

## OB SERVICES – SPECIAL EDITION #2

Coding for OB services can be complicated; per the CPT® guidelines the global OB package includes “uncomplicated care” to the patient in the antepartum period, the delivery and the postpartum period.

However, there may be circumstances that create the need to “break” the global period and bill certain components of the services rendered as individual services.

### Breaking the global can include (but is not limited to):

- Late transfer into UHA – many late transfer cases do not have enough antepartum visits to qualify for global billing
  - Coding will be based on the actual services received by the patient
- Transfer out of UHA – number of visits/services rendered to patient determines how the billing is handled
  - Transfers within UHA (to different practices) will be billed out a global services because there is one Tax ID number for all of UHA and is therefore considered as one
- Change in patient’s insurance
  - Billing to the insurance is based on the effective/term dates of the insurance and requires breaking down global services accordingly
- Missed abortion
  - Billing occurs for the services actually received by the patient and is billed as the appropriate E/M level
- Delivery, including the placenta in another location (e.g. on route to hospital)
- Payer driven rules/requirements
  - Minimum antepartum visits required to bill global (primarily Medi-Cal/Medi-Cal Advantage Plans)
  - Billing must go out under the physician who delivered

Individual component codes for OB services are listed in the table below:

OB/Delivery CPT Codes	Billing Code Descriptors
59409	Vaginal delivery only
59410	Vaginal delivery only; including postpartum
59515	Cesarean delivery only; including postpartum
59614	Vaginal delivery only after previous cesarean; including postpartum
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7+ visits
99212-99215	E/M visits are used for 1-3 visits, level based on documentation
59430	Postpartum care only
59414	Delivery of placenta (separate procedure)

\* First- or second- degree repairs are included in the delivery.

\* Repair of third- or fourth-degree lacerations at the time of delivery may be reported using codes from CPT integumentary section code; (e.g., 12041-12047 or 13131-13133) based on the size and complexity of the repair.

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### Reporting Delivery of Twins

#### Twin Vaginal Delivery

To report a global vaginal delivery of twins, code 59400 (Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care. The second delivery is billed 59409 for vaginal delivery only with modifier -59 to indicate a distinct procedural service.

#### Twin Vaginal and Cesarean Delivery

If one twin is delivered vaginally and one twin is delivered by cesarean, reporting code 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care) and code 59409 (Vaginal delivery only (with or without episiotomy and/or forceps) appended with modifier **51 (Multiple procedures)** is appropriate.

#### Twin Cesarean Delivery

If cesarean delivery of twins is performed, code 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care) **ONLY** is appropriate. However, if the physician performed significant, additional work, modifier **22 (Increased procedural service)** may be appended to the delivery code to indicate that significant additional work was performed.

Modifier 22 is reported when the work of the delivery required substantially greater physician work than usual, but the documentation must support the substantial additional work and the reason for the additional work, such as:

- Increased intensity or time
- Increased technical difficulty of performing the procedure
- Severity of patient's condition
- Increased physical and mental effort required

If increased time was involved, the physician should specifically document the total time and how it compares with the typical time for the procedure. Note that insurers will manually review claims using this modifier.

### Postpartum vs. Post-Op 99024

When a patient is seen after a cesarean delivery for routine postpartum care, the appropriate code is 0503F (postpartum tracking code) as this is still part of the OB global package. Reporting a Post-op visits (99024) would not be appropriate for reporting this service.

### Assist at surgery

An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. He or she does not have primary responsibility for the surgical procedure and does not perform a distinct part of the surgery. The assistant surgeon is not required to provide an operative note. However, he/she may want to confirm that the primary surgeon has documented the information below in order to be reimbursed for his or her assistant surgeon services. CPT 59514-80 Cesarean delivery only; modifier 80 signifies the assist.

#### Resources:

<https://www.aapc.com/blog/25857-from-antepartum-to-postpartum-get-the-cpt-ob-basics/>  
<https://www.aapc.com/blog/47295-correct-common-ob-gyn-coding-mistakes/>