PAYMENT POLICY ID NUMBER: 19-065

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Obstetric Services

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DESCRIPTION:

Current Procedural Terminology (CPT®) guidelines describe Global Obstetrical (OB) package services provided in uncomplicated maternity cases, including antepartum care, the delivery, and postpartum care.

This policy describes reimbursement for global OB codes and itemization of obstetrical services for professional services reported on a CMS-1500 claim or its electronic equivalent.

REIMBURSEMENT INFORMATION:

Global Obstetrical Package

Global OB codes are reported when a provider from an individual or group practice provides the global routine obstetric care, which includes the antepartum care, delivery, and postpartum care. Providers are reimbursed a global payment for the total provider services related to the pregnancy from the initial diagnosis of the pregnancy until the end of the postpartum period.

These global services (antepartum, delivery and postpartum care) are reported using the following codes: 59400, 59510, 59610 and 59618.

Florida Blue will reimburse these global OB codes when all the antepartum, delivery and postpartum care are provided by the Same Group Physician and/or Other Health Care Professional.

Services included in the Global Obstetrical Package

According to CPT® guidelines and the American College of Obstetricians and Gynecologists (ACOG), the following services are included in the global OB package (CPT® codes 59400, 59510, 59610, 59618).

Antepartum Services

- All routine prenatal visits until delivery
  - Monthly visits up to 28 weeks
  - Biweekly visits to 36 weeks
  - Weekly visits from 36 weeks until delivery
- Initial and subsequent history and physical exams
- Recording of weight, blood pressures and fetal heart tones
- Routine chemical urinalysis

Delivery Services

- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Management of uncomplicated labor
- Vaginal or cesarean section delivery
- Delivery of placenta
- Induction of labor (unless the obstetrician personally starts the IV and sits with the patient during the infusion)
- Insertion of cervical dilator on same date as delivery
- Repair of lacerations
- Simple removal of cerclage (not under anesthesia)
- Uncomplicated inpatient visits following delivery

Postpartum Services

- Routine outpatient E/M services provided within 45 days of delivery
- Discussion of contraception
- Removal of sutures (if appropriate)

Services Excluded from the Global Obstetrical Package

Per CPT® guidelines and ACOG, the following services are excluded from the global OB package (CPT® codes 59400, 59510, 59610, 59618) and may be reported separately if warranted:

- Pregnancy confirmation during a problem oriented or preventive visit is not considered a part of antepartum care and should be reported using the appropriate E/M service code for that visit.
- Laboratory tests (excluding routine chemical urinalysis)
- Maternal or fetal echography procedures
- External cephalic version
- Insertion of cervical dilator more than 24 hours before delivery
- E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.
- Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
- Facility-based E/M service that occurs on the calendar date of delivery or the calendar date before delivery is included in the delivery and cannot be billed separately.

- Management of surgical complications during pregnancy (e.g., appendicitis, hernia, ovarian cyst, Bartholin cyst)

Provisions of less than Global Obstetric Package

Global OB codes are utilized when the Same Group Physician and/or Other Health Care Professional provides all components of the OB package. However, providers from different group practices may provide individual components of obstetrical services to a patient. Itemization of Obstetric Services may occur in the following situations:

- A patient transfer into or out of a physician or group practice.
- A patient is referred to another physician during her pregnancy.
- A patient has the delivery performed by another physician or other health care professional not associated with her physician or group practice.
- A patient terminates or miscarries her pregnancy.
- A patient changes insurers during her pregnancy

Antepartum Care Only

The CPT® codes 59425 (Antepartum care only; 4-6 visits) and 59426 (Antepartum care only; 7 or more visits) accommodate situations when all the routine antepartum care (usually 13 visits) or global OB care may not be provided. If the patient is treated for antepartum services only, the physician and/or other health care professional should use CPT® code 59426 if 7 or more visits are provided, CPT® code 59425 if 4-6 visits are provided, or itemize each E/M visit if only providing 1-3 visits.

Delivery Services Only

Per the CPT® book, "Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery."

The following are the CPT® defined delivery only codes: 59409, 59514, 59612, and 59620.

The delivery only codes should be reported by the Same Group Physician and/or Other Health Care Professional for a single gestation when only the delivery component of the maternity care is provided, and the postpartum care is performed by another physician or group of physicians. If the provider has also performed some but not all of the antepartum care, then an antepartum care only code can be reported along with a delivery only code.

When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient post-delivery` management and discharge services using E/M service codes (99238-99239). Delivery and postpartum care (59410, 59515, 59614. 59622) includes delivery services and all inpatient and outpatient postpartum services.

Postpartum Care Only

Sometimes a provider will provide only postpartum care for a patient. This is reported using code 59430 (postpartum care only). This code includes only postpartum outpatient care, not postpartum inpatient care. Florida Blue considers routine outpatient E/M services to be within 45 days of the date of the cesarean or vaginal delivery.

The postpartum care only code should be reported by the Same Group Physician and/or Other Health Care Professional that provides the patient with services of postpartum care only. If a physician provides any component of antepartum along with postpartum care, but does not perform the delivery, then the

services should be itemized by using the appropriate antepartum care code and postpartum care code (CPT® code 59430).

Delivery Only including Postpartum Care

If the provider performed the delivery and the postpartum care with minimal or no antepartum care, then the appropriate delivery plus postpartum care code is reported. The following are CPT® defined delivery plus postpartum care codes: 59410, 59515, 59614, and 59622.

The delivery only including postpartum care codes should be reported by the Same Group Physician and/or Other Health Care Professional for a single gestation when delivery and postpartum care services are the only services provided or the delivery and postpartum care services are provided in addition to a limited amount of antepartum care (e.g., CPT® code 59425).

Multiple Gestations

The following table outlines the appropriate code submission and reimbursement information regarding delivery of multiple births:

Delivery Method		Procedure Code	Reimbursement
Vaginal	First Newborn	59400, 59409, or 59410	100% of the allowance
	Subsequent Newborn(s)	59409-59	50% of the allowance
Vaginal Birth After Cesarean (VBAC)	First Newborn	59610, 59612, or 59614	100% of the allowance
	Subsequent Newborn(s)	59612-59	50% of the allowance
Cesarean	First Newborn	59510, 59514, or 59515	100% of the allowance
	Subsequent Newborn(s)	59514-59	50% of the allowance
Cesarean Delivery After attempted VBAC after Previous Cesarean Delivery	First Newborn	59618, 59620, or 59622	100% of the allowance
	Subsequent Newborn(s)	59620-59	50% of the allowance
Vaginal Delivery & Cesarean Delivery	First Newborn	59510, 59514, or 59515	100% of the allowance
	Subsequent Newborn(s)	59409-59	50% of the allowance
VBAC & repeat Cesarean Delivery	First Newborn	59618, 59620, or 59622	100% of the allowance
	Subsequent Newborn(s)	59612-59	50% of the allowance

Multiple surgery guidelines will apply to the second and succeeding delivery codes.

Reimbursement for multiple surgical procedures is as follows:

- 100 percent of the allowance for the highest valued procedure.
- 50 percent of allowance for subsequent deliveries.

Please refer to the **Multiple Surgical Procedure Reduction (10-026)** for additional information

Increased Procedural Services

If there is significant increased physician work involvement for delivery of subsequent deliveries, modifier 22 may be appended to the usual procedure code. Please refer to Florida Blue's payment policy **Increased Procedural Services (Modifier -22) (10-034)** for reimbursement information.

Assistant Surgeon and Cesarean Sections

Only a non-global cesarean section delivery code (CPT® codes 59514 or 59620) is a reimbursable service when submitted with an appropriate assistant surgeon modifier. Refer to **Surgical Assistant policy (10-027)** for additional information regarding modifiers and reimbursement.

BILLING/CODING INFORMATION:

Maternity CPT® Codes	
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
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
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
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
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

Modifiers

22	Increased Procedural Services: Note: This modifier should not be appended to an E/M service.
25	Significant, Separately Identifiable E/M Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.
59	Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

RELATED MEDICAL COVERAGE GUIDELINES OR PAYMENT POLICIES:

Global Surgery Package 10-009
Increased Procedural Services (Modifier -22) 10-034
Multiple Surgical Procedure Reduction 10-026
Surgical Assistant policy 10-027

REFERENCES:

1. American Medical Association, *Current Procedural Terminology* (CPT®), Professional Edition
2. Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG), 2023.

GUIDELINE UPDATE INFORMATION:

02/14/2019	New Payment Policy
02/13/2020	Annual Review
02/11/2021	Annual Review: Added Modifier 59 to the “Billing/Coding Information:” section.
02/10/2022	Annual Review – No changes
02/09/2023	Annual Review – Discharge E/M service codes revised to remove deleted CPT® codes. References reviewed and updated.
02/08/2024	Annual Review – CPT® code descriptors removed from Reimbursement Information section. Clarifying language added to Postpartum Care Only and Delivery Only including Postpartum Care sections. References reviewed and updated.
02/13/2025	Annual Review – References reviewed and updated.