Pregnancy: Per Visit Billing

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This section contains information 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.

Pregnancy Care: Billing

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

Per-Visit Billing

A provider who does not render total obstetrical care during the recipient's entire pregnancy, or who renders fewer than 13 antepartum visits, must bill each visit or procedure separately. Each visit is subject to the six-month billing limit. Recipient eligibility must be verified for each month of service.

Antepartum Visits

HCPCS code Z1034 is used for billing antepartum visits and is reimbursable only when obstetrical care is billed on a per-visit basis. Reimbursement for antepartum visits is limited to 13 visits in a nine-month period for the total of all primary obstetrical providers. Providers may bill more than 13 antepartum follow-up visits in nine months if the provider documents a second pregnancy within those nine months

Delivery

Providers billing a vaginal delivery on a per-visit basis must use CPT® code 59409 (vaginal delivery only) or 59612 (vaginal delivery only, after previous cesarean delivery). Providers billing a cesarean delivery on a per-visit basis must use code 59514 (cesarean delivery only) or 59620 (cesarean delivery only, following attempted vaginal delivery, after previous cesarean delivery).

Reimbursement for these codes includes all applicable post-delivery care except the postpartum follow-up visit (HCPCS code Z1038). Claims for visits, hospital visits or consultations that are related to the delivery and that occur within the 45-day follow-up period will not be separately reimbursed. One postpartum follow-up visit (Z1038) is separately reimbursable. See additional instructions on following page.

Reimbursement for a per-visit delivery includes hospital admission, patient history, physical examination, management of labor, vaginal or cesarean section delivery, hospital discharge, and all applicable postoperative care.

Note: Medical Services Providers – Refer to *Figures 1* and *2* in the *Pregnancy Examples: CMS-1500* section of this manual for examples of claims billing deliveries on a per-visit basis.

Postpartum Visit

HCPCS code Z1038 is used for billing the postpartum visit and can be reimbursed when billed in conjunction with one of the following per-visit delivery CPT codes: 59409, 59514, 59612 or 59620. Code Z1038 may be billed either by the primary maternity care provider or by a provider who saw the patient for only the postpartum visit. Reimbursement is limited to one visit in a six-month period unless the individual has a medical or mental health postpartum complication or is at risk for a postpartum complication. Providers may bill more than one postpartum visit in six months by documenting the 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.

Note: Providers billing globally are not to use code Z1038 for routine postpartum care. Reimbursement for the postpartum visit is included in the global fee

Referrals for Specialty Care or Medically Necessary Care

When referring any pregnant or postpartum woman for specialty care or other 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 reimbursement. Claims should be billed with either CPT Evaluation and Management (E&M) consultation codes 99241 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 99417›› 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