If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Global Obstetrical/OB Maternity Services Policy

Policy Number: CPCP044

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: May 9, 2025

Plan Effective Date: August 19, 2025

Description

This policy provides information for obstetrical maternity services occurring during the global obstetrical/OB period for professional health care provider claims and is not meant to be all inclusive. This policy describes certain services that may or may not be separately eligible for reimbursement for uncomplicated maternity services.

Providers are expected to exercise independent medical judgement in providing care to members. Providers are responsible for accurately, completely, and legibly documenting services performed.

Providers may file global OB maternity care when they provide the antepartum, delivery, and postpartum care. A global OB charge should only be billed when all maternity-related services are provided by the same qualified health care professional or another QHP practicing at the same location reporting under the same Federal Tax Identification Number.

Reimbursement Information

The Plan reserves the right to request supporting documentation to determine eligible reimbursement. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Submission of any code should be fully supported in the medical documentation. Appropriate coding is key to minimizing delays in claims processing.

Maternity care includes antepartum care, delivery services, and postpartum care.

Initial OB Visit

Pregnancy confirmation during a problem-oriented or preventive visit is **not** considered part of the antepartum care and should not be reported using the antepartum service codes.

When prenatal care/OB record is initiated, the initial visit becomes part of the global OB package, and it is not reimbursed separately. The initial visit to confirm the pregnancy, regardless of when the prenatal care/OB record has been initiated should be submitted at that time of the visit and not upon delivery. Providers should report this service with the appropriate quality measurement code (**0500F or 0501F**). CPT Category II codes **0500F/0501F** are for quality measurement reporting purposes only and will not affect reimbursement.

All subsequent office visits for uncomplicated maternity care (antepartum and postpartum care) and delivery are considered part of the global OB package.

Global OB Package

As stated above, all subsequent office visits for uncomplicated antepartum care, delivery, and postpartum care, are considered part of the global OB package. Claims should be submitted upon delivery.

The following is included in the global OB package for CPT codes **59400** (vaginal delivery) or **59510** (cesarean delivery):

Antepartum Care	• Initial and subsequent history • Physical examinations following the initial diagnosis of pregnancy. • Obtaining and recording of weight • Blood pressure • Fetal heart tones • Routine dipstick urinalysis • Monthly routine visits up to 28 weeks gestation (typically 5 to 6 visits) • Biweekly routine visits to 36 weeks gestation (typically 4 visits) • Weekly routine visits after 36 weeks until delivery (typically 3 to 4 visits)

Delivery Services	• Admission to the hospital
	• Admission history and physical examination
	• Management of uncomplicated labor
	  ○ Induction of labor
	  ○ Insertion of cervical dilator on day of delivery
	  ○ Simple removal of cerclage
	• Vaginal delivery (with or without episiotomy, with or without forceps), or cesarean (C-section) delivery
	• Delivery of the placenta
	• Routine inpatient care immediately after the delivery

Postpartum Care	• Hospital and office visits following a vaginal or C-section delivery

Multiple Births

Vaginal Delivery		
Delivery Of	**Eligible Codes**	**Additional Information**
First Newborn	59400: Global vaginal delivery 59409: Vaginal delivery only 59410: Vaginal delivery only that includes postpartum 59610: Global vaginal delivery, after VBAC* 59612: VBAC delivery only 59614: VBAC including postpartum	• Use the appropriate vaginal delivery code for the first newborn, typically 59400 or 59610. • The primary procedure will be allowed at 100% of the contracted rate, subject to the member's benefits.
Subsequent Newborn(s)	59409: Vaginal delivery only 59612: VBAC delivery only	• Use the appropriate vaginal delivery-only code for each subsequent newborn with modifier -59 appended. • The secondary procedure will be subject to the multiple surgical procedure reduction rate for each newborn, subject to the member's benefits.

*VBAC- Vaginal delivery after previous cesarean delivery

Cesarean (C-section) Delivery		
Delivery Of	**Eligible Codes**	**Additional Information**
Newborns	59510: Global C-section 59514: C-section delivery only 59515: C-section delivery only including postpartum	• Use the appropriate C-section delivery code one time. Only one c-section is performed regardless of the number of newborns delivered.

	59618: Global C-section after VBAC 59620: C-section delivery only after VBAC 59622: C-section delivery only after VBAC including postpartum	

Vaginal Delivery followed by C-section Delivery		
Delivery Of	**Eligible Codes**	**Additional Information**
First Newborn -Vaginal	59409: Vaginal delivery only 59612: VBAC delivery only	• Use the appropriate vaginal delivery-only code for each newborn delivered vaginally with modifier -59 appended. • The secondary procedure will be subject to the multiple surgical procedure reduction rate for each newborn, subject to the member's benefits.
Subsequent Newborn(s) -C-section	59510: Global C-section 59514: C-section delivery only 59515: C-section delivery only including postpartum 59618: Global C-section after VBAC 59620: C-section delivery only after VBAC 59622: C-section delivery only after VBAC including postpartum	• If one or more newborns are delivered vaginally and subsequent newborn(s) are delivered by cesarean, use the appropriate cesarean delivery code (typically 59510 or 59618) for the cesarean delivery and the appropriate vaginal delivery-only code for the vaginal delivery with modifier -59 appended. • The primary procedure will be allowed at 100% of the contracted rate, subject to the member's benefits. • The secondary procedure(s) will be subject to the multiple surgical procedure reduction rate for each newborn, subject to the member's benefits.

Obstetrical Care Provided by Two Different Providers/QHPs from Unaffiliated Groups

If a provider provides all or part of the antepartum and/or postpartum care for a member but does not perform the delivery, the provider should report the antepartum or postpartum care only codes: 59425, 59426, or 59430.

Antepartum Care Only	Postpartum Care Only
• Appropriate Evaluation and Management E/M Codes: for 1 to 3 visits • 59425 with 1unit: for 4 to 6 visits • 59426 with 1 unit: for 7 or more visits	• 59430: Reported after delivery for postpartum visits

Example:

1. A member was being treated by **Provider A** but relocated to a different state and was treated by **Provider B**. **Provider A** provided four antepartum visits, and **Provider B** provided eight antepartum visits, performed a vaginal delivery, and rendered the postpartum care.
    a. **Provider A** would report CPT code 59425 for the 4 antepartum visits with 1 unit.
    b. **Provider B** would report CPT code 59426 for the 8 antepartum visits with 1 unit, and CPT code 59410 for the vaginal delivery and postpartum care.

Obstetrical Care Provided by Two Different Providers/QHPs at the Same Location/Same TIN

If two different providers are practicing at the same location, and both are providing maternity care over the course of the member's pregnancy, the following options may be reported:

- Global Billing: One single claim may be submitted with the appropriate global maternity code.
- Separate Billing: A global code would not be submitted by either provider and the appropriate codes would be submitted for the care rendered for the antepartum only, delivery only, and/or the postpartum care only for each provider accordingly.

Example:

1. A member was being treated by **Provider C** for the antepartum care, but **Provider D** provided the delivery and postpartum care. **Provider C** provided 12 antepartum visits, and **Provider D** performed a vaginal delivery, and rendered the postpartum care.
    a. **Provider C** would report CPT code 59426 for the 12 antepartum visits with 1 unit.
    b. **Provider D** would report CPT code 59410 for the vaginal delivery and postpartum care.

Assistant Surgeon Charges

Only a non-global C-section delivery-only code (59514) is eligible for reimbursement when submitted with an appropriate assistant surgeon modifier. Providers should append the appropriate assistant surgeon modifier for each delivery. Reimbursement for the assistant surgeon charge is paid at a percentage of the primary physician's contracted rate.

Complications

Surgical Complications

Services for surgical complications should be coded separately utilizing appropriate codes listed in the *Surgery* section of the CPT book, and/or related HCPCS codes (e.g., some HCPCS Level II G codes).

For example: An appendectomy, hernia repair, ovarian cyst, Bartholin cyst

Medical Complications of Pregnancy

Services for medical complications of pregnancy should be coded separately utilizing appropriate codes listed in the *Medicine* and/or the *Evaluation and Management Services* sections of the CPT book.

For example: Cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes

High-Risk vs At Risk Maternity Care Complications of Pregnancy

Guidelines for maternity care state that uncomplicated maternity care includes monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery. A member who is **high-risk** may be seen more frequently. Additional visits may be reported in addition to the global services with

appropriate coding if the member is seen for more than 13 antepartum visits. If a member is **at risk** and does not require additional visits, no additional charges should be submitted. Documentation must reflect the necessity of the additional visits as well as any additional laboratory or radiologic tests performed.

- *High-Risk*-Member has problems in current pregnancy. Additional visits may be reported only if the patient is seen for more than 13 antepartum visits.
- *At Risk*- Member had a problem with a previous pregnancy but no additional visits are needed, and no issues develop during current pregnancy. Therefore, no additional charges may be submitted for reimbursement.

Examples of Services Reported in Addition to the Global OB

- Pregnancy confirmation visit when the OB record is not initiated - Also, see quality measurement reporting section.
- Antepartum services, such as:
    - Amniocentesis and cordocentesis (59000- 59012)
    - Chorionic villus sampling (59015)
    - Diagnostic ultrasounds (maternal and fetal (76801- 76828)
    - External cephalic version (59412)
    - Fetal biophysical profile (76818- 76819)
    - Fetal stress test & fetal non-stress test (59020, 59025)
- Labor and Delivery services, such as:
    - E/M facility services for complications provided more than one calendar day prior to the delivery date
    - Insertion of a cervical dilator by the provider prior to hospital admission
    - Repair of a third- or fourth-degree perineal laceration.

Prolonged Physician Services

Prolonged physician services for labor and delivery are **not** separately reimbursable services. CPT codes 99415-99418 are add-on codes that may be appropriately reported for E/M services as they describe a set amount of time.

Services Unrelated to Pregnancy

Services that are unrelated to the member's pregnancy but that are provided by the provider who is rendering global maternity care, should be documented, and reported separately with the appropriate E/M code, and/or modifier(s) with the condition that is unrelated to the pregnancy as the primary diagnosis code.

Quality Measurement Reporting

Providers are encouraged to report the following in addition to the global OB package claim, when applicable:

Initial Visit: Submit claim for the initial visit with CPT Category II code 0500F (Quality measure: prenatal care) or 0501F (Quality measure: prenatal care flow sheet).

Postpartum Visit: Submit claim with the actual date the postpartum service was rendered with CPT Category II code 0503F (Quality measure: pregnancy).

Date of LMP: Include information in Box 14 of the CMS 1500 Claim Form.

Additional Resources

Clinical Payment and Coding Policy

CPCP006 Preventive Services Policy

CPCP010 Anesthesia Information

CPCP015 Multiple Surgical Procedures- Professional Provider

CPCP023 Modifier Reference Policy

CPCP043 Lactation Support Services

References

Healthcare Common Procedure Coding System (HCPCS)

Policy Update History

05/09/2025	New policy