Priority Health	BILLING POLICY No. 071
MATERNITY AND PRENATAL CARE	
Date of origin: Jan. 3, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

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).

MEDICAL POLICY

Reference PH current medical policy

POLICY SPECIFIC INFORMATION

Coding specifics

Global obstetric (OB) codes

When one practitioner or practitioners from the same group provide 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

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 with modifier 25
- **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

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).

- 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.

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 of 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 procedure were performed.
- **59** - For multiple deliveries append modifier 59 to indicate additional vaginal delivery performed with the global code.

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.

CHANGE / REVIEW HISTORY

Date	Revisions made