Global Maternity & Multiple Births Coding & Billing Quick Reference Guide

Global Maternity

Global maternity care includes pregnancy-related antepartum care, admission to labor and delivery, management of labor including fetal monitoring, delivery, and uncomplicated postpartum care until six weeks postpartum. A global charge should only be billed when all maternity-related services are provided by the same physician/qualified healthcare practitioner (QHP) or another physician/QHP's practicing at the same location reporting under the same Federal Tax Identification Number (TIN). The global maternity code is reported after the delivery.

It is not appropriate to report the antepartum, delivery or postpartum care separately unless only certain services were provided. Individual Evaluations and Management (E/M) codes should not be billed to report maternity-related E/M visits. Prenatal care is considered an integral part of the global reimbursement and will not be paid separately.

Services not included in Global Maternity Care:

- An initial visit, confirming the pregnancy, is not a part of global maternity care services.
- Antepartum services such as laboratory tests (excluding dipstick urinalysis), diagnostic ultrasound, amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, and fetal non-stress test are not considered part of global maternity services and should be billed separately.

Prenatal Delivery and/or Postpartum Services Billed Separately

It is appropriate to file prenatal, delivery and/or postpartum services separately, if:

- The member's coverage started after the onset of pregnancy.
- The coverage terminates prior to delivery.
- The pregnancy does not result in delivery.
- Another provider in a different practice assumes care of the member prior to completion of global services.
- During the member's pregnancy, there was a change in the member's benefit package or certificate number due to an employer change only.

Maternity Service	Number of Visits	Coding & Billing
Antepartum Care Only	1 to 3 visits	Use the appropriate E&M code(s)
Antepartum Care Only	4 to 6 visits	Use CPT code 59425 and one (1) unit
Antepartum Care Only	7 or more visits	Use CPT code 59426 and one (1) unit
Postpartum Care Only		Use CPT 59430

In the event a physician/QHP in a different practice provides the prenatal and/or postpartum care but does not perform the delivery, the delivering physician/QHP may file using the antepartum/postpartum care-only codes. The applicable code may be reported based on the above criteria.

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Multiple Birth Guidelines			
Newborn(s)	Procedures Codes		Coding & Reimbursement
Vaginal delivery			
First Newborn	59400 59409 59410 59610 59612 59614	Global vaginal delivery Vaginal delivery only Vaginal delivery only; including postpartum (PP) Global vaginal delivery, after previous cesarean delivery (VBAC) VBAC delivery only VBAC; including PP	▪ Use the appropriate vaginal delivery code for the first newborn ▪ Reimbursed at 100% of the allowable charge
Subsequent Newborn(s)	59409 59612	Vaginal delivery only VBAC delivery only	▪ Use the appropriate vaginal delivery-only code with modifier 59 appended ▪ Reimbursed at 50% of the allowable charge for each newborn **Note:** If more than one subsequent baby is delivered, the total number of subsequent newborns should be indicated in the unit's field.
Cesarean (C-section)			
First Newborn	59510 59514 59515 59618 59620 59622	Global C-section C-section delivery only C-section delivery only; including PP Global C-section after VBAC C-section delivery only after VBAC C-section delivery only after VBAC; including PP	▪ Use the appropriate Cesarean delivery code for the first newborn ▪ Reimbursed at 100% of the allowable charge regardless of the subsequent newborns
Subsequent Newborn(s)	59514 59620	C-section delivery only C-section delivery only after VBAC	▪ Use the appropriate Cesarean delivery-only code with modifier 59 appended **Note:** Report only once regardless of the number of babies delivered.
Vaginal delivery followed by Cesarean delivery			
First Newborn (Vaginal)	59409 59612	Vaginal delivery only VBAC delivery only	▪ Use the appropriate vaginal delivery-only code with modifier 59 appended ▪ Reimbursed at 50% of the allowable charge
Subsequent Newborn(s) (C-section)	59510 59514 59515 59618 59620 59622	Global C-section C-section delivery only C-section delivery only; including PP Global C-section after VBAC C-section delivery only after VBAC C-section delivery only after VBAC; including PP	▪ For the subsequent newborn(s) delivered by Cesarean, use the appropriate C-section delivery code ▪ The primary procedure will be reimbursed at 100% of the allowable charge and secondary procedure will be reimbursed at 50% of the allowable charge **Note:** If more than one subsequent baby is delivered via C-section report only once regardless of the number of babies delivered.

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Quality Reporting - HEDIS

In support of quality tracking and in accordance with HEDIS guidelines, we encourage that claims be submitted with the following:

- Date of first prenatal visit
- Date of postpartum visit
- Date of last menstrual period (LMP)

Date of first prenatal visit - Submit a claim reflecting the date of the first visit for prenatal care. Use CPT Category II code **0500F** (Initial prenatal care visit) or **0501F** (Prenatal flow sheet documented in medical record by first prenatal visit).

Date of postpartum visit - The postpartum visit should occur 4-6 weeks after delivery. Submit a claim with the date the postpartum service was rendered. Use CPT Category II Code **0503F** (Postpartum care visit)

Date of last menstrual period – Box 14 of the CMS 1500 Claim Form

Maternity CPT Codes

Code	*Description*
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery only; including 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
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

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Billing Scenarios

Scenario 1: Maternity care provided by two different physicians in two different unaffiliated groups

Dr. Blue provides only antepartum and/or postpartum patient care and does not perform the delivery. Therefore, Dr. Blue should file the appropriate CPT code(s) for only the antepartum/postpartum care. Dr. Cross, who is unaffiliated with Dr. Blue's practice, performs the delivery. Therefore, Dr. Cross should file the appropriate CPT code for only the delivery. In this scenario, the prenatal care, labor and delivery, and post-delivery care were provided by two different physicians in two different unaffiliated groups. A global CPT code is not applicable and should not be filed by either physician.

Scenario 2: Maternity care provided by two different physicians practicing at the same location (group)

When two different physicians are practicing at the same location, and both are providing the maternity care (for example, Dr. Blue provides antepartum & postpartum care, and Dr. Cross performs the delivery), a single claim should be filed with the appropriate global maternity CPT code. Two different claims should not be filed since Dr. Blue and Dr. Cross are rendering the maternity care and practice at the same location.

Scenario 3: Sterilization performed in addition to providing all services for a cesarean delivery

Dr. Blue provides all services for a cesarean delivery. In addition to providing all services for a cesarean delivery, Dr. Blue performs a sterilization procedure immediately following the delivery. Dr. Blue's office should submit a claim with the global maternity code (cesarean delivery) on one line and the appropriate CPT code(s) for sterilization services provided post-cesarean delivery within the same maternity stay.

Scenario 4: Repair of fourth laceration only; physician performs no other maternity-related services

Dr. Blue provides all services for a vaginal delivery. Dr. Cross repairs a fourth-degree laceration to the cervix during the delivery. The claim for Dr. Blue's services should be filed first and reflect the global maternity services (vaginal delivery). Dr. Cross's services for the laceration repair during the delivery should be billed separately. Third and fourth-degree laceration repairs are considered separately identifiable services.

Additional Information

Ultrasound During Pregnancy	Ultrasound performed during routine screening during pregnancy is considered an integral part of patient care during pregnancy. Reimbursement is included in the global maternity care fee. Ultrasound during pregnancy is reimbursed separately only when used for the diagnosis or treatment of a specified medical condition(s).
Unrelated to Pregnancy (Performed by the physician rendering global maternity care)	Services unrelated to pregnancy, but performed by the physician rendering global maternity care, should be documented and reported separately with the appropriate inpatient or outpatient E/M code with modifier 24 appended, using the condition unrelated to pregnancy as the primary diagnosis code. Additionally, the diagnosis should reflect the separately identifiable service.
Surgical Complications	Services related to surgical complications should be filed separately.
Referral to Perinatologist	When a member is referred to and evaluated by a perinatologist, the perinatologist should bill an E/M consultation code with the problem diagnosis that necessitated the referral. Maternity health status codes should not be used, as they may cause the visit to be attributed to global maternity care.
Complications of Pregnancy	Complications of pregnancy per member certificate language are medical conditions with diagnoses that are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible, and which require the mother to be treated prior to the full term of pregnancy.
PrenatalPlus+ Program	The program gives mothers-to-be helpful tools and information, so they can make healthy decisions throughout their pregnancy. A case manager from BCBSND will be assigned for high-risk pregnancies to help navigate the health care system and increase the likelihood of a healthy pregnancy. For more information contact us at 844-363-8457.
Provider Resources	Physicians can reference the following resources for additional information related to filing claims for maternity care: The Current Procedural Terminology® manual

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