

## Maternity Care

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Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a

**Policy #: RPM020**

### Scope

**Companies:** Moda Partners, Inc. and its subsidiaries & affiliates (All)

**Provider Contract Status:** Any

**Claim Forms:** CMS1500 & CMS1450 (paper and electronic versions)

**Claim Dates:** All

### Reimbursement Guidelines

#### A. Single Claim for All Global OB and Delivery Services

1. All delivery charges, antepartum care, postpartum care, and any additional surgical services from the date of delivery (e.g., 58611 *tubal at time of cesarean delivery*) must be submitted on the same claim.
2. Multiple Procedure Fee Reductions apply to global OB and delivery-only codes.<sup>E</sup> These procedure codes are assigned a multiple procedure indicator of “2” on the Medicare Physician Fee Schedule Database (MPFSDB).
3. Other non-surgical services which may be reported separately in addition to the global OB package may be submitted on separate claims.
4. Date of delivery clarified for billing purposes:
  - a. When delivery crosses midnight, the date of delivery equals the date listed as the infant’s birthday.
  - b. In the case of multiples delivered before and after midnight, the date of delivery for both delivery codes is the date of the first infant’s birth (due to multiple procedure reduction rules).

#### B. Initial Prenatal Visit

In addition to billing with the appropriate global maternity services, please report the initial prenatal visit with CPT code 0500F (Initial prenatal care visit) with a date of service of the initial prenatal visit as a no-charge line item. This can be done on a separate claim at the date of the first prenatal visit, or on the same claim as the global maternity billing, based on what will work best for your billing system.

**Why:** We use the Healthcare Effectiveness Data and Information Set (HEDIS) to measure our quality performance (most health plans do). HEDIS requires that we gather this information on all of our members receiving maternity care.

**Results:**

- Reduce medical records requests to your office to collect this information.
- CPT code 0500F is for reporting purposes only and will not affect your reimbursement in any way.
- Will not delay the processing of your claim in any way, in accordance with our claim processing policy and state law.

#### C. Maternity Global Period

The CMS Physician Fee Schedule assigns maternity procedure codes a global days indicator of MMM and does not identify the number of days for a Maternity global period.

- For claims processed on or after July 1, 2018 (regardless of service date):
  - The global maternity period for vaginal delivery is 49 days (59400, 59410, 59610, & 59614).
  - The global maternity period for cesarean delivery is 90 days (59510, 59515, 59618, & 59622). A cesarean delivery is considered a major surgical procedure.

- For claims processed prior to July 1, 2018, we use a Maternity Global Period of 45 days.
- The date of delivery is day zero. The day after delivery is postpartum day one, just as the surgery global period days are calculated. <sup>B</sup>

#### **D. Global OB Package**

We reimburse global maternity codes for services provided during the maternity period for uncomplicated pregnancies. Services [considered part of the global OB package](#) will not be reimbursed separately. The global maternity reimbursement includes antepartum care, delivery, and postpartum care.

The global obstetrical package code must be billed when one physician, one midwife, or the same physician group practice provides all of the patient's routine obstetric care, which includes the antepartum care, delivery, and postpartum care.<sup>1</sup> For this purpose, a physician group practice is defined as a clinic or an obstetric clinic with an electronic health record (EHR), or where there is no EHR, but one hard-copy patient record and each physician/nurse practitioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. All locations of a multi-location clinic with an EHR (or one hard-copy patient record) are considered the same physician group practice.

One primary care provider is responsible for overseeing patient care during the patient's pregnancy, delivery, and postpartum care. The clinic is expected to bill globally for all prenatal, delivery, and postpartum care services provided by the clinic, using the primary care provider's individual National Provider Identifier (NPI) as the performing provider. An exception to this rule occurs when the group practice clinic includes both physicians and nurse midwives. If the member's primary OB provider is a nurse midwife, but the delivery must be performed by a physician (e.g., complications, need for cesarean), then the billing office for the group practice may split the global OB package to ensure the midwife and the physician each get reimbursed at the correct rate for their portion of services.

##### Example # 1:

The patient received antepartum care with Dr. Smith. Dr. Jones, who is in the same practice as Dr. Smith, provides the delivery. Dr. Smith does the postpartum care. In this case, the billing office must code and bill the entire package under the patient's primary physician using a global maternity package code. Provide an in-office relative value unit (RVU) or payment allocation of reimbursement to the delivering physician. <sup>10</sup>

We will reimburse:

- One provider for delivery.
- One provider for post-partum care
- One assistant surgeon for a cesarean delivery, if documented.

It may be appropriate to reimburse more than one provider for antepartum care when the patient transfers care during the antepartum period. (See [Transfer of Antepartum Care](#) for more information.)

#### **E. Services Included in the Global OB/Maternity Package**

Maternity care and the global OB package have three distinct stages: antepartum care, delivery, and postpartum care. The global OB package includes a large number of services which are considered bundled into the global OB code or the antepartum care, delivery, and postpartum care codes and are not eligible to be reported separately. The bundled services are summarized below.

## 1. Stage I: Antepartum care

Antepartum care begins with conception and ends with delivery. Antepartum care includes the following services which may not be billed separately:

- Initial history and physical, subsequent physical exams, and routine urinalysis.  
**Note:** Please report the initial prenatal visit with CPT code 0500F (Initial prenatal care visit) with a date of service of the initial prenatal visit as a no-charge line item. (See [Initial Prenatal Visit](#) for more information.)
- Monthly visits up to 28 weeks of gestation.
- Biweekly visits to 36 weeks gestation.
- Weekly visits from 36 weeks until delivery.
- Note: these antepartum care visits may be office visits or home visits (e.g., midwife visits in home).
- At each of these visits, the recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis (code 81000 or 81002) are included as part of the global obstetrical package. Therefore, these services are not reported separately.
- Pap smear at first prenatal visit. *Note:* This applies only to the Pap smear procedure. The laboratory processing is separately identifiable and payable.
- Education on breast feeding, lactation and pregnancy (HCPCS level II codes S9436–S9438, S9442–S9443)
- Exercise consultation or nutrition counseling during pregnancy (HCPCS level II codes S9449–S9452, S9470)

The initial visit to establish pregnancy is allowable under the member's medical benefit. Once the pregnancy has been confirmed, the global maternity period begins.

Note: See [High-Risk Pregnancy and/or Complications of Pregnancy](#) for more information.

## 2. Stage II: Intrapartum Care or Delivery

Delivery begins when the fetus enters the birth canal, and ends when the mother leaves the delivery room/operating room. Delivery care (and reimbursement for delivery procedure codes) includes the following services which may not be billed separately:

- Admission to hospital.
- Admission history and physical exam.
- Management of labor including fetal monitoring.  
**Note:** See [Labor Care by Midwife When Care Transferred to MD for Delivery](#) for details and requirements for this circumstance.
- Placement of internal fetal and/or uterine monitors.
- Catheterization or catheter insertion.
- Preparation of the perineum with antiseptic solution.
- Delivery, any method:
  - Vaginal delivery with or without forceps or vacuum extraction.
  - Cesarean delivery.
    - The decision for surgery to do a cesarean delivery is included in the Intrapartum Care and Delivery; it is not eligible to be separately reported.
    - Use of modifier 57 will not bypass an edit denying an E/M code as included in the maternity global.
- Delivery of the placenta, any method (59414, *Delivery of placenta (separate procedure)*), may not be separately coded in addition to the code for the delivery service).<sup>1,3</sup>
- Injection of local anesthesia.
- Induction of labor with pitocin or oxytocin. This is considered an inherent part of the delivery service(s) provided. There is no separate procedure code assignment for this service.<sup>1,6</sup>

- Artificial rupture of membranes (AROM) before delivery. This is an inclusive component of the delivery code reported. Therefore, it would not be appropriate to report a separate code for this service. <sup>1,9</sup>
- **Note:** If a C-section is performed by a separate provider not providing the antepartum and postpartum care, the reimbursement for the cesarean delivery-only procedure code includes payment for the post-surgical (postpartum) care while in the hospital. If the surgeon will be providing post-surgical care after discharge, then cesarean delivery including postpartum care must be reported instead.
- Exploration of uterus.
- Episiotomy and repair.
- Repair of any delivery lacerations, regardless of degree and severity, in the absence of or in addition to an episiotomy.
- Repair of cervical, vaginal or perineal lacerations. <sup>1,4,5</sup>
- Placement of a hemostatic pack or agent during or at the completion of the delivery.
- Any other management of complications while the patient is in the delivery room. The work associated with returning a patient to the appropriate post-procedure state is included in standards of medical and surgical care expected to complete the surgical procedure. <sup>B, 39, 40, 41</sup>

### 3. Stage III: Postpartum Care

Postpartum care begins after the delivery is complete (following the conclusion of the surgical session or birth event). Postpartum care includes the following services which may not be billed separately:

- Recovery room visit.
- Hospital visits.
- Placement of a hemostatic pack or agent during or at the completion of the delivery, if it does not require a return to an operating room. <sup>42</sup>
- Office visits or home visits (e.g., midwife care) during the Maternity Global Period.
- Treatment and care of any incisional problems or infections (episiotomy, cesarean).
- Education and assistance with lactation, breast and nipple care, and breast feeding.
- Treatment and care of nipple problems and/or infection during the Maternity Global Period.

#### F. **Criteria for Splitting the Global OB Package**

1. Maternity care and delivery must be billed as a single code except when certain circumstances occur which require the package to be broken into components. Circumstances which require splitting the global OB package include the following:
  - a. The patient has a change of insurer during her pregnancy.
  - b. The patient has received part of her antenatal care somewhere else, e.g., from another group practice.

**Note:** If the patient changes from one provider to another within the same group practice, and someone from that same group practice also provides the delivery services, then the global OB package may not be split.
  - c. The patient leaves her care with your group practice before the global OB care is complete.
  - d. The patient misses all postpartum visit appointments (“no show”).
  - e. The patient must be referred to a provider from another group practice or a different licensure (e.g., midwife to MD) for a cesarean delivery.
  - f. The patient has an unattended, precipitous delivery.
  - g. Termination of pregnancy without delivery (e.g., miscarriage, ectopic pregnancy).

Additional information about billing in these circumstances is provided below under [“Billing a Split OB Package.”](#)
2. It is the provider’s responsibility to obtain information from the patient if the patient has received antepartum care elsewhere or is concurrently seeing another provider for antepartum care. A single visit for evaluation to confirm a pregnancy is not considered prior antepartum care.

- If the patient starts antepartum care late in the pregnancy, but your clinic is the only source of antepartum care and at least five antepartum visits have occurred before delivery, then the global maternity codes must be used.

### G. Billing a Split OB Package

- Component Coding for Split OB Package.

CPT codes for antepartum care only, delivery only, delivery including postpartum care, and postpartum care only are provided for use when criteria is met for splitting the global OB package. Report the services performed using the most accurate, most comprehensive procedure code available. No code exists for delivery including antepartum care without postpartum care.

OB Package Component	Coding Instructions
Antepartum care only, 1 to 3 visits	Use the appropriate Evaluation and Management (E/M) codes. Select level based upon the history, examination, and medical decision making documented in the record for that visit.
Antepartum care only, 4 to 6 visits	Use CPT code 59425. Units = 1.
Antepartum care only, 7 or more visits	Use CPT code 59426. Units = 1.
Postpartum care only	Use CPT code 59430. Units = 1.
Delivery only	See CPT book. Code selection based on type of delivery.
Delivery, including postpartum care	See CPT book. Code selection based on type of delivery.

- Change of insurance during pregnancy.

When a patient changes insurance during her antepartum care but stays with the same group practice for her care, the visits performed during her eligibility with carrier A will be billed to carrier A, and the visits performed during her eligibility with carrier B will be billed to carrier B, along with the delivery and postpartum care if performed by the clinic/group. All services to carrier B will be billed with the delivery date as the date of service.

#### Example # 2:

The patient presents to your clinic for obstetrical care in the 8<sup>th</sup> week of her pregnancy. She is seen monthly, and in her 21<sup>st</sup> week she has a change of insurer. She continues to be seen monthly for the remainder of her first 28 weeks, then biweekly to 36 weeks, and then weekly until her delivery at 39 weeks for a total of 13 visits. The clinic performs the vaginal delivery and provides the postpartum care.

The billing office bills the first four visits to carrier A with CPT code 59425 using the date of the first visit as the From date and the date of their last visit before the change in insurance as the To date. The additional 9 visits are billed to carrier B with CPT code 59426. This claim also bills the delivery and postpartum care with CPT code 59410. The delivery date must be used as the date of service for all services on both claims.

#### Example # 3:

The patient presents to your clinic for obstetrical care in the 8<sup>th</sup> week of her pregnancy. She is seen monthly for the first 28 weeks, then biweekly to 36 weeks, and then weekly until her delivery before her 40-week visit for a total of 13 visits. She has a change of insurer between her 36-week and 37-week visits. The clinic performs a cesarean section delivery and provides the postpartum care.

The billing office bills the first ten visits to carrier A with CPT code 59426 using the date of the first visit as the From date and the date of their last visit before the change in insurance as the To date.

The final three visits (weeks are billed to carrier B with individual E/M codes using the date of each visit as the date of service for those line items. This claim also bills the cesarean delivery plus postpartum care with CPT code 59515 using the delivery date for the date of service.

### 3. Transfer of Antepartum Care.

Patients change OB provider groups during antenatal care for a variety of reasons, which may include relocating to another city, personal preference, or developing high-risk conditions requiring a specialized OB provider for the remainder of their antenatal care.

When a patient changes clinics during her antepartum care, each clinic bills the insurer for the services performed.

- a. First OB practice group (before the patient transferred care to another clinic).
  - i. When fewer than four antepartum care visits have been performed, the visits are billed using evaluation and management (E/M) visit procedure codes. Each visit is billed with a separate E/M code and the date of service the visit occurred, and the E/M level is selected based upon the history, examination, and medical decision making documented in the record for that visit.
  - ii. If four or more visits have been performed, the appropriate antepartum care only code is reported (4 to 6 visits, use CPT code 59425) (7 or more visits, use CPT code 59426). The date of service is reported as a range, with the date of the first visit in the From date field and the date of the last visit in the To date field.
- b. Second OB practice group (patient transfers care to this clinic and delivery is performed).

The clinic who completed the antepartum care and delivery reports an antepartum care only code or individual E/M visits based on the number of antepartum visits performed and bills the appropriate delivery including postpartum care code based on the type of delivery.

#### Example # 4:

The patient presents to Dr. Anderson's clinic for obstetrical care in the 8<sup>th</sup> week of her pregnancy. She is seen monthly, and in her 21<sup>st</sup> week she moves to another city and establishes care with Dr. Baker. Dr. Anderson's office sends copies of her records to Dr. Baker's office. Dr. Baker sees her monthly for the remainder of her first 28 weeks, then biweekly to 36 weeks, and then weekly until her delivery at 39 weeks for a total of 13 visits. Dr. Baker performs the vaginal delivery and provides the postpartum care.

Dr. Anderson's billing office bills the first four visits to the insurer with CPT code 59425 using the date of the first visit as the From date and the date of her fourth visit as the To date.

Dr. Baker's billing office performed 9 visits after the transfer of care and bills for these services with CPT code 59426. This claim also bills the delivery and postpartum care with CPT code 59410 on the same claim. The delivery date is used as the date of service for all these line items.

### 4. Delivery by Another Group Practice

A variety of circumstances may result in one physician group practice providing antepartum care and another physician from an unrelated group practice performs the delivery. Again, each group practice bills for the services performed.

#### Example # 5:

The patient has received antepartum care with Dr. Smith but delivers unexpectedly while visiting family out of town. Dr. Davison, who is unaffiliated with Dr. Smith's office, provides the delivery care. The patient returns home to receive her postpartum care from Dr. Smith.

Dr. Smith's billing office bills for the antepartum and postpartum services provided by Dr. Smith. Dr. Davison's office bills for a delivery only. The specific code will be based on the type of delivery.<sup>10</sup>

#### 5. Precipitous Delivery

If the patient delivers vaginally prior to admission or prior to the physician/midwife's arrival, the delivery charge cannot be billed. The delivery or global maternity service also may not be reported with modifier 52.<sup>F</sup> If the provider arrives in time to deliver the placenta, CPT code 59414 (*Delivery of placenta, separate procedure*) may be reported.<sup>2</sup> The antepartum care only, and postpartum care only procedure codes may also be reported as appropriate.

Thus, if the patient has a precipitous delivery but all the patient's routine obstetric care was provided, the services must be reported with the antepartum care code, the postpartum care code, and the delivery of placenta service code (if performed).

#### 6. Miscarriage or Other Termination of Pregnancy

Sometimes the patient is receiving antepartum care and the unexpected happens (e.g., the patient miscarries or has an ectopic pregnancy which ruptures). In these cases, the billing office must carefully review the record and bill only for the number of antepartum visits performed (1 – 3 use E/M codes; 4 – 6 use 59425; 7 or more use 59426) and any other separately eligible antepartum services the patient received. Any surgical care which is needed is also eligible to be separately reported. The surgical global period for that service applies.

#### 7. Transfer from Midwife to MD within same group practice.

- a. A midwife may provide antepartum care and manage early labor and then the patient may need to be transferred to the care of a physician for further care and delivery, whether vaginal or cesarean. In these situations, the maternity global may be split.
  - i. The midwife reports the antepartum care, and postpartum care if performed.
  - ii. The physician reports the delivery services, and postpartum care if performed.
  - iii. Payment to the midwife for the pre-delivery management of labor is handled via the clinic's internal accounting process (e.g., similar to call-share coverage payments).
- b. If the patient transfers from a midwife to a physician or from one physician to another physician within the same group practice during the antepartum care, and someone from that same group practice also provides the delivery services, then the global OB package may not be split.
  - i. The physician who is considered the primary provider at the time of delivery bills for the global OB services.
  - ii. The early portion of the antepartum care is not separately reported by the midwife or the first physician but is handled via the clinic's internal accounting process (e.g., similar to call-share coverage payments).

#### 8. Patient misses all postpartum visit appointments (“no show”).

When the patient is scheduled for postpartum visits but does not keep any of the postpartum visit appointments during the Maternity Global Period, then a global maternity procedure code may not be billed because the postpartum care for the global OB period was not completed. In this situation, only the portion(s) of the maternity care performed may be billed.

- Report the appropriate antepartum care code (59425, 59426) if performed.
- Report the appropriate delivery only procedure code (59409, 59514).

#### 9. For other scenarios, refer to the CPT manual for the correct coding.

### H. High-Risk Pregnancy and/or Complications of Pregnancy

1. CPT guidelines for maternity care and delivery specify that normal antepartum care includes monthly visits up to 28-weeks gestation, biweekly visits to 36-weeks gestation and weekly visits until delivery.
2. For the patient at risk who is seen more frequently or for other medical/surgical intervention, the visits included in the schedule above are included in the global OB package.

3. The *additional* necessary antepartum visits *only* may be reported separately.
  - a. See examples below.
  - b. Select a code representing the appropriate level of Evaluation and Management service.
  - c. A diagnosis code stating “pre-eclampsia” or “complicating pregnancy” from the Pregnancy, Childbirth, and the Puerperium chapter (O00 – O9A) needs to be reported as the first-listed diagnosis code on the claim to indicate the reason for the additional antepartum visit.
  - d. The documentation must reflect the necessity of these visits as well as any additional laboratory or radiologic tests performed.

4. Examples:

Example # 6:

Patient is seen at 12 weeks gestation and would not routinely be seen again until 16 weeks. Another visit is performed at 14 weeks gestation, due to High-Risk needs.

- The visit at 12 weeks is the first visit of the month and is included in the routine visit schedule. Reimbursement for the 12-week visit is included in the global OB package; do not separately report.
- The 14-week visit is not on the routine schedule, is the second visit of the month, and is eligible to be reported separately.

Example # 7:

Patient is seen at 28 weeks gestation and would not routinely be seen again until 30 weeks. Another visit is performed at 29 weeks gestation, due to high-risk needs.

- The visit at 28 weeks is the first visit of the month and is included in the routine visit schedule. Reimbursement for the 28-week visit is included in the global OB package; do not separately report.
- The 29-week visit is not on the routine schedule and is eligible to be reported separately.

Example # 8:

Patient is seen twice a week from 37 weeks gestation onward, due to high-risk needs. The routine OB package only includes weekly visits at this stage of pregnancy.

- The first visit each week is included in the routine visit schedule. Reimbursement is included in the global OB package; do not separately report.
- The second visit each week is not on the routine schedule and is eligible to be reported separately.

5. Surgical care during the antepartum period may be coded and reimbursed separately. This could include incompetent cervix, hernia repair, appendicitis, etcetera.
6. Delivery of High-Risk Pregnancy  
When a patient who is considered high-risk during her pregnancy has an uncomplicated delivery with no special monitoring or other activities, the delivery is to be coded as usual. Use of modifier 22 is not supported for an uncomplicated delivery such as this. For further details, see [Modifier 22 – Increased Procedural Services](#).<sup>B</sup> With regard to "high-risk" pregnancy, there are no codes to indicate the level of "risk." CPT designates procedure codes; therefore, only services provided, not potential risks, are coded.<sup>7</sup>
7. Postpartum Care After A High-Risk Pregnancy or with Complications
  - a. Separate reimbursement is not allowed for additional visits by OB or Hospitalist providers on the date of delivery or days following. These are included in the RVU calculations of the postpartum care, just as for the global surgery package postoperative care.
    - i. All postpartum visits, regardless of the amount or frequency, are included in the global OB package payment.

- ii. Postpartum visits due to complications during the postpartum period may not be separately reported or reimbursed. Use of modifier 24 is not supported or appropriate; postpartum complications are related to the pregnancy and delivery condition.
- b. When a complication requires the mother to return to the operating room following delivery for a post-delivery surgical procedure, the surgical procedure code is reported with modifier 78, and the OB provider may be separately reimbursed for this complication surgical procedure at the 70% rate for modifier 78.<sup>h</sup>
- c. Reimbursement is allowed for hospital or office visits by non-OB specialist providers (e.g., cardiology, endocrinology, pulmonology, nephrology) providing treatment for complications. These specialists did not provide the routine antepartum care and/or delivery, and so their postpartum care for complicating conditions is not included in the reimbursement for the global OB care package.

#### I. Services Not Bundled in the Global OB Package

Some procedures are not bundled with the global maternity package and may be reported at the time of service. Physicians may perform these procedures during routine antepartum or postpartum OB visits or schedule them as separately identifiable visits. However, do not bill a separate E/M visit performed on the same day as a planned procedure. Common separately eligible ancillary procedures and services include the following:<sup>10</sup>

- Obstetric ultrasound
- Cerclage
- Insertion of a cervical dilator
- Echocardiography
- External cephalic version done in the clinic
- Fetal biophysical profile
- Administration of Rh immune globulin
- Amniocentesis
- Fetal nonstress test (NST)
- Routine OB/maternity laboratory services such as HIV testing, Blood glucose testing, sexually transmitted disease screening, and antibody screening such as for Rubella or Hepatitis
- Blood typing and Rh factors
- Thyroid testing
- Fetal scalp blood sampling.
- External cephalic version.
- Antepartum: Surgical care during the antepartum period may be coded and reimbursed separately. This could include treatment of an incompetent cervix, hernia repair, appendicitis, etcetera.
- Administration of regional anesthesia (e.g., epidural).
- Tubal ligation performed at the same operative session as cesarean delivery, or later during the postpartum period.
- Management of inpatient or outpatient problems complicating pregnancy (e.g., diabetes, hypertension, toxemia, premature rupture of membranes, etc.).
- Complications of pregnancy or delivery which require a return to the operating room after the delivery event is completed. Report with modifier 78.<sup>11</sup>

Reminder: [Treatment of complications during the delivery](#) may not be coded separately.

#### J. Midwife Care

##### 1. Eligible providers

##### a. Commercial plans:

Our Standard Commercial Plans consider midwives to be eligible providers when they are who are licensed and certified in the state where they practice, including, but not limited to:

- i. Certified Nurse Midwife (CNM)
  - ii. Nurse Practitioner Midwife (NPM, NMNP)
  - iii. Certified Professional Midwife (CPM)
  - iv. Certified Midwife (CM)
  - v. Licensed Direct-Entry Midwife (LDM, LDEM)
- b. Medicare Advantage covered midwives:<sup>26</sup>
- i. Certified Nurse Midwife (CNM)
  - ii. Nurse Practitioner Midwife (NPM, NMNP)
- c. Medicaid covered midwives:<sup>27</sup>
- i. Certified Nurse Midwife (CNM)
  - ii. Nurse Practitioner Midwife (NPM, NMNP)
  - iii. Licensed Direct-Entry Midwife (LDM, LDEM)

Note: For questions about out-of-hospital/community births, verify benefits with the Medicaid Customer Service team.<sup>27</sup>

- d. Medicaid also covers doula services.<sup>31, 32, 33, 35</sup>

## 2. Providers which are not eligible

Other types of non-licensed, non-certified midwives and/or birth support providers are not considered eligible providers, including, but not limited to:

- a. Practical midwife.
- b. Lay midwife.
- c. Trained birth attendant.
- d. Doulas are not eligible for standard Commercial plans or Medicare Advantage plans.<sup>34</sup> Some self-funded or specific employer groups may offer coverage for doula services; verify benefits online using [Medical Benefit Tracker](#) or by contacting Customer Service.

## 3. Provider Taxonomy and Specialty for Midwives

All providers who provide Maternity and obstetrics care are considered to be in the same specialty for billing and coding purposes, regardless of the level of licensure of the various providers involved.

- a. Midwives are in the exact same specialty as an MD who is also providing antepartum, labor and delivery, and postpartum care.
- b. Taxonomy codes 207V00000X – Obstetrics and Gynecology (for an MD/DO) and 367A00000X – Advanced Practice Midwife are both considered to be the exact same specialty. The difference in taxonomy codes is created by a different licensure level between a midwife and a physician, not a different specialty.
- c. For example, per CPT coding guidelines, when a patient is seen in the office and subsequently admitted to the hospital, all the office evaluation is included in the initial hospital visit E/M code and may not be billed separately. If the midwife saw the patient at home or in the office and determined a hospital admit to an MD care in the same Obstetric clinic was needed, the physician's E/M service includes the midwife's E/M services in the pre-hospital setting; these are two practitioners of the same clinic and same specialty, and do not qualify for billing separate visit codes.

## 4. Labor Care by Midwife When Care Transferred to MD for Delivery

A patient may be laboring with a midwife in attendance providing labor care and then need to be transferred to the care of a physician for further care and delivery, whether vaginal or cesarean. Management of labor including fetal monitoring is considered part of intrapartum care and delivery ([see Stage II: Intrapartum Care or Delivery](#)). No CPT code exists to report management of partial labor prior to transfer of care to the physician.

- a. The midwife reports the antepartum care.
- b. The physician reports the delivery services.
- c. Whomever performs the postpartum care (midwife or MD) reports the postpartum care code.

- d. For the midwife's pre-delivery management of labor:
  - i. If the midwife and physician are in the same group practice, payment to the midwife for the pre-delivery management of labor is handled via the clinic's internal accounting process (e.g., similar to call-share coverage payments).
  - ii. If the midwife and physician are in different group practices (different clinic name, different tax ID numbers), the midwife's pre-delivery management of labor is considered included in the antepartum care and is not eligible to be separately reported.

#### 5. Home Visits

Home visits for antepartum care or for postpartum care are billed in the same way as office visits for antepartum and postpartum care. These home visits are included in the global service codes or the antepartum and postpartum service codes. Home visits are only eligible to be separately reported when they exceed the frequency specified by the CPT guidelines for services included in the global OB/Maternity Package.

#### 6. Home Births

Eligible professional fees by the Certified Nurse Midwife or Nurse Practitioner Midwife are eligible for coverage. Other home birth expenses are not eligible for reimbursement and are generally excluded by the member's contract. This includes but is not limited to: travel, portable hot tubs, supplies, and transportation of equipment, etc.

### K. Multiple Gestation Guidelines (Twins, Triplets, etc.)

#### 1. Obstetrical Ultrasounds

Obstetrical ultrasound code descriptions (76801 – 76828) specify "single or first gestation," "each additional gestation," "per fetus," "fetal," etc. In some cases, the CPT book also includes parenthetical guidelines instructing how to bill the service for the second fetus. These guidelines must be followed when submitting claims for multiple gestations.

Procedure codes which specify "single or first gestation" may not be billed with two units to report procedures for twins. These procedure codes allow a maximum of one (1) unit per date of service. Additional billed units will be denied. The exam for the second fetus must be reported with the "each additional gestation" procedure code.

#### Example # 9:

76801 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation)

76802 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure))

Patient is seen for initial ultrasound including determination of the number of gestational sacs and fetuses and to take gestational/fetal measurements.

- For first gestation/fetus, bill 76801 x 1 unit.
- For twins (one additional gestation/fetus), bill with 76802 x 1.
- For quadruplets (three additional gestations/fetuses), bill with 76802 x 3.

#### Example #10

76815 (Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses)

A mother pregnant with twins is seen for a limited ultrasound to determine placental location, fetal position and/or qualitative amniotic fluid volume.

- The code description for a limited scan is performed (76815), is “1 or more fetuses.”
- Report 76815 x 1 unit to cover scans of both twins.
- 76816 and indicate number of fetus’ in units (76815 x2 for twins)

#### Example #11

76816 (Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus)

A mother pregnant with twins is seen for a follow-up ultrasound for a re-evaluation to check the growth of both twins.

- The code description for a follow-up scan is performed (76816), is “per fetus.”
- Report 76816 x 2 units to cover scans of both twins.

#### Example #12

76818 (Fetal biophysical profile; with non-stress testing)

76819 (Fetal biophysical profile; without non-stress testing)

A mother pregnant with twins is seen for a fetal biophysical profile of both twins.

- The unit of service is per fetus profiled.
- Fetal biophysical profile assessments for the second and any additional fetuses, may be reported separately by code 76818 or 76819 with modifier -59 or -XS appended.<sup>12</sup>
- For twins with non-stress testing, report 76818 x 1 and 76818-XS x 1.

## 2. Delivery of Multiple Gestations

- a. Global billing for multiple gestations must include one global procedure code and a “delivery only” code for each subsequent delivery. The specific codes submitted will depend on the method of delivery and number of infants delivered.
- b. When submitting claims for deliveries of more than one newborn, we require that all delivery charges, any global services, and any additional surgical services from the date of delivery (e.g., 58611 *tubal at time of cesarean delivery*) be submitted on the same claim and use the same date of delivery (due to multiple procedure reduction rules).
- c. [For billing purposes, use the date of birth of the first infant as the date of service](#) for all procedure codes associated with the delivery, even if the delivery of multiple infants spans midnight.<sup>43, 44, 45</sup>
- d. The appropriate diagnosis code for the multiple gestations must be reported.
- e. Multiple surgery fee reductions apply to multiple delivery services for multiple gestations.
  - i. The code submitted for the secondary delivery(ies) must include a modifier 51 and a modifier 59 to indicate a separate newborn.
  - ii. In most cases the delivery of the first newborn is considered primary and allowed at 100% and the delivery of all subsequent newborns are considered secondary and reimbursed at 50% of the contracted allowable. An exception to this rule occurs if one or more newborns are delivered vaginally and then a cesarean delivery is needed for the remaining newborn(s); in this case the cesarean delivery is more comprehensive and becomes the primary delivery procedure (100%) and the vaginal delivery(ies) are secondary and allowed at 50%.<sup>28</sup>
- f. The table below provides a summary of billing examples for multiple gestations, depending upon whether the deliveries are performed vaginally, via cesarean, or a combination of both.
  - i. Reminder: [Use the date of birth of the first infant as the date of service for all procedure codes](#) associated with the delivery.
  - ii. This summary addresses only scenarios where a global OB procedure code is appropriate:

Delivery Method	First Newborn	Subsequent Newborn(s)	Coding / Reimbursement
Vaginal	59400	59409-51-59	Deliveries of the subsequent newborns are reimbursed at 50% for multiple procedure reductions.
Vaginal Birth After Cesarean (VBAC)	59610	59612-51-59	Deliveries of the subsequent newborns are reimbursed at 50% for multiple procedure reductions.
Vaginal delivery(ies) followed by Cesarean delivery(ies)	59409-51-59 (vaginal – processed as secondary) or 59614-51-59 (VBAC – processed as secondary)	59510 (if this is the first cesarean) or 59622 (if there was a previous cesarean delivery)	If two or more newborns are delivered vaginally and subsequent newborn(s) are delivered by Cesarean, use the appropriate cesarean global OB code and the appropriate vaginal delivery-only code. <sup>28</sup>  Deliveries of the secondary newborns are reimbursed at 50% for multiple procedure reductions.  If more than one baby is delivered by cesarean after a baby delivered vaginally, only one unit of cesarean delivery may be reported.
Cesarean delivery (all babies) Elective or after failed vaginal delivery (not VBAC attempt)	59510	No separate code. 59510 includes delivery of all gestations delivered by cesarean.  If significant extra difficulty, append modifier -22 and submit explanation and op report with claim.	“If both twins are delivered via cesarean delivery, then report code 59510, Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, since only one cesarean delivery is performed. If the cesarean delivery is significantly more difficult, then append modifier '-22' to code 59510. When reporting modifier '-22' with 59510, a copy of the operative report should be submitted to the third-party payer with the claim.” <sup>1</sup>

Delivery Method	First Newborn	Subsequent Newborn(s)	Coding / Reimbursement
Attempted VBAC unsuccessful, cesarean delivery of all babies	59618	No separate code. 59518 includes delivery of all gestations.  If significant extra difficulty, append modifier -22 and submit explanation and op report with claim.	The same principle as for 59510 applies. <sup>1</sup>  If both twins are delivered via cesarean delivery after an unsuccessful VBAC, then report code 59518 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery), since only one cesarean delivery is performed. If the cesarean delivery is significantly more difficult, then append modifier '-22' to code 59518. When reporting modifier '-22' with 59518, a copy of the operative report should be submitted to the third-party payer with the claim.

**L. Assistant Surgeon Charges (Single or Multiple Births)**

Assistant surgeon charges are eligible for cesarean delivery-only codes. Assistant surgeon charges are denied for cesarean delivery global service codes or delivery including postpartum care, because the assistant surgeon service is limited to the surgery only and does not extend to the antepartum or postpartum care.<sup>c</sup> A maximum of one assistant surgeon is eligible for reimbursement.

When billing assistant surgeon charges, please use the appropriate modifier(s) for each delivery. Assistant surgeon reimbursement will be a percentage of the primary physician's contracted rate, subject to the member's contract benefits.

Vaginal and VBAC deliveries are not eligible for assistant surgeon; these procedure codes are assigned an assistant surgeon indicator of "0" on the Medicare Physician Fee Schedule Database (MPFSDB). Claims for assistant surgeon services for vaginal deliveries will be considered on appeal only. Submit the written appeal to the attention of Provider Appeals in accordance with the provider appeals process. Phone requests for adjustment will not be considered.

**M. Anesthesia for unplanned cesarean delivery or hysterectomy (01967 / 01968, 01969)**

When neuraxial analgesia/anesthesia (e.g., spinal, epidural) is provided for a planned vaginal delivery which ultimately results in a cesarean delivery or an emergency cesarean hysterectomy, two anesthesia procedure codes must be reported. 01967 is the primary/"parent" code, and 01968 or 01969 are the related add-on codes.

Add-on codes normally are required to be billed by the same provider and on the same date of service as the principle/primary procedure code. However, special considerations apply to unplanned cesarean deliveries. Therefore, we will allow 01968 and 01969 even when 01967 has been billed for the preceding date of service or by a different provider or provider group.

Rationale:

When the neuraxial labor analgesia/anesthesia is initiated prior to midnight, and the cesarean delivery or cesarean hysterectomy is performed after midnight, the total anesthesia service is provided as a continuous service, but the two portions occur on different, sequential dates. Thus, the primary/"parent" code 01967 may legitimately be billed for a different date of service immediately preceding the date for the add-on code(s).

When a cesarean delivery is performed after a lengthy vaginal labor, the vaginal neuraxial analgesia/anesthesia (01967) and the cesarean anesthesia (01968, 01969) may be performed and billed by two separate anesthesia providers.

## **N. Nitrous Oxide for Pain Management During Labor**

1. The use of nitrous oxide inhaled gas for pain management during labor is separately reimbursable when:
  - a. Performed by a physician anesthesiologist or certified registered nurse anesthetist (CRNA).
  - b. Submitted with CPT code 01999 (Unlisted anesthesia procedure).<sup>23</sup>
  - c. Appropriate medical records documentation of the anesthetic procedure and services performed must be available for review upon request.
2. Nitrous oxide during labor is not eligible for reimbursement and will be denied to provider responsibility when any of the following occur:
  - a. Submitted with CPT codes:
    - i. 01960 (Anesthesia for vaginal delivery only).
    - ii. 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor).
    - iii. 99151-99157 (Moderate conscious sedation codes).
  - b. Performed by:
    - i. Naturopathic physicians (NDs).
    - ii. Registered nurses (RNs who are not CRNAs).
    - iii. Other provider types outside of anesthesiologist or CRNA.
3. The above decisions have been made with the input of a same specialty medical physician consult review.  
14, 15, 16, 17, 18, 19, 20, 21, 22

## **O. Birthing Centers**

1. For Medicare Advantage, birthing centers are not an eligible provider.<sup>29</sup> Facility claims from a birthing center will be denied as not an eligible provider. Claims for a nurse midwife's professional services are eligible for coverage, even if performed at a birthing center (POS 25).<sup>30</sup>
2. Birthing centers are expected to bill a global packaged service, not hourly or per diem charges. The coding described below includes immediate postpartum care for both the mother and the baby.

Note, Medicare documentation and guidelines do not address birthing center coding and billing. therefore, we reference Medicaid guidelines as our source for birthing center billing and coding.<sup>13, 24</sup>

- a. Single gestations – Report procedure code 59409 only once for a single vaginal delivery, regardless of the total days that the client was in the facility for labor management, delivery and immediate postpartum care.
- b. For delivery of twins or multiple gestations –
  - i. Oregon & Alaska plans:
    - 1) Report procedure code 59409 for the delivery of the first twin.
    - 2) On a separate line item, report procedure code 59409 with a modifier indicating a separate and distinct procedure (e.g. -XS, -59) for the delivery of the second twin.
    - 3) No additional codes or units may be reported, regardless of the total days that the client was in the facility for labor management, delivery, and immediate postpartum care.
  - ii. Texas plans:
    - 1) Report procedure code 59409 for the delivery of all babies. No provision is made for billing additional units for the delivery of multiple gestations in the Texas Medicaid guidelines for birthing centers.<sup>24</sup>
    - 2) No additional codes or units may be reported, regardless of the total days that the client was in the facility for labor management, delivery, and immediate postpartum care.

- c. For management of labor only –  
When labor was managed in the birthing center but delivery did not result (e.g., mother was transferred to the hospital for cesarean delivery, etc.), the birthing center is to report procedure code S4005 and attach a report documenting the circumstances.
  - d. Postpartum care. No separate charges may be submitted for postpartum care. These services are included in the facility fee for the labor and delivery.
  - e. Newborn care. No separate charges may be submitted for newborn care. These services are included in the facility fee for the labor and delivery.
3. If the facility employs the midwife, a separate claim may be submitted for the midwife’s professional services. List the midwife as the rendering provider (not the birthing facility) on the claim for professional services.

**P. Lactation Services**

- 1. Lactation counseling is a covered benefit for mothers on our plans.<sup>36</sup>
- 2. While the lactation counselor often interacts with the mother and baby together, and the baby does benefit from improved breastfeeding, the mother is the patient for lactation counseling or breast-feeding support services.<sup>37</sup>
  - a. Claims for lactation services need to be billed under the mother’s name and plan, not the baby’s coverage.
  - b. Claims for lactation services billed under the baby’s name and plan will be denied, most often for a procedure to patient age conflict.
- 3. Lactation counselors, regardless of their type of certification, are not eligible to report evaluation and management visit procedure codes for lactation counseling services. Their scope of license or certification does not include medical decision making, which must be performed as part of an E/M service, even if the code selection is based upon time spent with the patient.<sup>1</sup>
  - a. S9443 (*Lactation classes, nonphysician provider, per session*) is a specific lactation procedure code accepted on our Commercial plans. From our perspective, this code can be used even when the lactation counseling is provided one-to-one. A “class” can be given to an individual or a group.
  - b. For Medicaid members, consider 98960 (*Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient*).

**Definitions**

**Acronyms/Abbreviations**

Acronym	Definition
AMA	American Medical Association
AROM	Artificial Rupture Of Membranes
CM	Certified Midwife
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CPM	Certified Professional Midwife
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DO	Doctor of Osteopathic Medicine
E/M	Evaluation and Management (services, visit)
E&M	(Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)
E & M	

Acronym	Definition
EHR	Electronic Health Record
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HEDIS	Healthcare Effectiveness Data and Information Set
HIV	Human Immunodeficiency Virus
LDEM	Licensed Direct-Entry Midwife
LDM	Licensed Direct-Entry Midwife
MD	Medical Doctor
MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
ND	Doctor of Naturopathy (aka Naturopathic Physician)
NMNP	Nurse Midwife Nurse Practitioner (see also NPM)
NPI	National Provider Identifier
NPM	Nurse Practitioner Midwife (see also NMNP)
NST	Non-stress test, fetal
OB	Obstetric, Obstetrics, Obstetrician
OHA	Oregon Health Authority
POS	Place of Service
RHEA	Reproductive Health Equity Act (ORS 743A.067) <sup>36</sup>
RN	Registered Nurse (not advanced practice nurse license)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit
TAC	Texas Administrative Code
VBAC	Vaginal Birth After Cesarean

### Definition of Terms

Term	Definition
High-Risk Maternity	Maternity care complicated by a documented condition during the patient's pregnancy requiring direct face-to-face practitioner care beyond the usual service.
Lactation Consultant	A health professional who specializes in breastfeeding and in offering breast milk to infants. (paraphrased from <sup>38</sup> )
Lactation Counseling	Education and coaching provided to the mother on a variety of topics and skills to help her more successfully breast feed her baby and navigate a variety of possible challenges. Lactation counseling can occur during later pregnancy, shortly after birth, or even several months into breast feeding. (paraphrased from <sup>38</sup> )
Maternity Global	Services provided in uncomplicated maternity cases including antepartum care, delivery and postpartum care.
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 (45 days after vaginal delivery).
Precipitous Delivery	The patient delivers the baby vaginally prior to admission or prior to the physician/midwife's arrival.

## Procedure codes (CPT & HCPCS)

Code	Code Description
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
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

## Modifier Definitions

Modifier	Modifier Description & Definition
Modifier 22	<p><b>Increased Procedural Services:</b> When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).</p> <p><b>Note:</b> This modifier should not be appended to an E/M service.</p>
Modifier 78	<p><b>Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period:</b> It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of the operating/procedure room, it may be reported by adding the modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76).</p>

## Related Policies

- A. [“Moda Health Reimbursement Policy Overview.”](#) Moda Health Reimbursement Policy Manual, RPM001.
- B. [“Global Surgery Package for Professional Claims.”](#) Moda Health Reimbursement Policy Manual, RPM011.
- C. [“Modifier 22 – Increased Procedural Services.”](#) Moda Health Reimbursement Policy Manual, RPM007.
- D. [“Therapeutic Drug Monitoring.”](#) Moda Health Medical Necessity Criteria.
- E. [“Modifier 51 - Multiple Procedure Fee Reductions.”](#) Moda Health Reimbursement Policy Manual, RPM022.
- F. [“Add-on Codes.”](#) Moda Health Reimbursement Policy Manual, RPM025.
- G. [“Modifier 52 – Reduced Services.”](#) Moda Health Reimbursement Policy Manual, RPM003.
- H. [“Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures.”](#) Moda Health Reimbursement Policy Manual, RPM010.
- I. [“Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service,”](#) Moda Health Reimbursement Policy Manual, RPM027.
- J. [“Scope Of License For Evaluation & Management Codes,”](#) Moda Health Reimbursement Policy Manual, RPM080.

## Resources

- 1. American Medical Association. “Maternity Care – Conception to Delivery”. *CPT Assistant*. Chicago: AMA Press, August 2002, p. 1.
- 2. American Medical Association. “Maternity Care and Delivery, 59414, 59430 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, June 1996, p. 10.
- 3. American Medical Association. “Maternity Care and Delivery 1, 59400, 59414 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, June 1998, p. 10.
- 4. American Medical Association. “Maternity Care and Delivery/Surgery, 59400 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, February 2003, p. 15.
- 5. American Medical Association. “Maternity Care and Delivery, 59400 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, April 1998, p. 15.
- 6. American Medical Association. “Maternity Care and Delivery, 59400, 59409, 59514 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, February 1997, p. 11.
- 7. American Medical Association. “Maternity Care and Delivery, High Risk Pregnancy (Q&A)”. *CPT Assistant*. Chicago: AMA Press, October 1996, p. 11.
- 8. American Medical Association. “Maternity Care and Delivery, 59510, 59514 (Q&A)”. *CPT Assistant*. Chicago: AMA Press, October 1996, p. 10.
- 9. American Medical Association. “Maternity Care and Delivery (Q&A)”. *CPT Assistant*. Chicago: AMA Press, August 1996, p. 10.
- 10. Webb, Lori-Lynne, CPC, CCS-P, CCP, CHDA. “OB Services: Coding Inside and Outside of the Package.” *JustCoding News: Outpatient*. April 7, 2010: March 19, 2013.
- 11. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C, 13.
- 12. American Medical Association. “Radiology Procedures Part II”. *CPT Assistant*. Chicago: AMA Press, September 2001, p. 4.
- 13. Oregon Health Authority. “Ambulatory Surgical Center and Birthing Center Services.” *Medical-Surgical Services Administrative Rulebook, Chapter 410, Division 130*. Effective January 1, 2016. 410-130-0365, pp 40-41.
- 14. Richardson, Michael G., Brandon M. Lopez, and Curtis L. Baysinger. "Should nitrous oxide be used for laboring patients?" *Anesthesiology clinics* 35.1 (2017): 125-143.
- 15. Rooks, Judith P. "Safety and risks of nitrous oxide labor analgesia: a review." *Journal of Midwifery & Women's Health* 56.6 (2011): 557-565.
- 16. Likis, Frances E., et al. "Nitrous oxide for the management of labor pain: a systematic review." *Anesthesia & Analgesia* 118.1 (2014): 153-167.

17. Collins, Michelle R., et al. "Nitrous oxide for labor analgesia: expanding analgesic options for women in the United States." *Reviews in obstetrics and gynecology* 5.3-4 (2012): e126.
18. Fleming, Sara A., and Nancy C. Gutknecht. "Naturopathy and the primary care practice." *Primary Care: Clinics in Office Practice* 37.1 (2010): 119-136.
19. Gross, Jeffrey B., et al. "Practice guidelines for sedation and analgesia by non-anesthesiologists." *Anesthesiology* 96.4 (2002): 1004-1017.
20. Migliaccio, Laura, et al. "Initiating intrapartum nitrous oxide in an academic hospital: considerations and challenges." *Journal of midwifery & women's health* 62.3 (2017): 358-362.
21. Pinyan, Toni, et al. "A nurse-directed model for nitrous oxide use during labor." *MCN: The American Journal of Maternal/Child Nursing* 42.3 (2017): 160-165.
22. Stewart, Lucinda Steen, and Michelle Collins. "Nitrous oxide as labor analgesia: clinical implications for nurses." *Nursing for women's health* 16.5 (2012): 398-409.
23. American Medical Association. "Frequently Asked Questions." *CPT Assistant*. Chicago: AMA Press, May 2015, p. 10.
24. Texas Medicaid & Healthcare Partnership (TMHP). "Birthing Center Services, Benefits, Limitations, and Prior Authorization." *Texas Medicaid Provider Procedures Manual, Volumes 1 & 2*. Page 618. Last updated December 31, 2021; Last accessed January 28, 2022. <https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2022-01-TMPPM.pdf> ,  
<https://www.tmhp.com/resources/provider-manuals/tmppm> .
25. Texas Public Law (TPL). "Midwives." *Texas Occupational Code, Title 3, Subtitle C, Chapter 203*. Last updated June 7, 2021; Last accessed January 28, 2022. <https://texas.public.law/statutes/tex.occ.code.title.3.subtitle.c.chapter.203> .
26. CMS. "Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants." *MLN901623*. Last updated March 2022. Last accessed October 19, 2022.
27. OHA. "Planned Community Births (Out-of-Hospital Births) Prior Authorization and Billing Guide." Oregon Health Authority Health Systems Division. Last updated September 2021. Last accessed November 3, 2022. <https://www.oregon.gov/oha/HSD/OHP/Tools/Planned-Community-Birth-Guide.pdf> .
28. AMA. "Coding Consultation - Maternity Care and Delivery, 59409, 59510 (Q&A)." *CPT Assistant*. Chicago: AMA Press, July 1996, p. 11.
29. CMS. "Providers/Suppliers Not Eligible to Enroll." *Medicare Program Integrity Manual* (Pub. 100-08). Chapter 10 – Medicare Enrollment, § 10.2.8.
30. CMS. "Nurse-Midwife (CNM) Services, Place of Service." *Medicare Benefit Policy Manual* (Pub. 100-02). Chapter 15 – Covered Medical and Other Health Services, § 180.F.
31. OAR. "Doula Services." Oregon Administrative Rules OAR 410-130-0015. Last updated June 8, 2021; Last accessed April 11, 2024. [https://oregon.public.law/rules/oar\\_410-130-0015](https://oregon.public.law/rules/oar_410-130-0015) .
32. OHA. "Billing Oregon Medicaid for Doula Services." Oregon Health Authority (OHA). Last updated January 2024; Last accessed April 22, 2024. <https://www.oregon.gov/oha/HSD/OHP/Tools/Doula-Billing-Guide.pdf> .
33. OHA. "OHA March 2023 Fee Schedule." Oregon Health Authority (OHA). Last updated March, 2023; Last accessed April 11, 2024. <https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/fee-schedule0323.pdf> .
34. Moda. Internal Moda Health Regulatory Compliance determination issued April 9, 2024. Copy on file.
35. OHA. "Birth doula procedure code change effective July 1, 2024." Oregon Health Authority (OHA). Last updated March, 2023; Last accessed April 25, 2024. <https://www.oregon.gov/oha/HSD/OHP/Announcements/Doula-Codes0224.pdf> .
36. Reproductive Health Equity Act (RHEA). ORS 743A.067(2)(h) Breastfeeding comprehensive support, counseling. [https://oregon.public.law/statutes/ors\\_743A.067](https://oregon.public.law/statutes/ors_743A.067) .
37. American Academy of Pediatrics. *Pediatric Coding Q&A: Expert Advice from the AAP Coding Hotline*. American Academy of Pediatrics. January 8, 2024; Last accessed July 1, 2025. <https://publications.aap.org/aapbooks/monograph/750/chapter-abstract/13317617/Breastfeeding-and-Lactation-Counseling?redirectedFrom=fulltext?autologincheck=redirected> .

38. Cleveland Clinic. "Lactation Consultant." Last updated March 13, 2025. Last accessed July 3, 2025. <https://my.clevelandclinic.org/health/articles/22106-lactation-consultant> .
39. CMS. National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies, § C.1, paragraph 1.
40. CMS. National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies, § B. paragraph 1.
41. CMS. National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies, § C.14, (1).
42. CMS. National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies, § C.14, (2).
43. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.8.B.
44. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.9.B.
45. CMS. *Medicare Benefit Policy Manual* (Pub. 100-2). Chapter 15 – Covered Medical and Other Health Services, § 20.1.A. "All expenses for surgical and obstetrical care, including preoperative/prenatal examinations and tests and post-operative/postnatal services, are **considered incurred on the date of surgery or delivery**, as appropriate. This policy applies whether the physician bills on a package charge basis, or itemizes the bill separately for these items."

## Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: [https://www.modahealth.com/medical/policies\\_reimburse.shtml](https://www.modahealth.com/medical/policies_reimburse.shtml)

Date	Summary of Update
2/11/2026	Clarified treatment of complications during delivery, additional reimbursement for high-risk pregnancy during delivery, when Intrapartum/delivery changes to Postpartum care, defined date of delivery, date of service for multiple gestations. Acronyms & Resources updated. No policy changes.
7/14/2025	Clarification of lactation counseling services coverage under mother’s plan, scope of license, & general coding options added. Acronyms, Definition of Terms, Related Policies, & Resources updated. Minor rewording. Formatting updates. No policy changes.
8/14/2024	Updated Commercial plan coverage information for doulas/doula services. Clarified 1) reimbursement of laceration repair; 2) billing when antepartum care transfers within a group practice at some point during antepartum care; 3) diagnosis code requirements for additional antepartum visits; 4) E/M visits for treatment of postpartum complications; 5) reimbursement for surgeries during postpartum period. Updated Cross References. Formatting updates.
5/8/2024	Clarified <a href="#">birthing center management of labor only</a> coding instruction are non-optional, changed “may” to “is to.” Updated information on coverage of doulas/doula services, with footnotes. Resources updated.
6/14/2023	Clarified coding instructions for <a href="#">Delivery of Multiple Gestations</a> with various combinations of delivery methods; typos corrected. Added information re: <a href="#">birthing centers for Medicare Advantage</a> claims. Resources updated.
11/9/2022	Clarified diagnosis coding requirements for additional antepartum visits, and eligible midwife providers for various lines of business. Acronyms, Related Policies, & Resources updated.
10/12/2022	Clarified reimbursement for <a href="#">postpartum complications and postpartum care after a high-risk pregnancy</a> . Idaho added to Scope. Acronyms & Modifiers updated. Formatting updates. No policy changes.

Date	Summary of Update
4/10/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on AMA/CPT guidelines.