

Maternity Billing

The Maternity Period - For billing purposes, the obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period (56 days after vaginal delivery and 90 days after c-section).

Global OB – The global obstetric (OB) code should be billed whenever one practitioner or practitioners of the same group provide all components of the patient’s obstetrical care, including; 4 or more antepartum visits, delivery and postpartum care. The number of antepartum visits may vary from patient to patient, however, if global ob care (more than 3 antepartum visits, delivery and postpartum care) is provided, ALL pregnancy related visits (excluding inpatient hospital visits for complications of pregnancy) should be billed under the global OB code. Individual E/M codes should **NOT** be billed to report pregnancy related E/M visits.

- Less than 4 antepartum visits, delivery and postpartum care bill; (the appropriate delivery including postpartum care code) and (E/M codes for the individual office visits). The 25 modifier should be appended to the E/M codes to indicate that the visits are outside of the global surgery period.
- 4-6 antepartum visits, delivery and postpartum care – Bill the appropriate global surgery code with the 52 modifier appended to indicate reduced services.
- 15 or more, medically necessary, antepartum visits (office or outpatient hospital)– Bill the appropriate OB global code and append the 22 modifier to indicate increased services. Individual E/M codes should **NOT** be billed for the excess office visits. Attach documentation (such as progress notes and/or the antepartum flow sheet) that clearly describes the medical necessity for each of the additional visits.. When documentation supports the medical necessity of the additional visits, IME will reimburse an additional \$55.44, for each additional visit.
- Inpatient hospital visits for complications of pregnancy may be billed using the appropriate level E/M code. The 25 modifier must be appended to the inpatient hospital E/M code.
- Normal antepartum care, complicated delivery and post partum care – Bill the appropriate OB global code and append the 22 modifier to indicate increased services. Attach documentation that clearly describes the increased service.
- Antepartum, delivery and postpartum care for multiple gestations – Bill the appropriate OB global code (determined by the method of delivery of baby A), for 1 unit, and append the 22 modifier. The diagnosis should indicate that there were multiple live

births. Attach documentation that describes the method of delivery (vaginal or c-section) for each baby.

- Antepartum, assisted in delivery and postpartum care – Bill the appropriate OB global code and append the AS (non-physician providers) or 80 (physician providers) modifier as appropriate.

Antepartum care only – “Antepartum care only codes” should be billed when the practitioner or practitioners of the same group, will **NOT** be performing all 3 components of global OB care (more than 3 antepartum visits, delivery and postpartum care). Only one antepartum care code is allowed to be billed per pregnancy.

- <3 antepartum visits are performed – bill appropriate E/M codes for the visits
- 4-6 antepartum visits – Bill 59425
- 7-14 antepartum visits – Bill 59426
- More than 14 antepartum visits due to complications of pregnancy – Bill 59426 and append the 22 modifier to indicated increased services. Attach documentation (such as progress notes and/or the antepartum flow sheet) that clearly describes the medical necessity for each of the additional visits. When documentation supports the medical necessity of the additional visits, IME will reimburse an additional \$55.44, for each additional visit.

Delivery Only – Delivery begins on the date of initial hospitalization for delivery and extends through the date in which the member is released from the hospital. Hospital care, related to the delivery, is considered part of the delivery charge and is NOT considered part of postpartum care. If a c-section is performed, the reimbursement for the delivery only charge includes payment for the surgical procedure as well as the post-surgical care.

- Vaginal delivery only – bill 59409
- C-section delivery only – bill 59514
- VBAC delivery only – bill 59612
- C-section after attempted VBAC delivery only – bill 59620
- Delivery of multiples – bill appropriate delivery code (determined by the method of delivery of baby A), for 1 unit, and append 22 modifier. Attach documentation showing the method of delivery for each baby.
- Complicated delivery – bill appropriate delivery code and append the 22 modifier. Attach documentation describing delivery complications.

Antepartum care and delivery – There is not a comprehensive CPT code that describes antepartum care including delivery. Therefore, when antepartum care and delivery are

performed, the provider must bill the appropriate antepartum code in addition to the appropriate delivery code. Antepartum and delivery codes should only be billed if postpartum care was **NOT** provided. Hospital care, related to the delivery, is considered part of the delivery charge and is NOT considered part of postpartum care.

Postpartum care only – postpartum care begins after the patient is discharged from the hospital stay for delivery and extends throughout the postpartum period (56 days for vaginal delivery and 90 days for cesarean delivery).

- postpartum care only – bill 59430

Delivery and postpartum care – When a provider performs the delivery and postpartum care, and did **NOT** perform the antepartum care, the appropriate delivery and postpartum code should be billed.

- Vaginal delivery including postpartum – bill 59410
- C-section delivery including postpartum care – bill 59515
- Vaginal birth after cesarean delivery (VBAC) including postpartum care – bill 59614
- C-section after attempted VBAC including postpartum care – bill 59622

Maternity billing codes

OB Global Billing:

59400 - Billed for vaginal delivery including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed. May have 22 or 52 modifier(s) appended.

59510 -Billed for c-section delivery including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed. May have 22, 52, AS, 80 modifier(s) appended.

59610 -Billed for VBAC delivery including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed. May have 22 or 52 modifier(s) appended.

59618 -Billed for c-section after attempted VBAC including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed. May have 22, 52, AS,80 modifier(s) appended.

Antepartum Care Only Billing:

59425 - Billed for 4-6 ante-partum visits only. May not be billed with delivery only charge unless postpartum care not done. May not be billed with delivery plus postpartum charge.

59426 - Billed for 7 or more ante-partum visits. May not be billed with delivery only charge unless postpartum care not done. May not be billed with delivery plus postpartum charge. May have 22 modifier appended.

** If less than 3 antepartum visits are performed, the appropriate E/M visit code should be billed, with the 25 modifier appended to indicate that the visit is outside of the OB global. This would also apply to consultative visits in the antepartum period by the provider who performs the delivery ***

Delivery Only Billing Codes:

59409 - Billed for vaginal delivery only. May have 22 modifier appended.

59514 -Billed for c-section delivery only. May have 22, AS, 80 modifier(s) appended.

59612 -Billed for VBAC delivery only. May have 22 modifier appended.

59620 -Billed for c-section only after attempted VBAC. May have 22, AS, 80 modifier(s) appended.

Postpartum Care Only Billing Codes:

59430 - Billed for postpartum care only. May only be billed if provider had no part in the delivery. No modifiers may be used.

Delivery including Postpartum Care Billing Codes:

59410 -Billed for vaginal delivery including postpartum. Use this code if less than 4 ante-partum visits performed. May have 22 modifier appended.

59515 -Billed for c-section delivery including postpartum. Use this code if less than 4 ante-partum visits performed. May have 22, AS, 80 modifier(s) appended.

59614 -Billed for VBAC delivery including postpartum. Use this code if less than 4 ante-partum visits performed. May have 22 modifier.

59622 -Billed for c-section after attempted VBAC including postpartum. Use this code if less than 4 ante-partum visits performed. May have 22, AS, 80 modifier(s) appended.

Misc Maternity Codes:

59414 - Billed for delivery of placenta, separate procedure. Use this code if unattended delivery.

59200 – Insertion of cervical dilator is included as part of the delivery charge and is NOT separately reimbursable.

H1005 – At Risk Pre-natal care can be billed in addition to the OB global charges.

Modifiers:

22 modifier - Appropriate to use when billing for delivery of multiples, complicated pregnancy and/or delivery, or excessive ante-partum visits.

25 modifier – Appropriate to append to E/M codes when billing;

- 3 or less antepartum visits
- Billing visits performed during OB global period that are unrelated to the pregnancy. Examples of some pregnancy related diagnosis include; irregular menstruation, abdominal pain, genital tract infection, yeast infection or inflammatory disease of female pelvic organs.
- For consultative services performed in the antepartum period by the provider who ultimately performs the delivery.

52 modifier -Appropriate to use when 4-6 ante-partum visits performed with a global code.

80 modifier -Appropriate to use when physician provider is the assistant for the c-section.

AS modifier -Appropriate to use when non-physician provider is the assistant for the c-section.