curative

TITLE:	GLOBAL MATERNITY/OBSTETRICAL SERVICES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	02/20/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

3.1. **Evaluation and Management (E/M) Services** Face-to-face and/or non-face-to-face provider work involving history, examination, medical decision-making (MDM), and/or time, as defined by CPT®.

3.2. **Global Period, Global Days** The number of days during which services furnished by the physician performing the procedure before, during and after are included in the reimbursement for the procedure performed.

3.3. **Global Maternity Package** The provision of antepartum care, delivery, and postpartum care, rendered by a provider or a provider of the same group and same primary specialty.

3.4. **Same Individual Provider** The same individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.

3.5. **Same Group Practice** Physicians and/or Other Qualified Health Care Professionals of the same specialty reporting the same Federal Tax ID number.

3.6. **Same Specialty Provider** Physicians and/or Other Qualified Health Care Professionals of the same group and same primary specialty reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

This policy outlines how Curative reimburses for maternity and obstetrical professional services. Maternity care includes antepartum care, delivery, and postpartum care. The American Medical Association (AMA) defines the Global Maternity Package as including the provision of all of these components.

When the components are provided by the Same Individual Provider or Same Group Practice, the codes representing the global codes are to be reported. The Global Maternity Package is represented by global maternity codes 59400, 59510, 59610 and 59618.

The following services are included in the global maternity codes per the AMA and the American College of Obstetricians and Gynecologists, (ACOG) and are not reimbursed separately.

- All routine prenatal visits until delivery (approximately 13 for uncomplicated cases)
- Initial and subsequent history and physical exams
- Recording of weight, blood pressures and fetal heart tones
- Routine chemical urinalysis (CPT codes 81000 and 81002)
- Admission to the hospital including history and physical
- Inpatient Evaluation and Management (E/M) service provided within 24 hours of delivery
- Management of uncomplicated labor
- Vaginal or cesarean section delivery (limited to single gestation; for further information, see Multiple Gestation section)
- Delivery of placenta
- Administration/induction of intravenous oxytocin
- Insertion of cervical dilator on same date as delivery
- Repair of first- or second-degree lacerations
- Simple removal of cerclage (not under anesthesia)

• Uncomplicated inpatient visits following delivery

• Routine outpatient E/M services provided within 6 weeks of delivery

• Postpartum care only

•Educational services e.g., breastfeeding, lactation, and basic newborn care

Confirmation of a pregnancy during an Evaluation and Management (E/M) visit is not considered part of the antepartum component and is reported as an E/M visit. Subsequent visits for uncomplicated maternity care prior to the delivery are part of the Global Maternity Package.

Individual Components of the Global Maternity Package

If providers from different group practices provide individual components of the Global Maternity Package to a patient during a pregnancy, the itemization of obstetric services may be reported. This may may occur in the following situations:

• A patient transfers into or out of a physician or group practice

• A patient is referred to another physician during her pregnancy

• A patient has the delivery performed by another provider not associated with her physician or group practice.

• A patient terminates or miscarries her pregnancy

• A patient changes insurer during her pregnancy

Antepartum Care

Antepartum care includes initial and subsequent history, physical examinations, routine recording of weight, blood pressures, fetal heart tones, routine urinalysis, and monthly visits up to 28 weeks gestation (typically 5-6 visits), biweekly visits to 36 weeks gestation (typically 4 visits), and weekly visits until delivery (typically 3-4 visits). These total approximately 13 visits for a routine pregnancy. If less than 3 antepartum visits occur, these are reported as E/M services.

Complications of pregnancy should be reported using the appropriate E/M code and the specific ICD-10 diagnosis code for the complication such as; pre-eclampsia or placenta previa. Routine prenatal or high-risk prenatal diagnosis codes should not be reported in addition to the complication code. The complication visits should only be reported after delivery if they resulted in prenatal visits beyond the typical 13 for a routine pregnancy.

If a provider performs part of the antepartum care but does not perform the delivery, the “antepartum care only” codes are reported as either 59425 (4-6 antepartum visits), 59426 (7 or more antepartum visits). A unit of one is reported with these codes with the “from” and “to” dates for the services also on the claim.

Delivery Services Only

The AMA includes admission to the hospital, the history and physical, the physical exam, uncomplicated labor management, vaginal delivery (with or without episiotomy or forceps) or a cesarean delivery as part of the “delivery only” codes. Pregnancy related observation or inpatient admissions occurring within 72 hours of the delivery are considered part of the Global Maternity Package and are not reimbursed separately.

“Delivery only” codes are reported when the total Global Maternity Package is not performed. These are used when only the delivery is performed but the antepartum and postpartum services are provided by another provider or group practice. The “delivery only” codes are 59409, 59514, 59612, 59620.

Delivery and Postpartum Care Only

The “delivery with postpartum services codes” are reported when they are the only components provided. These services are represented by codes 59410, 59515, 59614, 59622. They include the delivery, hospital visits related to the delivery and the stay, as well as uncomplicated postpartum care further defined below.

Postpartum Care Only

If a patient receives routine postpartum care only from a different individual provider or group practice, code 59430 should be reported once per pregnancy.

Postpartum Period

The postpartum period is considered to be the six weeks after a vaginal delivery or Cesarean delivery. Additional visits for surveillance of potential problems are also included as part of the routine postpartum period. Visits unrelated to the pregnancy should be reported with modifier -24.

-24 Modifier Unrelated E/M visit during a 10 or 90 day global period of a procedure by the Same Individual Provider or Same Group Provider

Maternity/Obstetrical Care Codes

Total Global Maternity Care (Includes antepartum and postpartum care)

- **59400:** Vaginal delivery
- **59510:** Cesarean delivery
- **59610:** Vaginal delivery after previous cesarean (VBAC)
- **59618:** Cesarean delivery following attempted VBAC

Antepartum Care Only

- **59425:** 4–6 visits
- **59426:** 7 or more visits
- *Note:* For 1–3 visits, report appropriate E/M codes (99202–99215).

Delivery Only

- **59409:** Vaginal delivery only (with or without episiotomy and/or forceps)
- **59514:** Cesarean delivery only
- **59612:** Vaginal delivery only, after previous cesarean (VBAC)
- **59620:** Cesarean delivery only, following attempted VBAC

Delivery + Postpartum

- **59410:** Vaginal delivery only; including postpartum care
- **59515:** Cesarean delivery only; including postpartum care
- **59614:** Vaginal delivery only, after previous cesarean (VBAC); including postpartum care
- **59622:** Cesarean delivery only, following attempted VBAC; including postpartum care

Postpartum Care Only

- **59430:** Postpartum care only (separate procedure)

Postpartum Complications

Management of postpartum complications occurring should be reported with the appropriate E/M code and reported with complication diagnosis instead of the routine postpartum care diagnosis code. These are not considered part of the routine postpartum period.

Non-Pregnancy Related Visits

If a pregnant patient is treated for an unrelated condition (e.g., acute sinusitis), services should be billed as a standard E/M visit using the ICD-10 diagnosis code for the specific condition. To ensure accurate reimbursement, do not include routine prenatal or postnatal ICD-10 diagnosis codes on the non-obstetric claims.

Pregnancy Related Visits by Other Providers

Providers not providing a component of the Global Maternity Package who see the pregnant patient for a specific condition should use the ICD-10 diagnosis code reflecting that specific condition.

Multiple Births

Multiple gestations may be delivered through different methods. The grid below outlines CPT codes to be considered for the possible scenarios.

Delivery	Newborn	CPT Codes	Coding
Vaginal	First Newborn	59400, 59409, 59410,	Primary procedure
	Subsequent Newborn	59409	Append -59 modifier
VBAC (vaginal birth after Cesarean)	First Newborn	59610, 59612, 59614	Primary procedure Multiple Procedure Reduction
	Subsequent Newborn	59612	Append -59 modifier
C-Section	All Newborns	59510, 59514, 59515	Report once to represent all deliveries
C-Section following attempted VBAC	All Newborns	59618, 59620, 59622	Report once to represent all deliveries
Vaginal and VBAC	All Newborns	59409, 59612	Append -59 modifier Multiple Procedure Reduction
C-Section and VBAC	All Newborns	CSection: 59510, 59514, 59515 VBAC: 59618, 59620, 59622	C-Section is the primary procedure Multiple Procedure Reduction

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

5.2. Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision, Clinical Modification

5.3. Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
02-20-2026		001	Initial Version