Note: This policy is not effective until 01/01/2027. To view the current policy, click here.

Reimbursement Policy

Reimbursement Policy: **Maternity Care**
Policy No: **Med 107**
Section: **Medicine**
Original Effective Date: **03/01/2012**
Last Reviewed: **09/01/2026**
Revision Effective Date: **01/01/2027**

This policy applies only to physicians and other qualified health care professionals.

DEFINITIONS

Code/Term	Code Description/Term Definition
Antepartum Care	Beginning on the date the prenatal record is initiated and extending to labor management.
Current Procedural Terminology (CPT®)	A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.
Delivery Care	When the fetus is visible or when labor has stopped (e.g. decision for cesarean delivery). This would be the period following labor management.
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	A morbidity classification system for classifying diagnoses and reason for visits in all health care settings for the purpose of coding and reporting.
Labor Management	Labor management is the process of making coordinated care decisions to support the health of the pregnant person and the fetus(es). It includes monitoring and managing any medical issues or complications, such as heart or brain conditions, diabetes, pre-eclampsia, abnormal fetal heart patterns, or slow or difficult labor.
Maternity Period	Beginning on the date the prenatal record is initiated and extending through the postpartum period (6 weeks (42 days)).
Modifier 22	Increased Procedural Services

Modifier 25	Significant, Separately Identifiable Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional on the same day of the procedure or other service.
Modifier 51	Multiple Procedures
Modifier 59	Distinct Procedural Service
Modifier TH	Obstetrical treatment/services, antepartum or postpartum.
Postpartum Care	Up to 6 weeks (42 days) of ongoing maternity care following delivery.

POLICY STATEMENT

Our health plan reimburses maternity-services provided during the maternity period for a Member's pregnancy.

The following antepartum and postpartum Evaluation & Management (E&M) codes are some of the services that may be eligible for reimbursement:

Office/Other Outpatient	Hospital Inpatient/Observation	Telemedicine (Audio-Video/Audio only)	Hospital Inpatient (Admission/ Discharge)	Critical Care
99202-99205	99221-99223	98000-98007	99234-99236	99291-99292
99211-99215	99231-99233	98008-98015		

Antepartum care

Antepartum care includes, but is not limited to, initial and subsequent history and physical examinations, assessment and monitoring of maternal and fetal status, recording of weight and blood pressure, fetal heart tones assessment and routine urinalysis.

Antepartum care is reimbursed when each encounter is reported with the appropriate E&M code for the services rendered by a physician or other qualified health care professional. Nonphysician qualified health care professionals, such as dieticians, should report the CPT® code (e.g. 97802, 97803, 97804) that best describes the specific service provided rather than an E&M code.

Pregnancy-related ICD-10-CM diagnosis codes must be reported when billing E&M services associated with antepartum or postpartum care. Applicable ICD-10-CM codes include, but are not limited to:

- Encounter for supervision of normal pregnancy - Z34.XX
- Conditions affecting the management of pregnancy, childbirth and puerperium – O00-O9A
- Encounter for maternal postpartum care and examination – Z39.XX

In addition to the appropriate ICD-10-CM code(s), modifier TH must also be appended to the appropriate antepartum or postpartum E&M code.

When a pregnant patient is admitted to the hospital for reasons unrelated to labor management or is placed in observation status and a significant, separately identifiable E&M service is performed on the same calendar date by the same physician or other qualified

health care professional, modifier 25 must be appended to the E&M service when appropriate.

Antepartum procedures and fetal invasive services may be eligible for reimbursement when the appropriate CPT code for the service performed is reported. Examples include, but are not limited to, amniocentesis, fetal non-stress testing, chorionic villus sampling, and fetal fluid drainage. In addition, surgical procedures unrelated to the pregnancy that may be performed during the antepartum period may also be eligible for reimbursement. Examples include, but are not limited to, hernia repair or appendectomy.

Labor Management

Labor management consists of the evaluation, monitoring, and clinical management of the pregnant patient and fetus(es) during labor. Labor management services include, but are not limited to, the following:

- Routine maternal monitoring.
- Fetal monitoring and physician or other qualified health care professional intervention when needed.
- Management of labor induction or augmentation.
- Management of stable or complex medical conditions during labor.

Labor Management codes include:

- CPT 59080 – Initial day labor management; straightforward, per day
- CPT 59081 – Initial day labor management; complex, per day
- CPT 59082 – Subsequent labor management; straightforward, per day
- CPT 59083 – Subsequent labor management; complex, per day

According to the American Medical Association (AMA), straightforward or complex labor management are classified as follows:

Levels of Labor Management

Straightforward	**Complex**
If all of the following are not met, refer to complex labor management:	Any labor management that is not defined as straightforward
Singleton vertex presentation	More than one fetus
Routine maternal/fetal monitoring	Fetal monitoring (eg, heart rate) abnormalities requiring a change in management requiring physician or other QHP intervention
Fetal monitoring (e.g., heart rate) not requiring physician or other QHP intervention	Prolonged first or second stage of labor
Normal progression of labor or routine labor induction or augmentation	Labor complications (eg, intraamniotic infection and/or inflammation, preeclampsia)
Stable medical conditions (e.g., well-controlled hypertension, diet-controlled diabetes) not requiring additional management during labor	One or more severe maternal morbidity indicator(s) (eg, acute renal failure, eclampsia)
No previous cesarean delivery	Maternal medical conditions (eg, hypertension, diabetes, morbid obesity) requiring additional medical management during labor
	Previous cesarean delivery

Some services that are included in labor management are periodic physical examination, collecting and interpreting physiologic data (uterine contraction monitoring, vital signs and pulse oximetry) and induction/augmentation of labor. These services are considered integral components of labor management and are not separately reimbursable.

Initial day labor management codes should be reported once for the initial day of admission. Subsequent day labor management codes may be reported once per day for each additional day that labor management services are provided during the admission. A delivery code may be reported in addition to the initial or subsequent labor management code when both services are provided on the same date of service.

Once labor management begins, billing E&M codes is no longer appropriate. One exception to this is if the patient is seen in a physician's office for the onset of labor and is subsequently admitted to the hospital on that same day.

When there are multiple fetuses only one complex labor management code should be reported regardless of the number of fetuses.

Delivery Care

Delivery care services include, but are not limited to, vaginal or cesarean delivery, delivery of the placenta, or simple removal of cerclage. A vaginal delivery begins when the fetus is visible and crowned, while a cesarean delivery begins when the decision is made to perform the cesarean delivery.

Delivery care codes include, but are not limited to:

Vaginal Delivery
- CPT 59431 – Vaginal delivery, with or without episiotomy
- CPT 59432 – Vaginal delivery, after previous cesarean delivery

Cesarean Delivery
- CPT 59502 – Cesarean delivery; primary
- CPT 59503 – Cesarean delivery; repeat

Cesarean-Related Procedures
- CPT 59504 – Subtotal or total hysterectomy after cesarean delivery

When a vaginal delivery is attempted but results in a cesarean delivery, only the cesarean delivery code should be reported.

When a cesarean delivery is performed, the appropriate cesarean delivery code should be reported only once, regardless of the number of fetuses delivered.

A planned cesarean delivery is not considered labor; therefore, a labor management code should not be reported. Because labor management services are not provided when a planned primary cesarean delivery is performed, an E&M code may be reported on the same date of service as the cesarean delivery.

Same-day routine postpartum care is included in the reimbursement for delivery care. However, delivery care and initial or subsequent labor management services may be reported separately when both are provided on the same date of service.

Delivery of the placenta is not separately reimbursable when a vaginal delivery code is reported by a physician or other qualified health care professional of the same specialty and subspecialty within the same group practice. However, delivery of the placenta is separately reimbursable only when performed by a physician or other qualified health care professional who did not perform the vaginal delivery.

For multiple gestations, report one vaginal delivery code for each fetus delivered vaginally and one cesarean delivery code, regardless of the number of fetuses delivered by cesarean delivery. If both a vaginal and cesarean delivery are performed, report one vaginal delivery code for each fetus delivered vaginally and one cesarean delivery code regardless of number of fetuses delivered by cesarean delivery.

Postpartum care

Postpartum care includes ongoing assessments and management tailored to the individual patient's postpartum needs. Reimbursement for postpartum care may be considered when the appropriate E&M code is reported based on the services rendered, a pregnancy-related ICD-10-CM diagnosis code is included on the claim, and the TH modifier is appended.

Routine postpartum care should not be reported on the same calendar date as delivery care.

Inpatient postpartum care provided on a date after the delivery date may be reported using the appropriate E&M code, such as subsequent hospital or observation care (99231-99233), hospital discharge services (99238-99239), or critical care services (99291-99292).

However, maternity delivery services and inpatient postpartum E&M services, including subsequent hospital or observation care (99231-99233), hospital admission and discharge services (99234-99236), or hospital discharge services (99238-99239), should not be reported on the same calendar date.

Outpatient postpartum care provided on a date after delivery may be reported using the appropriate E&M service, including but not limited to office or other outpatient visits (99202-99205 or 99211-99215), telehealth services (98000-98015).

Postpartum care services may include, but are not limited to:

- Postpartum home, office, telehealth, or hospital visits following vaginal or cesarean delivery
- Assessment and management of postpartum recovery and complications
- Contraceptive counseling
- Intrauterine device (IUD) insertion and related follow-up care
- Lactation support and management of lactation-related complications
- Screening, evaluation, and medical management of postpartum depression or other behavioral health conditions
- Suture or incision evaluation and removal, when appropriate
- Other medically necessary postpartum evaluation and management services based on the patient's condition and clinical needs

The following postpartum procedures may be eligible for separate reimbursement when medically necessary:

- 59X10 Uterine tamponade (e.g., balloon, catheter, vacuum device, or packing material)
- 59160 Curettage, postpartum
- 59350 Hysterorrhaphy of ruptured uterus

Uterine tamponade is separately reimbursable when performed to manage postpartum hemorrhage. Code 59X10 should not be reported for pharmacologic management of postpartum hemorrhage alone.

Multiple Gestations

The specific procedure codes reported will depend on the method of delivery and the number of fetuses delivered.

When reporting multiple gestation vaginal deliveries, report the appropriate vaginal delivery code once per fetus. For multiple gestation deliveries performed via cesarean section, report a single cesarean delivery code, regardless of the number of fetuses delivered.

Refer to the table below for coding guidelines applicable to multiple gestation deliveries. Services must be reported with the appropriate CPT code and modifier, if applicable, to be considered for reimbursement.

	CPT Codes
Twin pregnancy, both delivered vaginally	
1st Newborn	59431
2nd Newborn	59431-51-59
Twin pregnancy, both delivered VBAC	
1st Newborn	59432
2nd Newborn	59432-51-59
Twin pregnancy, VBAC followed by C-section	
1st Newborn	59432
2nd Newborn	59502-51-59
Twin pregnancy, vaginal delivery followed by C-section	
1st Newborn	59431 or 59432
2nd Newborn	59502 or 59503-51-59
Twin pregnancy, both delivered by C-section	
1st Newborn	59502 or 59503-22
2nd Newborn	No code

Modifier 22

Modifier 22 (Increased Procedural Services) is appropriate only when a procedure requires substantially greater effort than typically required and the additional work cannot be reported with a separate CPT code. Use of modifier 22 must be supported by documentation describing the increased complexity, intensity, or time required to perform the service. Modifier 22 is not appropriate when the additional work is routine, inherent to the procedure, or separately reportable.

- Examples of appropriate use of modifier 22 include, but are not limited to:
  - Delivery of a single fetus that requires substantially greater effort than typically required (e.g. e.g. Vacuum assisted delivery, Severe hypertension/preeclampsia, Maternal sepsis, Hemorrhage, etc)
  - Cesarean delivery of twins is performed and only code 59502 or 59503 is reported.

Home birth kits

For Commercial health plans, home birth kits are eligible for reimbursement up to 1 kit per pregnancy, billed on the mother's claim with procedure code S8415, *Supplies for Home Delivery of the fetus(es).* Allowable supplies included in the reimbursement of the home birth kit are not separately reimbursable.

REFERENCES

American Medical Association, “CPT® 2027 Maternity Care Services code changes” https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes

ACOG, “Payment for Obstetric Services” https://www.acog.org/practice-management/coding/coding-library/payment-for-obstetric-services

CROSS REFERENCES

Policy Cross References
Mod 101 - Modifier 51 and Multiple Procedure Payment Reduction Logic
Mod 103 - Modifier 25; Significant, Separately Identifiable Service
Mod 105 - Modifiers 59, XE, XP, XS, XU; Distinct Procedural Service
Mod 111 - Modifier 22; Increased Procedural Services

DISCLAIMER

Your use of this Reimbursement Policy constitutes your agreement to be bound by and comply with the terms and conditions of the Reimbursement Policy Disclaimer.

HISTORY

Date	Updates
10/01/2026	Updated policy to remove global billing information and added new AMA billing guidelines, including E&M codes for antepartum and postpartum care, labor management and delivery. Added additional modifiers and new references.