT code 59400 or 59410. The patient will be responsible for the difference, even in the case of participating providers as coverage is limited to the amount allowed for the medically necessary procedure.

**\*END OF POLICY\***