Pregnancy: Per-Visit Billing Codes

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This section contains codes for billing obstetrical (OB) services on a per-visit basis (for providers who do not render total OB care or who render fewer than 13 antepartum visits).

Note: For assistance in completing claims for pregnancy services, refer to the Pregnancy Examples section in this manual.

Per Visit Obstetrical Codes

HCPCS/CPT® Code	Definition	Frequency Limit
Z1032 *	Initial antepartum office visit	1 in 6 months
Z1034 * [2]	Antepartum follow-up office visit	13 in 9 months
Z1038 * ‡	Postpartum visit	1 in 6 months
59409 [1] †	Vaginal delivery only	1 in 6 months
59514 [1]	Cesarean delivery only	1 in 6 months
59525 [1]	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	1 in 6 months if subtotal or once in-a-lifetime if total
59612 [1] †	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps)	1 in 6 months
59620 [1]	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	1 in 6 months

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	A surgical modifier is not required for billing
1	Refer to the CPT code book for complete procedure descriptions
2	More than 13 antepartum visits in nine months are allowed if the provider documents a second pregnancy within those nine months. The limit of 13 antepartum visits is for the total of all primary obstetrical providers.
†	Assistant surgeon services require medical justification with the claim.
‡	Refer to the *Pregnancy: Per-Visit Billing* section of the Part 2 manual for frequency limitation exceptions.