
Pregnancy: Global Billing

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This section contains information for billing delivery services on a global basis.

Pregnancy Care Billing

When billing any medically necessary service during pregnancy or the postpartum period, include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

Global Billing

The intent of global billing (CPT® codes 59400, 59510, 59610 and 59618) is to offer a convenient means of billing for providers who render total obstetrical care to a woman throughout her pregnancy. Global obstetrical (OB) billing consists of antepartum care, delivery and postpartum care, including the following:

- Hospital admission
- Patient history
- Physical examination
- Labor management
- Postpartum visit
- Vaginal or cesarean section delivery
- Vaginal or cesarean section delivery, after previous cesarean delivery
- Hospital discharge
- All applicable postoperative care

Note: Medical Services Providers – Refer to *Figure 7* in *Pregnancy Examples: CMS-1500* for a sample claim showing how to bill CPT code 59510.

Providers choosing the global method cannot separately bill per-visit antepartum (HCPCS code Z1034) or postpartum (code Z1038) office visits except for the Medi-Cal initial antepartum visit (code Z1032). Services that are not separately reimbursable on a global basis include:

- Antepartum visits (code Z1034), paid to the same provider, for dates of service either within the from-through period of the global billing or within 270 days prior to the global OB delivery date.
- Hospital visits.
- Postpartum visits (code Z1038) for routine postpartum care, paid to the same provider and within the 45-day follow-up period of the global OB delivery date.

«Assistant Surgeon Billing for Cesarean Section Delivery

When global billing is used by the primary surgeon, the assistant surgeon should bill with the appropriate per visit CPT billing code for cesarean delivery: 59514 or 59620, with modifier 80.»

Outpatient Providers: Completing the CMS-1500

OB services rendered in an inpatient setting must be billed on a *CMS-1500* claim form using the physician's provider number. Claims billed by outpatient providers for global OB services with facility type code "11" or "12" on a *UB-04* claim form will be denied.

Global Billing Requires 13 OB Visits

A provider who bills for global obstetrical care must render services during at least 13 antepartum OB visits and must document the visits in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on an attachment for reimbursement. The initial pregnancy-related office visit may not be counted as one of the 13 visits. If fewer than 13 visits are rendered, the provider must bill services on a per-visit basis.

Plan to Perform Delivery Does Not Materialize

If a provider plans to bill a global fee, but then does not perform the delivery, each antepartum visit (HCPCS code Z1034) must be billed separately. For any of these visits that exceed the six-month billing limit, providers should enter code "1" in the *EMG* field (Box 24C) and state in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim the date the patient left their care.

Hiring Substitute Doctor to Perform the Delivery

Occasionally, circumstances prevent the primary physician from performing the delivery. In these circumstances, global billing is allowed only when the primary physician who gives antepartum and postpartum care employs another doctor to perform the delivery and the delivering physician does not bill Medi-Cal for the delivery or any other maternity service.

“From-Through” Billing

Global OB claims (CPT codes 59400, 59510, 59610 and 59618) must be billed in the “from-through” billing format (called “from-to” on the CMS-1500) with modifier AG (primary surgeon). The “from” date of service is the first date the recipient was seen for this pregnancy, and the “through” or “to” date of service is the date of the delivery. Enter a quantity of “1” in the *Days or Units* field (Box 24G).

Note: Medical Services Providers – Refer to Figure 5 in *Pregnancy Examples: CMS-1500* for a sample claim showing “from-through” billing.

Verifying Eligibility

To be reimbursed for global claims, providers must verify the recipient’s eligibility for services during the month of delivery.

Billing Limit

Global claims are subject to the six-month billing limit, based on the delivery date.

Transfer of Care

Providers who accept a Medi-Cal transfer patient must bill each antepartum visit separately, regardless of the number of times the provider sees the recipient prior to delivery.

Providers who accept Medi-Cal transfer patients are not restricted in the number of visits for which they may be reimbursed (up to the Medi-Cal limit of one initial comprehensive and 13 antepartum visits for all primary obstetrical providers within nine months.)

Note: More than 13 antepartum visits in nine months are allowed if the provider documents a second pregnancy within those nine months.

Visits for Postpartum Complications

If a recipient requires additional treatment or evaluation by the primary physician during the postpartum period, other than routine postpartum care, bill with Z1038 and document the medical or mental health postpartum complication or risk factor for postpartum complication in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form or in the attachment for reimbursement.

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum woman for specialty or medically necessary care, providers should advise the specialist or other provider that the referral is for a medically necessary service and remind the specialist to include a pregnancy diagnosis code on the claim form to ensure reimbursements. «Claims should be billed with either CPT Evaluation and Management (E&M) consultation codes 99242 thru 99245 or the most appropriate billing code for the service provided.» These visits must not be billed with either procedure code Z1034 (antepartum office visit) or E&M procedure codes 99202 thru 99215 (new or established outpatient visits), or the claim may be denied.

<<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.