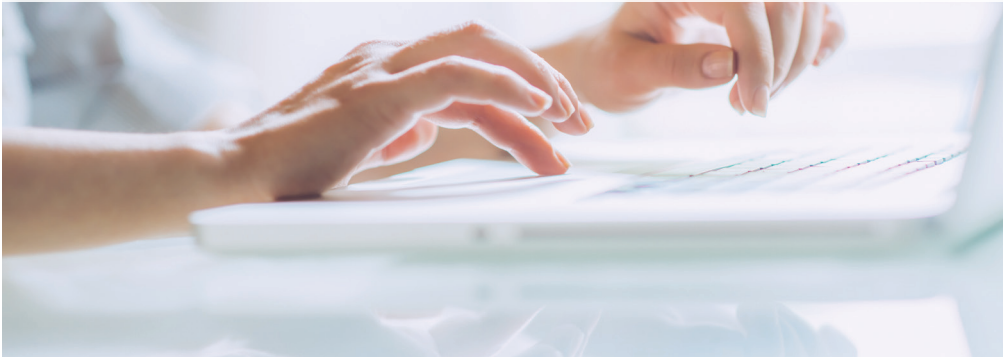




Obstetrics Coding and Documentation Reference Guide



This Quick Reference Guide is for informational purposes only. Providers should reference the Current Procedural Terminology (CPT®) manual for the most current updates and for any additional maternity-related service codes. The most current codes should be submitted on a claim. Member eligibility and benefits should be determined before medical guidelines and reimbursement guidelines are applied.

Obstetrics Coding and Documentation Reference Guide

Global maternity care reporting services include maternity care and delivery codes related to antepartum care, admission to the hospital for labor and delivery, management of labor (including fetal monitoring), delivery and postpartum (uncomplicated) care until six weeks postpartum.

A global charge should be billed for maternity claims when all maternity-related services are provided by the same physician or physicians within the same group. Individual Evaluation and Management (E&M) codes should not be billed to report maternity visits. Prenatal care is considered part of the global reimbursement and is not reimbursed separately.

The CPT manual identifies and describes the following codes as global maternity services:

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

Prenatal, Delivery and/or Postpartum Services Billed Separately

The following are instances where it is appropriate to submit a claim separately for prenatal, delivery and/or postpartum services:

- When the member's coverage started after the pregnancy started
- When the member's coverage terminates before the delivery
- When the pregnancy does not result in a delivery
- When another provider in a different location takes over care of the member before completion of the global services
- When, during the member's pregnancy, there is a change in the member's benefits

Maternity Service	Number of Visits	CPT Coding
Antepartum Care Only	1-3 visits	Use E&M Codes
Antepartum Care Only	4-6 visits	59425
Antepartum Care Only	7 or more visits	59426
Postpartum Care		59430

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If a provider in a different practice provides the prenatal and/or postpartum care but does not handle the delivery, the delivering provider can file a claim using the antepartum/postpartum care only codes according to how many times the provider sees the patient.



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CPT Coding *CPT defines maternity-related services as:*

59400	<i>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</i>
59409	<i>Vaginal delivery only (with or without episiotomy and/or forceps);</i>
59410	<i>Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care</i>
59425	<i>Antepartum care only; 4-6 visits</i>
59426	<i>Antepartum care only; 7 or more visits</i>
59430	<i>Postpartum care only (separate procedure)</i>
59510	<i>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care</i>
59514	<i>Cesarean delivery only;</i>
59515	<i>Cesarean delivery only; including postpartum care</i>
59610	<i>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery</i>
59612	<i>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);</i>
59614	<i>Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care</i>
59618	<i>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery</i>
59620	<i>Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;</i>
59622	<i>Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care</i>

Quality Reporting

For quality tracking and in accordance with Healthcare Effectiveness Data Information Set (HEDIS) and guidelines, Blue Cross and Blue Shield of Alabama requires that claims (outside of the global billing claim) be submitted with both of the following:

- Date of first prenatal visit
- Date of postpartum visit

Date of first prenatal visit – Submit a claim reflecting the actual 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 – A postpartum visit and/or wound check should occur 1-12 weeks after delivery. Use CPT II code 0503F (postpartum care visit) and ICD-10 diagnosis code Z39.2 (routine postpartum follow-up).

Diagnosis Coding

For diagnosis coding, use ICD-10-CM code range of 000-09A with sequencing priority over codes from other categories. Additional codes can be used from other categories in conjunction with maternity codes to further specify the condition(s). Should the provider specify that the pregnancy is incidental to the encounter, ICD-10-CM code Z33.1 (pregnancy state, incidental) should be used in place of ICD-10-CM codes 000-09A. Include the condition being treated and document that it is not affecting the pregnancy.

Obstetrics Principle Diagnosis

For routine outpatient prenatal visits when no complications are present, a code from category Z34 (encounter for supervision of normal pregnancy) should be used as the first-listed diagnosis. These codes are not to be used with the 000-09A category codes.

Prenatal Outpatient Visits for High-Risk Patients

For outpatient routine prenatal visits, for high-risk pregnancies, use an ICD-10-CM code from category O09 (supervision of high-risk pregnancies) as the first listed diagnosis. Secondary codes can also be used to further describe the patient's condition.

Episodes When No Delivery Occurs

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complication codes may be sequenced first.

When a Delivery Occurs

When a delivery occurs, the principal diagnosis should correspond to the main circumstance or complication of the delivery. In cases of cesarean delivery, the selection of the principal diagnosis should be the condition established that was responsible for the patient's admission.

Normal Delivery, ICD-10-CM Code O80

Full-term uncomplicated delivery ICD-10-CM code O80 should be assigned when a patient is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery or postpartum. ICD-10-CM code O80 is always principle and is not used with any other code to describe a current complication. ICD-10-CM code Z37.0, single live birth, is the only outcome of delivery code appropriate for use with ICD-10-CM code O80.



Additional Information

Outcome of Delivery

A code from ICD-10-CM category Z37, outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on newborn records.

Claims Submission Tips:

- An initial visit confirming the pregnancy is **not** a part of global maternity care services. Verification of benefits will determine the member's portion of the reimbursement.
- A global charge should be used for one physician or multiple physicians within the same group (tax identification) and provide all components of the patient's maternity care, which include: four or more antepartum visits, delivery and postpartum care.
- Antepartum services such as laboratory tests (excluding dipstick urinalysis), diagnostic ultrasounds, amniocentesis, cordocentesis, chorionic villus samplings, fetal stress tests and fetal non-stress tests are not considered part of global maternity services and should be billed separately.



International Classification of Diseases - Tenth Revision - Clinical Modification (ICD-10-CM)

Services Unrelated to Pregnancy <i>(Performed by the physician rendering global maternity care)</i>	Services unrelated to the pregnancy but performed by the physician rendering global maternity care should be reported separately with the appropriate inpatient or outpatient E&M code(s) and the diagnosis code for the condition unrelated to the pregnancy. The diagnosis should reflect the separately identifiable service.
Surgical Complications	Services related to surgical complications should be filed separately. Physicians should reference the most recent version of the CPT manual for appropriate surgical codes.
Ultrasound During Pregnancy	Diagnostic ultrasounds are reimbursed outside of the global maternity care fee.
Referral to Perinatologist	When a member is referred to and evaluated by a perinatologist, the service should be billed with an E&M consultation code and include the problem diagnosis code that necessitated the referral. Maternity health status codes should not be used as they may be included as part of the global maternity care.
Complications of Pregnancy	Complications of pregnancy are medical conditions that are distinct from pregnancy but have adversely affected or caused the member's life to be in jeopardy or the birth of a viable infant impossible, requiring the mother to be treated prior to the full term of pregnancy.

SCENARIO A

Maternity care provided by two different physicians in two different groups

Dr. A provides only the antepartum and/or postpartum patient care and does not perform the delivery. Dr. B from another group performed the delivery. Dr. A should file the appropriate CPT code(s) for only the antepartum/postpartum care. Dr. B should file the appropriate CPT code for only the delivery. A global CPT code is **not** applicable for this scenario by either provider.

SCENARIO B

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

When two different providers are practicing at the same location and are both providing maternity care services, a single claim should be filed with the appropriate global maternity CPT code. Two different claims should **not** be filed for the two providers since they are in the same location.

SCENARIO C

Repair of fourth laceration only; provider performs no other maternity-related services

Dr. A provides services for a vaginal delivery. Dr. B repairs fourth-degree lacerations to the cervix during delivery. The claim for Dr. A's services should be filed first and show the global maternity services (vaginal delivery). Dr. B's services for the laceration repair during the delivery should be billed separately. Third and fourth-degree laceration repairs are considered separate services.



Obstetrics Documentation Requirements Tips



Documentation should specify:

- Patient's pregnancy by week of gestation
- Patient's first or subsequent pregnancy
- Gestational week(s) and day(s) (e.g., 30 weeks, 3 days) complications developed
- Reason pregnancy is high-risk (e.g., elderly gravida, poor prenatal history)
- Underlying or pre-existing conditions (e.g., hypertension, diabetes, anemia)
- Control of gestational diabetes (e.g., diet, insulin)
- Fetal condition affecting management of pregnancy and trimester
- Multiple fetuses:
 - ▶ Condition(s) affecting some or all of the fetuses
 - ▶ Number or alpha assigned to each fetus (e.g., 1-8, A-H)
- Result of patient's group B streptococcus (GBS)
 - ▶ Patient has an active GBS infection
 - ▶ Patient is a carrier

Conditions Due to Complications, Outpatient Setting, when applicable

- Patient seen for supervision of normal pregnancy
- Gestational week(s) and day(s) (e.g., 30 weeks, 3 days) complications develop
- Patient's first or subsequent pregnancy

Conditions Due to Complications, Inpatient Setting, when applicable

- Condition(s) requiring admission
- Gestational week(s) and day(s) (e.g., 30 weeks, 3 days) at time of admission and throughout hospital stay
- Gestational week(s) and day(s) (e.g., 30 weeks, 3 days) complications develop (e.g., patient admitted at 35 weeks, 3 days; patient developed preeclampsia on day 3 of hospital stay)
- Delivery during admission
 - ▶ Normal, full-term, uncomplicated
 - ▶ Delivery complications
 - ▶ Delivery outcome
 - ▶ Number of fetuses
 - ▶ Living number of fetus(es) (i.e., liveborn vs. stillborn)
 - ▶ Location of delivery (e.g., hospital, car)



**BlueCross BlueShield
of Alabama**

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Information and Guidelines from ICD-10-CM coding manual and the Current Procedural Terminology (CPT) Manual, 2025.
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