Priority Health	BILLING POLICY No. 071
Maternity Services	
Date of origin: Jan. 3, 2025	**Review dates: 2/2025, 8/2025, 1/2026, 3/2026, 4/2026**

DEFINITION

This policy outlines billing and coding requirements for care during the Maternity/Obstetrical Period.

Maternity/Obstetrical Period: The range of time from the first visit confirming pregnancy through the end of postpartum care (56 days post vaginal delivery and 90-day post c-section).

POLICY SPECIFIC INFORMATION

Coding specifics

Maternity Care Policy Update

Due to the CPT code changes for maternity care services taking effect in 2027, patients who begin prenatal care on or after June 1, 2026, will no longer be billed using global maternity care codes. Instead, all visits must be billed using the appropriate E/M codes, with the required TH modifier, and the correct pregnancy-related diagnosis codes.

Global obstetric (OB) codes

When one practitioner or practitioners from the same group provides all components of antepartum, delivery and postpartum care, a global code should be billed for the entire period of care. Individual E/M codes should not be billed.

- **59400**: Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- **59510**: Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- **59610**: Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- **59618**: Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
- Bill the date of service as the date of delivery when the complete global service is rendered (antepartum, delivery and postpartum).
- All prenatal dates MUST be noted on the claim in box 19.
    - Failure to include ALL prenatal visits in the claim notes (box 19) will result in a denial.

Antepartum care only

These codes should be billed when one practitioner or practitioners from the same group will **not** be performing all aspects of global OB care and will only be providing antepartum care.

- Appropriate E/M code(s) should be billed for 3 or less antepartum visits
- **59425**: Antepartum care only; 4-6 visits
- **59426**: Antepartum care only; 7 or more visits
- For 1-3 antepartum visits, the appropriate E/M code should be reported
- Bill the date of service as the first prenatal visit for the date span with a unit of 1 when billing either 59425 or 59426.
- All prenatal dates MUST be noted on the claim in box 19.
    - *Failure to include ALL prenatal visits in the claim notes (box 19) will result in a denial.

Delivery only
The delivery period begins at the initial date of hospitalization for delivery and ends at discharge from the hospital. If a c-section is performed, the surgical procedure and post-surgical care are included in the delivery period.

- **59409**: Vaginal delivery only (with or without episiotomy and/or forceps)
- **59514**: Cesarean delivery only
- **59612**: Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- **59620**: Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Antepartum care and delivery
When the same provider or group of providers provides antepartum care and delivery, but **not** postpartum care, the appropriate antepartum code **and** appropriate delivery code should be billed. There's not a comprehensive code for antepartum and delivery only.

Delivery and postpartum care
When the same provider or group of providers provides delivery and postpartum care, but **not** antepartum care, the appropriate delivery and postpartum code should be billed.

- **59410**: Vaginal deliver only (with or without episiotomy and/or forceps); including postpartum care
- **59515**: Cesarean delivery only; including postpartum care
- **59614**: Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
- **59622**: Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Postpartum care only
The postpartum care period begins after hospital discharge and extends through the postpartum period (56 days for vaginal delivery and 90 days for c-section).

Office visits with a postpartum diagnosis will be denied if a global OB code is billed within the last 42 days.

- 59430: Postpartum care only

Multiple gestation deliveries

- Both vaginal deliveries:
    - Newborn A: 59400, 59409, or 59410
    - Additional newborns: 59409-59 or 59612-59
- Vaginal birth after cesarean (VBAC) delivery:
    - Newborn A: 59610, 59612, or 59614
    - Additional newborns: 59612-59
- One vaginal birth and cesarean birth:
    - Newborn A: 59409-51 or 59612-51
    - Additional newborns: 59510 or 59618
- One VBAC and one repeat cesarean:
    - Newborn A: 59612-51
    - Additional newborns: 59618
- Both cesarean:
    - 59510, 59514, 59515, or 59618 (only 1 incision was performed, so no additional codes needed for additional newborn)
        - Note: Modifier 22 is not appropriate for multiple cesarean deliveries, nor will additional compensation be returned.

Diagnosis Sequencing

Cesarean delivery procedures (59510, 59514, 59515) will not be reimbursed when submitted with a diagnosis of encounter for cesarean delivery without indication (O82) in combination with a gestational age of less than 39 weeks (Z3A.01-Z3A.29, Z3A.30-Z3A.38).

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

When appending modifier 22, an operative note or special report is required to verify increased services. Complications or increased difficulty must be proven.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Ger more information on modifier use in our Provider Manual.

- **22** - Increased procedural services. Appropriate to append for a complicated delivery or excessive antepartum visits caused by complications. Appropriate documentation is required to prove the necessity of increased procedural services.
- **25** - Append to E/M codes when billing 3 or less antepartum visits, visits during OB global period that are unrelated to pregnancy, & consult services performed in the antepartum period by the provider who ultimately performs the delivery.
- **51** - For multiple deliveries append modifier 51 to indicate separate vaginal or cesarean procedures were performed.
- **59** - For multiple deliveries, append modifier 59 to indicate additional vaginal delivery performed with the global code.
- **76** - Indicates that a procedure or service was repeated in a separate session on the same day by the same physician.
- **77** - Indicates that a procedure had to be repeated by a different physician in a separate session on the same day.
- **TH-** Obstetrical treatment/services, prenatal or postpartum

Related denial language

E1H - Diagnosis Codes on the claim do not support the billed Procedure Code

AZ4 - Resubmit with the correct date of service

O69 - Need OB dates of service

RESOURCES

- Physicians Current Procedural Terminology CPT 1997. American Medical Association. 1996. p 197
- Witt, Melanie, RN, MA. Am Col of Obstet and Gyn Newsletter. Supplement 1995. 1995. p6
- CPT Coding in Obstetrics and Gynecology 1996 Edition. American College of Obstetricians and Gynecologists. 1996. pp 39-40,46-48,51-54.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization is not being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis, and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry-standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies, and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing, or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal, or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align with these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 2025	Added "Disclaimer" section
Sept. 2025	Added information on diagnosis sequencing – effective 11/17/25
Jan. 2026	Removed medical policy section due to no associated medical policy Removed "with modifier 25" with first bullet under Antepartum section Added billing date of service information Added include ALL antepartum dates in box 19

	Added additional related denial language
March 2026	Added modifiers 76 & 77 Added information on office visits with postpartum diagnosis Changed name to Maternity Services
April 2026	Added Maternity Care Policy update Added TH modifier