Guide to Global Maternity Billing

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CareOregon®

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Scope and history

This guide applies to licensed providers practicing within the scope of their license for prenatal, labor and delivery, and postpartum care provided to eligible OHP members. Maternity services should be billed to CareOregon for Oregon Health Plan (OHP) members using the appropriate global billing guidelines.

CareOregon requires that maternity services are billed globally using the appropriate codes from the CPT® codes, published by the American Medical Association (AMA) and the ICD-10-CM codes. The codes selected should be properly sequenced, according to national coding guidelines, and should describe the services rendered. Additionally, the documentation in the patient's medical record should support the codes billed.

Maternity billing and coding is often challenging for providers. This guide is to clarify CareOregon's policies and requirements for appropriate billing and reimbursement of maternity services.

Provider qualifications

Providers must:

- Have a valid license to provide services in the state of Oregon
- Meet all requirements according to state and federal statutes and regulations, including but not limited to OAR 410-120-1260, and OAR 943-120-0320
- Not have any existing patient safety-related disciplinary investigation or action, pending or in process

CareOregon covers hospital birth services if a physician, or Certified Nurse Midwife (CNM) attends the birth. The services must be provided by a licensed provider, except in situations where a non-licensed or certified provider is under the direct supervision of a licensed provider.

Doulas, while not medical providers, can offer non-medical support during childbirth and are recognized by CareOregon for their role in the birthing process. Further details regarding doulas can be found in Doula services.

Planned community birth services take place outside of the hospital setting. These services are commonly rendered at the member's home or local birthing center. For reimbursement, the community birthing center must have a specific contract with CareOregon, otherwise services should be billed directly to the State of Oregon. Birthing centers that do not have a contract with CareOregon should follow the requirements detailed in the Planned Community Births (Out-of-Hospital Births) Prior Authorization and Billing Guide[1] published by the Oregon Health Authority.

Global maternity services

Global maternity services include:

- Risk assessment (at initiation of care and throughout pregnancy and delivery)
- Antepartum care (up to 13 visits), vaginal, vaginal birth after cesarean, or cesarean delivery, and postpartum care through 12 months post delivery
- Tests performed and interpreted by the provider including:
- Routine Prenatal labs
- Standardized Gestational Diabetes Mellitus (GDM) screening between 24 weeks, 0 days gestation and 28 weeks 0 days gestation. Either a 2-step or 1-step approach.
- Ultrasound-for the evaluation of placental, uterine, or fetal anomalies (ultrasounds are billed separately from the global maternity package and CareOregon does cover this ultrasound)
- Provider-administered medications and procedures listed at Codes Billable In Addition To Routine OB Care
- Labor support

CareOregon will reimburse services referred to a lab or another provider. Pass-through billing is not allowed. Medical necessity should be substantiated in the medical record.

The complete global maternity package codes list below should only be billed when the same provider:

- Completes at least 7 prenatal care visits
- Delivers the baby
- Provides post-partum care

59400: Routine obstetric care includes prenatal care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510: Routine obstetric care includes prenatal care, cesarean delivery, and postpartum care

59610: Routine obstetric care includes prenatal care, vaginal delivery after previous cesarean delivery (VBAC) (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59618: Routine obstetric care includes prenatal care, cesarean delivery following attempted VBAC delivery, and postpartum care

Antepartum care only

Bill the proper code for antepartum (prenatal) care if the provider only provided prenatal care or did not provide the Delivery services.
Antepartum care typically includes up to 13 antepartum visits. The antepartum care includes:

- History
- Physical examination
- Recording of weight, blood pressure, and fetal heart tones
- Routine chemical urinalysis
- Monthly visits up to 28 weeks gestation; biweekly visits from 29 to 36 weeks gestations; weekly visits 36 weeks gestation until delivery.

The initial visit for the confirmation of pregnancy is not included in the global package and should be reported using the most appropriate E/M service or procedure code.

Report the appropriate antepartum care only code when a physician or other qualified healthcare professional provides all, or part, of the antepartum care, but does not perform the delivery, due to termination of pregnancy, spontaneous abortion, or referral to another physician for delivery.

If less than 4 antepartum visits were performed, the appropriate evaluation and management code should be billed for visits 1-3.

Less than 4 visits: use the appropriate E/M service codes and bill each visit separately.

59425: 4-6 antepartum visits performed by the same provider group

59426: 7 or more antepartum visits performed by the same provider or provider group

Services typically included in the global maternity package (not separately billable)

- Routine prenatal visits (13 visits for an uncomplicated pregnancy)
- Routine urinalysis at prenatal visits
- Hospital admission and history & physical prior to delivery
- Management of uncomplicated labor
- Delivery of the baby and placenta
- Routine postpartum visits through 12 months post delivery

The following services are not included in the global maternity package.
These services should be billed separately and must meet medical necessity criteria to be eligible for coverage:

- Additional visits or procedures due to complications of the pregnancy
  **Provider discretion determines what qualifies as a complication. Medical necessity must be clearly documented in the medical record.*
- Evaluation and management for problems unrelated to pregnancy.
- Lab tests that are performed outside of routine chemical urinalysis and chemical blood analysis
- Venipuncture for covered lab tests performed outside of routine chemical analysis
- Complications or other problems related to pregnancy, including surgical complications
- Amniocentesis
- Chorionic villous sampling
- Cordocentesis
- Fetal stress testing
- Fetal non-stress testing
- OB ultrasounds, limited or complete
- Fetal biophysical profile
- Fetal electrocardiography
- RH immune globulin administration
- Repositioning of the baby prior to delivery

Common codes billable in addition to the global maternity package

Delivery only

Delivery-only codes may be used to report the delivery when the delivering provider did not provide other portions of the global maternity package. When there is a single gestation. In the case of multiple gestation pregnancy see section on multiples: Delivery is to be used for baby b, c, etc.

59409: Vaginal delivery only (with or without episiotomy and/or forceps)

59514: Cesarean delivery only

59612: Vaginal delivery only after previous Cesarean delivery (VBAC) (with or without episiotomy and/or forceps)

59620: Cesarean delivery only following attempted VBAC

Delivery services include admission to the hospital, history and physical, exam, and uncomplicated labor management. E/M services within 24 hours of delivery are also included.

Inpatient E/M services including postpartum, are also included in the delivery only or the delivery services provided in the global package. These include:

- Labor induction using Pitocin or Oxytocin
- Anesthesia
- Artificial rupture of membranes
- Insertion of cervical dilators for vaginal deliveries if the insertion occurs on the same date as delivery.
- Delivery of the placenta. Please note that if it occurs at a separate encounter from the delivery (e.g. the patient delivers enroute to the hospital, and the provider delivers the placenta.
- Repair of first- or second-degree lacerations
- Delivery aids
- Repositioning of the baby at the time of delivery

Services not inclusive that may be reported separately include:

- Scalp blood sampling on the newborn
- External cephalic version
- Epidural administration

Delivery including postpartum care

Postpartum care includes office visits or other outpatient services that are provided in the office after delivery. Report Postpartum care only if the physician did not perform the delivery. Postpartum visits are covered through 12 months after delivery.

59410: Vaginal delivery (with or without episiotomy and/or forceps) and postpartum care

59515: Cesarean delivery including postpartum care

Postpartum care only

If the provider is only providing postpartum services for care after the delivery, the postpartum care code should be billed. This is listed as a separate procedure, indicating that the clinician did not perform the delivery. Postpartum visits are covered for 12 months after the delivery.

59430: Postpartum care (separate procedure)

Maternity behavioral health services

Behavioral health (BH) and mental health (MH) services are bundled into the global maternity billing package under most circumstances. However, sometimes services can and should be separately billed.

If an OB provider that is rendering maternity care administers a routine screening during a prenatal or postpartum visit, the service is bundled into the global package. On the other hand, if a routine screening is administered by a licensed BH/MH specialist, the screening is separately billable from the global package. The licensed BH/MH specialist should be the rendering provider for these services.

Medically necessary therapy or counseling services provided by a licensed BH/MH specialist would be billed independently. In that case, the BH/MH specialist should be the rendering provider, and the services are under BH/MH rather than physical health.

Documentation of medical necessity, diagnosis, and a treatment plan need to be documented in the medical record if a separate claim is submitted.

Ultrasounds

CareOregon covers one ultrasound for a routine pregnancy for detection or evaluation of placental, uterine, or fetal anomalies. Ultrasounds should be billed separately from the global package. Medically necessary ultrasounds performed for non-routine reasons should be billed separately from the global package. Common reasons for additional ultrasounds include high-risk pregnancy monitoring or investigation of abnormal findings.

All diagnostic imaging services are billed outside of the global maternity package. All services must be medically necessary and documented.

Common OB Imaging Codes

CPT® Code	Description
76801	OB ultrasound; First trimester, complete
76805	OB ultrasound; Second/third trimester, complete
76816	OB ultrasound, follow up
76815	Limited OB Ultrasound
76819	Fetal biophysical profile
76820	Doppler of fetal vessels

The appropriate code for services rendered should be billed, along with any applicable modifier(s).

- **26:** Professional component only (interpretation and report)
- **TC:** Technical component only (equipment and technician)
- **52:** Reduced service (e.g., incomplete study)
- **59:** Distinct procedural services (multiple ultrasound same day)
- **76/77:** Repeat procedure (same or different provider)
- **No modifier:** if billing globally for both components

**Additional information can be found in OAR 410-130-0220 Not covered/Bundled Services/Not Valid* [8]
CareOregon Global Radiology Procedure Billing Guide[9]

Multiple gestation pregnancies

When a provider renders all components of maternity care, including prenatal, delivery, and postpartum, **only one global maternity CPT® code** should be billed for the entire episode of care.

When a provider performs **delivery services only**, the provider must bill the appropriate **delivery-only CPT® code** for each infant delivered. For multiple gestations, append **modifier 51** to the second and subsequent delivery-only codes to indicated multiple procedures performed during the same operative session.

When imaging multiple fetuses, bill the appropriate primary CPT® code for the first/primary gestation and the corresponding add-on code for each additional fetus on the same date of service.

OB Imaging Codes (including multiple gestations)

CPT® Code	Description
76801	OB ultrasound; First trimester, transabdominal approach, fetal and maternal eval, single or first gestation
(add-on) 76802	OB ultrasound; first trimester, transabdominal approach; each additional gestation (list in addition to code for primary procedure)
76805	OB ultrasound Second/third trimester, transabdominal approach; single or first gestation
(add-on) 76810	OB ultrasound; second/third trimester, transabdominal approach; each additional gestation (list in addition to code for primary procedure)
76816	OB ultrasound, follow up
76815	Limited OB Ultrasound
76819	Fetal biophysical profile
76820	Doppler of fetal vessels

Additional visits due to complications

If a patient has complications that require an additional service, they should be billed separately. Medical necessity must be clearly documented in the medical record, and the selected ICD-10 diagnosis code should indicate the complication that necessitates the additional services. Complications are identified according to the professional judgement of the treating provider.

Termination of pregnancy

CareOregon provides coverage related to miscarriage management or treating complications following a termination of pregnancy or abortion (spontaneous or voluntary).
Voluntary abortion termination of pregnancy services is not covered by CareOregon.
However, these services may be covered by OHA for OHP-enrolled members.

Postpartum coverage is not dependent on the outcome of delivery. Postpartum services for mothers are covered 12 months after the pregnancy ends.
*Claims received by CareOregon for OHA-covered services will be returned.

External Cephalic Version (ECV)

Repositioning the baby prior to delivery, or ECV, is not included in the global maternity package and should be billed separately. Report 59412 in addition to the appropriate global delivery code(s). CPT® guidance should be followed for this service. This applies whether or not tocolysis is used. Documentation must support medical necessity.

False labor

Encounters for false labor (ICD-10 category O47) are considered part of antepartum care if provided by the same group during the global period and should not be billed separately unless the patient is not in the global period (ex. care started elsewhere). Visits for contractions that do not result in admission or delivery are included in the global package.
False labor can be billed separately if:

- The patient's coverage began after pregnancy care started.
- If care is transferred to another provider mid-pregnancy.
- If the pregnancy does not result in delivery.

Doula services

CareOregon covers doula support once per pregnancy for any birthing parent whose benefit package includes labor and delivery. The standard doula package includes:

- Two prenatal visits
- Labor and delivery support
- Two postpartum visits
- Up to four additional visits may be billed separately beyond the global package. These visits can occur in any combination of prenatal or postpartum visits (up to 12 months postpartum).
- Doula visits may occur in the home, office, hospital, or virtually.
- Additional payment is not available for multiple births (e.g. twins, triplets)

A doula must be THW-certified and listed on the Oregon THW Registry. They must also have an NPI and be enrolled as an Oregon Medicaid provider (DMAP).

Billing guidelines
Procedure:

- T1033-Doula services

Modifiers:

- HD-Global benefit, including delivery support-to be billed once per pregnancy
- 22-Doula support (if itemized) on the day of delivery only

Support visits and additional visits should not have a modifier appended to them.

Claims must be submitted within 365 days of the service date with a certified Doula listed as the rendering provider. The correct place of service (POS) code must be on the claim.

- Home: 12
- Office: 11
- Hospital: 21
- Virtual: 10 (patient is home, use modifier to identify communication mode i.e. 93,95)
- Birthing Center: 25

Doula Billing Codes

Procedure code	Description	Modifier
T1033	Global benefit including delivery support	HD
T1033	Support visit (up to 2 prenatal and 2 postpartum)	
T1033	Doula support on the day of delivery only	22
T1033	Additional visits, up to 4	

Additional information about Doula services can be found in OAR 410-130-0015[2]

Common codes and supplies billable in addition to the global maternity package

**Please note that all eligible/medically necessary procedures may not be included in this list*

Code	Description	Coverage criteria
57170	Fitting of diaphragm/cap	1 unit per DOS
76801	OB ultrasound, real time w/image documentation, fetal and maternal eval, 1st trimester, transabdominal, single or 1st gestation	1 unit for single or 1st gestation, use add-on for multiple gestation
+76802	OB ultrasound, real time with image documentation, fetal and maternal eval, 1st trimester, transabdominal; each additional gestation	Add on to parent code (76801) for each gestation beyond the first
76805	OB ultrasound, real time with image documentation, fetal and maternal eval, after 1st trimester, transabdominal; single or 1st gestation	1 unit for single or 1st gestation, use add-on for multiple gestation

+76810	OB ultrasound, real time with image documentation, fetal and maternal eval, after1st trimester, transabdominal; additional gestation	Add on to parent code (76805) for each gestation beyond the first.
76815	OB ultrasound, real time with image documentation, limited (e.g. fetal heart beat, pacental location, fetal position, etc.); 1 or more fetuses	1 unit per service, for 1 or more fetuses
76816	OB ultrasound, follow-up (e.g. re-evaluation of fetal size by measuring, amniotic fluid volume, etc.) transabdominal, per fetus	Report with modifier 59 for each additional fetus
76818	Fetal biophysical profile; with non-stress testing	Report with modifier 59 for each additional fetus
76819	Fetal biophysical profile without non-stress testing	Report with modifier 59 for each additional fetus
82951	Glucose tolerance test (GTT) 3 specimens (includes glucose)	****
90371	HepB ig IN	-One unit per DOS -NDC must be included on claim - provider bills unless POS is birthing center (25) or hospital (21)
90471	Immunization administration	1 unit per DOS
90472	Immunization administration, each additional	Up to 5 units per DOS
92950	Cardiopulmonary Resuscitation (CPR)	Up to 3 units per DOS
96360	Hydration IV	1 unit per DOS
96361	Hydration IV (add on)	Up to 8 units per DOS
96372	Therapeutic Prophylactic Injection (subcutaneous or IM)	Up to 4 units per DOS
A4261	Cervical cap (contraceptive use)	-1 unit per DOS -NDC must be on claim
A4266	Diaphragm	-1 unit per DOS -NDC must be on claim
J0171	Adrenalin inj. Epinephrine, 0.1 mg	-up to 120 units per DOS -NDC must be on claim
J0290	Ampicillin, injection, sodium, up to 500mg (separate line for each 500 mg)	-up to 24 units per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J1364	Erythromycin lactobionate injection per 500mg (bill each 500 mg on a separate line)	-up to 2 units per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)

J2210	Methylergonovine maleate injection up to 0.2 mg	-1 unit per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J2540	Penicillin G potassium, up to 600,000 units, injection	-up to 75 units per DOS -NDC must be on claim -provider b130ills unless POS is birthing center (25) or hospital (21)
J2790	Rh Immune globulin	-1 unit per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J3875	Magnesium sulfate injection, 500 mg	-Up to 20 units per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J7050	Normal saline solution infusion, 250cc	-Up to 10 units per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J7120	Ringers lactate infusion, up to 1000cc	-Up to 4 units per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J7121	5% dextrose in lactated ringers solution, up to 1000cc	-Up to 4 units per DOS -NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)
J8499	Oral methergine, 0.2 mg	-1 unit per DOS - NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21) -dosage must be included to price this code
S0077	Clindamycin phosphate injection, 300mg	-1 unit per DOS - NDC must be on claim -provider bills unless POS is birthing center (25) or hospital (21)

Diagnosis coding

ICD-10-CM guidelines should be followed for accurate pregnancy coding.
Further information regarding diagnosis coding and standard ICD-10-CM guidelines can be found at the CMS website, specifically page 61. [3]

Definitions

Evaluation and Management: (E/M) Evaluation and management services.

Prenatal Period: From confirmation of pregnancy through the date of delivery.

Postpartum Period: The period following delivery as defined by payer policy (CareOregon covers medically necessary physical health and behavioral health services 12 months after the end of the pregnancy.

Global Maternity Billing: A bundled payment system in which routine maternity services are billed together under a single code, rather than itemized individually.

CMS: Centers for Medicare & Medicaid Services

Doula: Expert (Not a doctor or midwife) in helping people through labor and childbirth. Offers emotional support and helps babies enter the world in a positive way.

Additional visit: A distinct, medically necessary E/M service or procedure that is not included in the global package (ex. problem-focused assessment).

Tocolysis: The medical intervention used to inhibit uterine contractions in order to delay or stop preterm labor.

References

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This document is provided for informational purposes only and should not be construed as legal advice. Any cited statutes are current as of the date of publication of this guide.

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT®) itself. Additions and deletions conform it to the most recent publications of CPT® and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2026. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT® codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.

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