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Reimbursement Policy
Maternity Services

Policy Number: **G-14001**
Policy Section: **Surgery**
Last Approval Date: **09/09/2026**
Effective Date: **02/01/2027**

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Policy

The health plan allows reimbursement for maternity care services, including antepartum care, labor management, delivery, and postpartum care, when appropriately reported, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

The routine antepartum and outpatient postpartum evaluation and management (E/M) visit limits in this policy apply only to routine pregnancies. The antepartum visit limit does not apply to E/M services associated with a high-risk pregnancy or active pregnancy-related complication. The outpatient postpartum visit limit does not apply to E/M services associated with a pregnancy-related or postpartum complication.

Antepartum care

Antepartum care must be reported per encounter with the applicable E/M code and modifier TH. The health plan allows reimbursement for up to 13 routine office or other outpatient E/M visits per pregnancy episode for services reported under the same federal tax identification number (TIN). The first prenatal E/M visit following confirmation of pregnancy is included in the 13-visit limit and, as a condition of reimbursement, must be reported with an applicable ICD-10-CM code from category Z3A identifying the completed weeks of gestation.

When a member transfers obstetric care to a provider or provider group reporting under a different TIN, the routine antepartum E/M frequency limit is applied separately to services furnished under the receiving provider TIN. Transfers between physicians or other qualified healthcare professionals reporting under the same TIN do not initiate a new frequency limit.

Labor management

Labor management must be reported with CPT® codes 59080–59083. Reimbursement is limited to one labor management service per calendar date, per setting, at the highest applicable level.

Delivery
Delivery must be reported with CPT code 59431, 59432, 59502, or 59503, as applicable. All professional delivery claims must also be reported with an applicable ICD-10-CM code from category Z3A identifying the completed weeks of gestation at delivery as a condition of reimbursement.

Postpartum care
Postpartum care must be reported per encounter with the applicable E/M code and modifier TH. The health plan allows reimbursement for up to three routine office or other outpatient E/M visits per pregnancy episode within 12 weeks after delivery for services reported under the same TIN. The combined routine antepartum and outpatient postpartum limit is 16 visits per pregnancy episode for services reported under the same TIN. An ICD-10-CM code from category Z3A is not required on postpartum E/M claims.

Documentation and review
Medical record documentation must support the reported code, date of service, place of service, maternity care phase, E/M level or labor management complexity, required modifier, any diagnosis used to support an exception to the routine frequency limits, and any separately reported procedure or service. The health plan reserves the right to request medical records and perform prepayment or post-payment review of claims.

Separately reimbursable
The following services are not included in the reimbursement for the applicable maternity care service and may be separately reimbursable:

- Pregnancy confirmation reported with the applicable E/M or preventive medicine service when antepartum care is not initiated during the encounter. This service does not count toward the routine 13-visit antepartum limit.
- Antepartum E/M visits above the routine 13-visit limit when reported with diagnosis coding that identifies a high-risk pregnancy or active pregnancy-related complication.
- A significant, separately identifiable E/M service performed at another site before admission for labor management and reported with modifier 25.
- Labor management reported on the same calendar date as delivery when rendered.
- Hospital inpatient or observation E/M services reported on the same calendar date as a planned primary cesarean delivery when the patient is not in labor.
- Repair of a first- or second-degree episiotomy or laceration reported with CPT code 59300, or delivery of the placenta reported with CPT code 59414, when performed by a physician or other qualified healthcare professional other than the professional reporting the vaginal delivery.
- Repair of a third- or fourth-degree episiotomy or laceration reported with CPT code 59433 or 59434 in conjunction with CPT code 59431 or 59432 when performed at the time of vaginal delivery.
- A subtotal or total hysterectomy performed during the same operative session as a cesarean delivery and reported with CPT code 59504. Modifier 51 is required when the same physician reports both the cesarean delivery and hysterectomy.

- Outpatient postpartum E/M visits above the routine 3-visit limit for services reported under the same TIN when reported with diagnosis coding that identifies a pregnancy-related or postpartum complication.
- Uterine tamponade reported with CPT code 59623 when the procedure is performed.

Not separately reimbursable
The following services are included in the reimbursement for the applicable maternity care service or are otherwise not separately reimbursable:

- Routine antepartum office or other outpatient E/M visits in excess of 13 per pregnancy episode for services reported under the same TIN.
- For routine and high-risk pregnancies, the following services are included in reimbursement for the applicable antepartum office or other outpatient E/M service and are not separately reimbursable when reported on the same calendar date, with an applicable maternity diagnosis, and under the same TIN as the E/M service:
  - Routine urinalysis and point-of-care urine testing: 81000, 81001, 81002, 81003, 81015
  - Urine pregnancy testing: 81025
  - Preventive counseling: 99401–99404
  - Self-management education: 98960–98962
  - Prenatal and lactation education: S9443, S9445
  - Behavioral screening: 96127
  - Depression screening: G0444
  - Health-risk assessments: 96160, 96161
  - Prolonged E/M services: 99417, G2212
  - Remote physiologic monitoring setup and device supply: 99453, 99454
  - Tobacco cessation services: 99406, 99407
- More than one labor management service for the same calendar date and setting. When more than one level is reported, reimbursement is limited to the highest applicable level.
- Interim physical examinations, collection and interpretation of physiologic data, maternal and fetal monitoring, and labor induction or augmentation performed as part of labor management.
- Labor management for a scheduled or planned cesarean delivery when the patient is not in labor.
- Immediate postpartum care rendered on the same calendar date as delivery.
- Hospital inpatient or observation discharge day management when the patient is discharged on the same calendar date as delivery.
- Delivery of the placenta and repair of a first- or second-degree episiotomy or laceration are included in the reimbursement for the vaginal delivery when performed by the same physician or other qualified healthcare professional reporting the vaginal delivery.
- Initial or subsequent hospital inpatient or observation E/M services reported on the same calendar date as a repeat cesarean delivery.
- Routine postpartum office or other outpatient E/M visits in excess of three per pregnancy episode within 12 weeks after delivery for services reported under the same TIN.
- Uterine tamponade when only pharmacologic management of hemorrhage is provided.
- Duplicate or otherwise overlapping maternity care services.

Related Coding

Maternity Services CPT codes

Definitions

- **Antepartum Care -** Management of the pregnancy before the onset of labor, reported per encounter with the applicable E/M code.
- **Delivery -** Management of the parturient and fetus(es) beginning when labor is complete or interrupted and continuing through vaginal or cesarean delivery. Immediate postpartum care on the delivery date is included.
- **High-Risk Pregnancy -** A pregnancy with a documented maternal, fetal, or obstetric condition, complication, or risk factor requiring surveillance, evaluation, or management beyond routine maternity care.
- **Labor Management -** Integrated decision-making and management of the parturient and fetus(es) while the parturient is admitted to a facility for labor management or induction.
- **Modifier 25 -** Indicates that a significant, separately identifiable E/M service was performed by the same physician or other qualified healthcare professional on the same date as another procedure or service.
- **Modifier TH -** Obstetrical treatment or services, prenatal or postpartum. Modifier TH is required on antepartum and postpartum E/M services under this policy.
- **Postpartum Care -** Ongoing assessment and management of the patient after delivery, reported per encounter with the applicable E/M code.
- **Pregnancy Episode -** The period beginning with the first pregnancy-related maternity service and ending 12 weeks after delivery, used to apply the routine antepartum and outpatient postpartum E/M visit limits. The 13-visit antepartum limit, 3-visit outpatient postpartum limit, and combined 16-visit limit are applied per pregnancy episode to services reported under the same federal TIN.
- **Routine Pregnancy -** A pregnancy without a documented maternal, fetal, or obstetric condition, complication, or risk factor requiring surveillance, evaluation, or management beyond routine maternity care.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Claims Requiring Additional Documentation
- Modifier Usage
- Modifiers 25 and 57: Evaluation and Management with Global Procedures
- Modifiers 50 and 51: Multiple and Bilateral Surgery
- Multiple Delivery Services

References and Research Materials

This policy has been developed through consideration of the following:

- American College of Obstetricians and Gynecologists
- American Medical Association
- CMS
- Optum EncoderPro 2026
- State contract
- State Medicaid

Policy History

- **09/09/2026 -** Review approved 09/09/2026 and effective 02/01/2027: updated policy to align with AMA CPT coding changes for maternity care services and to replace the global obstetric care package with service-level reimbursement guidance; updated Related Coding by adding a code list; updated Definitions section by adding multiple new definitions
- **10/23/2025 -** Review approved 10/23/2025 and effective: no changes
- **12/10/2024 -** Review approved and effective: updated language to reimburse lactation consultant services separately from the global obstetrical package
- **07/07/2023 -** Review approved and effective: policy template updated
- **08/07/2020 -** Review approved
- **06/27/2018 -** Review approved: policy template updated
- **09/15/2016 -** Review approved 09/15/2016 and effective 11/15/2017: outcome of delivery/weeks of gestation section added
- **02/29/2016 -** Review approved: updated template
- **04/14/2014 -** Initial approval 04/14/2014 and effective 02/01/2015

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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