

## Coding and Billing Maternity Care When a Patient Changes Insurance

To bill “normal, uncomplicated” maternity care, report a single, “global” CPT® code, based on the delivery:



- 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 post-partum 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

If the physician does not perform all services as described by these global codes (for example, the patient receives irregular or late prenatal care, experiences a miscarriage or terminates a pregnancy, or changes providers during the pregnancy), you may report delivery, antepartum care, and postpartum care independently of one another, using dedicated codes. CPT® maternity care guidelines (and related CPT Assistant articles) give ample guidance to apply these maternity care codes correctly, in most situations.

But there is a common maternity care coding and billing scenario that CPT® guidelines do not address: The patient switches insurance during the pregnancy, while retaining the same physician for the entire pregnancy.

In such a case, proper billing will depend on the payer. As a general rule, each insurer will pay only for that exact portion of care for which it is responsible. To illustrate, the following guidance is taken from the Health Reimbursement Policy of Moda Health, a private insurer in Alaska, Oregon, and Washington.

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 [Antepartum care only; 4-6 visits] 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 nine visits are billed to carrier B with CPT® code 59426 [Antepartum care only; 7 or more visits]. This claim also bills the delivery and postpartum care with CPT code 59410 [Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care].

There may be exceptions to this general rule. For example, if the patient delivers late or has multiple “worried well” visits from the point she switched insurance, the requirements of insurance “B” might be met, and global billing (e.g., 59400) – not itemized billing – may be warranted. This is a gray area; therefore, your best strategy is to contact insurance “B” prior to billing.