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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 4 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.
- 7-14 antepartum visits, delivery and postpartum care- Bill the appropriate global surgery code.
- 14 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 visit. When documentation supports the medical necessity of the additional visits, Iowa Medicaid 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 delivery of multiple births – See Multiple Birth Guidelines table below for specific guidance.
    - Modifier 22 can be added to the global delivery code for subsequent newborn(s) if there is increased physician work.
    - Claims submitted with modifier 22 must include medical record documentation that supports the use of the modifier.
- 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 4 antepartum visits, delivery, and postpartum care). Only one antepartum care code is allowed to be billed per pregnancy.

- <4 antepartum visits are performed – Bill the appropriate E/M codes for the visits.
- 4-6 antepartum visits – Bill code 59425
- 7-14 antepartum visits – Bill code 59426
- More than 14 antepartum visits due to complications of pregnancy – Bill code 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, Iowa Medicaid 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 code 59409
- C-section delivery only – Bill code 59514
- VBAC delivery only – Bill code 59612
- C-section after attempted VBAC delivery only – Bill code 59620
- Delivery of multiple births – See Multiple Birth Guidelines table below for specific guidance.
- Complicated delivery – Bill the 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 code 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 code 59410
- C-section delivery including postpartum care – Bill code 59515
- Vaginal birth after cesarean delivery (VBAC) including postpartum care – Bill code 59614

- C-section after attempted VBAC including postpartum care – Bill code 59622

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MATERNITY BILLING CODES

Global OB Billing Codes			
Code	Definition	Billing Guidance	Modifiers
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Billed for vaginal delivery including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed.	52
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	Billed for c-section delivery including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed.	52
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	Billed for VBAC delivery including ante-partum and postpartum. Do not use this code if less than 4 ante-partum visits performed.	52
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	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.	52, AS, 80

Antepartum Care Only Codes			
Code	Definition	Billing Guidance	Modifiers
59425	Antepartum care only; 4-6 visits	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.	52, AS, 80
59426	Antepartum care only; 7 or more visits	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.	52, AS, 80
** 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 **			

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Delivery Only Codes			
Code	Definition	Billing Guidance	Modifiers
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	Billed for vaginal delivery only.	52, AS, 80
59514	Cesarean delivery only	Bill for cesarean delivery only.	52, AS, 80
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	Bill for vaginal delivery after cesarean delivery (VBAC).	52, AS, 80
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	Bill for cesarean delivery only following an attempted VBAC.	52, AS, 80

Postpartum Care Only Codes			
Code	Definition	Billing Guidance	Modifiers
59430	Postpartum care only (separate procedure)	Billed for postpartum care only. May only be billed if the provider had no part in the delivery.	52, 59

Delivery including Postpartum Care Billing Codes			
Code	Definition	Billing Guidance	Modifiers
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	Billed for vaginal delivery only including postpartum care. Use this code if less than 4 antepartum visits performed.	52
59515	Cesarean delivery only; including postpartum care	Billed for cesarean delivery only including postpartum care. Use this code if less than 4 antepartum visits performed.	52
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Bill for vaginal delivery only after previous cesarean delivery (VBAC). Use this code if less than 4 ante-partum visits performed.	52, AS, 80

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Delivery including Postpartum Care Billing Codes			
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	Bill for cesarean delivery only following an attempted VBAC. Use this code if less than 4 antepartum visits performed.	52, AS, 80

Miscellaneous Maternity Codes			
Code	Definition	Billing Guidance	Modifiers
59414	Delivery of placenta (separate procedure)	Billed for delivery of placenta only. Use this code if unattended delivery.	52, AS, 80
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)	Billed for cervical dilator only. Insertion of cervical dilator is included as part of the delivery charge and is NOT separately reimbursable.	52
H1005	Prenatal care, at-risk enhanced service package	At risk prenatal care can be billed in addition to the OB global charges.	59

Modifiers		
Modifier	Definition	Billing Guidance
22	Increased Procedural Services	Appropriate to use when billing for a complicated delivery, as well as a complicated pregnancy and/or excessive antepartum visits.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service	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	Reduced Service reports a partially reduced or eliminated service or procedure	Appropriate to use when 4-6 antepartum visits performed with a global code.

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Modifiers		
80	Assistant surgeon	Appropriate to use when physician provider is the assistant for the cesarean section.
AS	Assistant at surgery	Appropriate to use when non-physician provider is the assistant for the cesarean section.

Multiple Birth Guidelines			
Newborn(s)	Procedure Codes		Coding/Modifiers
Vaginal Delivery			
First Newborn	59400 59409 59410	Global vaginal delivery Vaginal delivery only Vaginal delivery only; including postpartum	Use the appropriate delivery code
Subsequent Newborn(s)	59409	Vaginal delivery only	Append modifier 59
Vaginal Birth After Cesarean (VBAC)			
First Newborn	59610 59612 59614	Global vaginal delivery, after previous cesarean delivery VBAC delivery only VBAC; including postpartum	Use the appropriate delivery code
Subsequent Newborn(s)	59612	VBAC delivery only	Append modifier 59
Cesarean Delivery			
First Newborn	59510 59514 59515	Global C-section C-section delivery only C-section delivery only; including postpartum	Use the appropriate delivery code.
Subsequent Newborn(s)		No additional allowance for subsequent newborns delivered via the same incision reimbursed under the first newborn's claim	
Cesarean Delivery After VBAC			
First Newborn	59618 59620 59622	Global C-section after VBAC C-section delivery only after VBAC C-section delivery only after VBAC; including postpartum	Use the appropriate delivery code.
Subsequent Newborn(s)		No additional allowance for subsequent newborns delivered via the same incision reimbursed under the first newborn's claim	
Vaginal Delivery Followed by Cesarean Delivery (Vaginal delivery, then a Cesarean)			

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Multiple Birth Guidelines			
First Newborn (Vaginal)	59409 59612	Vaginal delivery only VBAC delivery only	Append modifier 51 to the appropriate delivery code
Subsequent Newborn(s) (C-section)	59510 59514 59515 59618 59620 59622	Global C-section C-section delivery only C-section delivery only; including postpartum Global C-section after VBAC C-section delivery only after VBAC C-section delivery only after VBAC; including postpartum	Use the appropriate Cesarean delivery code