Maternity Care, 2027 Coding & Pregnancies Spanning 2026 - 2027

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Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No
If yes, Texas Last Update Effective Date: n/a
Policy #: RPM020-C

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All)
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions)
Provider Contract Status: Any
Claim Dates: All

Reimbursement Guidelines

A. Maternity Care Services Overview

Maternity care includes antepartum care, labor management, delivery care, and postpartum care provided in outpatient and inpatient settings.

1. For dates of service on or after January 1, 2027 coding guidelines for Maternity Care Services changed significantly.
2. See Maternity Care Policy for deliveries on or before December 31, 2026.
3. See antepartum care billing guidelines for patients who begin antepartum care during 2026 and deliver on or after January 1, 2027.
4. See postpartum care billing guidelines for patients who deliver during 2026.

B. Confirmation of Pregnancy Visit

Report a pregnancy confirmation visit with the following:

1. The appropriate evaluation and management (E/M) code for the setting, such as office or other outpatient E/M or a preventive medicine service.
2. 81025, *Urine pregnancy test, by visual color comparison methods*.
3. Any other laboratory tests needed after pregnancy is confirmed.
4. Z32.01 *Encounter for pregnancy test, result positive*.

C. Initial Prenatal Visit

In addition to the appropriate antepartum care codes, report 0500F (Initial prenatal care visit) with the date of service (DOS) of the initial prenatal visit as a no-charge line item. This may be reported on the same claim as the global maternity billing, based on the billing system requirements.

Reason: We use the Healthcare Effectiveness Data and Information Set (HEDIS) measures to evaluate quality performance. HEDIS requires that we gather this information for all members receiving maternity care.

Results:

- Reduces medical record requests to provider offices to collect this information.
- CPT code 0500F is for reporting purposes only and will not affect your reimbursement in any way.
- Does not delay claim processing, consistent with claim processing policy and applicable state law.

D. Additional Medicaid Requirements for Subsequent Prenatal Care and Postpartum Care Visits

The Oregon Health Authority (OHA) requires certain providers to report subsequent prenatal care (0502F) and postpartum care (0503F) visit tracking codes. These performance measures tracking codes are for reporting

purposes only and do not affect reimbursement. Requirements may change; billing offices are responsible for monitoring current OHA guidelines and submitting Medicaid claims in compliance with the most current requirements. [46]

E. Antepartum Care

Antepartum care includes care and management of the pregnant mother and fetus(es) before labor begins.

1. When the mother begins antepartum care during 2026 and delivers (or miscarries) on or after January 1, 2027:
   a. Report antepartum care visits performed on or before December 31, 2026 using the code that corresponds to the total number of routine antepartum care visits completed in 2026:
      i. 1-3 routine antepartum visits, use the appropriate E/M office visit code.
      ii. 59425 *Antepartum care only; 4-6 visits*
      iii. 59426 *Antepartum care only; 7 or more visits*
   b. Code selection depends upon the exact number of routine antepartum care encounters completed in 2026.
      i. This will not be known with certainty until near the end of 2026.[49]
      ii. Due to this, no more than three (3) E/M procedure codes for routine antepartum care (diagnosis Z34.xx) will be accepted with 2026 dates of service (DOS).
   c. Report additional antepartum care visits for high-risk patients or pregnancy complications separately using:
      i. The appropriate E/M code for the setting.
      ii. A first-listed diagnosis code from the Pregnancy, Childbirth, and the Puerperium chapter (O00 – O9A) which indicates an appropriate reason for the additional antepartum visit, such as pre-eclampsia or another pregnancy complication.
2. When the mother begins antepartum care on or after January 1, 2027:
   a. Report antepartum care with the appropriate E/M code for the setting.
   b. When during an antepartum visit the pregnant patient is admitted to inpatient or observation status for labor management or another reason: [47]
      i. The initial-site E/M may be reported separately in addition to the inpatient/observation E/M service.
      ii. When the same physician or qualified health care professional (QHP) performs both E/M services, append modifier 25 to the initial antepartum visit.

F. Antepartum Procedures and Fetal Invasive Services

1. Antepartum and fetal invasive procedures may be reported separately from antepartum E/M visits, including but not limited to:
   a. Amniocentesis
   b. Chorionic villus sampling
   c. Fetal stress tests and/or non-stress tests (NST)
   d. Intrauterine surgery or procedures
   e. Diagnostic imaging, (obstetric ultrasound, fetal MRIs, etc.)

2. Obstetrical ultrasounds for multiple gestations
   a. Obstetrical ultrasound code descriptions (76801 – 76828) specify when a code applies to a "single or first gestation," "each additional gestation," "per fetus," "fetal," etc. Follow all CPT code descriptions and parenthetical instructions when submitting claims for multiple gestations.
   b. Do not report two units of a code that specifies "single or first gestation" to report procedures for twins. These codes allow a maximum of one (1) unit per DOS. Additional billed units will be denied. Report the second fetus with the applicable "each additional gestation" code.

      Example # 1:

      76801 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation)

      76802 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure))

      Patient is seen for initial ultrasound including determination of the number of gestational sacs and fetuses and to take gestational/fetal measurements.

      - For first gestation/fetus, bill 76801 x 1 unit.
      - For twins (one additional gestation/fetus), bill with 76802 x 1.
      - For quadruplets (three additional gestations/fetuses), bill with 76802 x 3.

      Example #2

      76815 (Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses)

      A mother pregnant with twins is seen for a limited ultrasound to determine placental location, fetal position and/or qualitative amniotic fluid volume.

      - The code description for a limited scan is performed (76815), is "1 or more fetuses."
      - Report 76815 x 1 unit to cover scans of both twins.
      - 76816 and indicate number of fetus' in units (76815 x2 for twins)

      Example #3

      76816 (Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus)

      A mother pregnant with twins is seen for a follow-up ultrasound for a re-evaluation to check the growth of both twins.

      - The code description for a follow-up scan is performed (76816), is "per fetus."
      - Report 76816 x 2 units to cover scans of both twins.

      Example #4

      76818 (Fetal biophysical profile; with non-stress testing)

      76819 (Fetal biophysical profile; without non-stress testing)

      A mother pregnant with twins is seen for a fetal biophysical profile of both twins.

      - The unit of service is per fetus profiled.
      - Fetal biophysical profile assessments for the second and any additional fetuses, may be reported separately by code 76818 or 76819 with modifier -59 or -XS appended.[12]
      - For twins with non-stress testing, report 76818 x 1 and 76818-XS x 1.

G. Labor Management

1. Labor management includes the following services. Do not separately report them:
   a. Integrated decision making to:
      i. Assess and support the pregnant mother and fetus(es).
      ii. Manage medical conditions or complications.
      iii. Optimize outcomes through delivery.
   b. Interim examinations.
   c. Physiologic data collection and interpretation.
   d. Induction or augmentation methods such as cervical ripening, prostaglandins, oxytocin, and amniotomy.

2. Report labor management codes for initial and subsequent day services provided to a pregnant patient admitted to a facility, such as a hospital or birthing center. Apply the following reporting rules:
   a. A face-to-face encounter with the pregnant mother is required to bill labor management. Phone orders are not sufficient to support labor management procedure codes.
   b. Report labor management once per calendar date.
   c. A continuous visit spanning two calendar dates is reported as one service on one of those dates.
   d. Multiple visits by the same physician, QHP, or same group practice in the same setting on the same calendar date are reported as one labor management service.
      i. When a physician or other QHP is on call for or covering for another physician or other QHP, regardless of specialty or group, the encounter is classified as it would have been for the unavailable physician or other QHP.
      ii. Advanced practice nurses (including certified nurse midwives) and physician assistants are working with physicians are considered to be working in **the exact same specialty and subspecialty** as the physician.

3. Initial day labor management (59080, 59081):
   a. Includes the E/M work for admission to the facility.
   b. May only be reported once per setting using the highest level (i.e., straightforward or complex) of labor management provided on that DOS.
   c. May be reported only when one of the following criteria is met:
      i. The first calendar date the pregnant mother requires labor management services or induction begins;
      ii. The physician or other QHP or same group practice has not previously performed labor management services during the same facility admission and stay;
      iii. The pregnant mother is transferred to a new facility after receiving labor management services at the previous facility; or
      iv. A physician or other QHP of a different specialty or subspecialty assumes care for reasons other than covering for another physician or other QHP (e.g., escalation of care for medical necessity).

      If no criterion above is met, subsequent day labor management (59082, 59083) is reported.
   d. When the pregnant mother is admitted to the facility (e.g., hospital, birthing center) for labor management during an encounter in another (initial) site of service (e.g., hospital emergency department, office), separately report an E/M service for the initial site with modifier 25 appended.[47]

4. Subsequent day labor management (59082, 59083):
   a. Do not report subsequent day labor management on the same DOS as initial day labor management.

b. May be provided on multiple DOS, provided the treatment by the physician or other QHP is intended to result in delivery.
c. Report only once per DOS. Select the code for the highest level (i.e., straightforward or complex) of labor management services provided on:
    i. Do not report subsequent labor management for the same DOS as initial labor management.
    ii. Each subsequent DOS until delivery, so long as there is a face-to-face encounter on that date.
    iii. When labor management services are performed prior to delivery on the date of delivery, both labor management and a delivery code may be billed.

5. Other Labor Management Reporting Rules:
    a. When a physician or other QHP is consulted during labor management but does not assume care for the pregnant patient or fetus(es), the consultant may report the services with an applicable E/M code, such as:
        i. Synchronous audio-video E/M (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007).
        ii. Initial hospital inpatient or observation care (99221, 99222, 99223) .
        iii. Inpatient or observation consultation (99252, 99253, 99254).
        iv. Interprofessional telephone/internet/electronic health record (99446, 99447, 99448, 99449, 99451).
    b. When a patient presents for a scheduled or planned cesarean delivery and is not in labor, a labor management code is not reported.
    c. When a hospitalized patient begins labor induction:
        i. Report initial day labor management (59080, 59081) for the calendar date labor or induction begins.
        ii. Do not report hospital inpatient and observation care services (99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236) on the same calendar date as labor management when the same physician or other QHP or another physician or other QHP in the same group practice is managing both the hospital care and labor.
    d. Multiple Gestations. For labor management of multiple gestations, report labor management only once per calendar date, regardless of the number of fetuses.

H. Levels of Labor Management

1. Labor management has two levels of service: straightforward and complex. For reporting purposes, the level is based on the condition of the pregnant patient and fetus(es), the complexity of medical decision making, and the complexity of medically necessary associated services. Labor duration does not determine the complexity, unless prolonged labor is diagnosed in documentation.

2. Report the highest level of labor management performed once per calendar date. For example, if labor management begins as straightforward, and transitions to complex labor management on the same calendar date, report only complex labor management for that date.

3. Straightforward and complex labor management are classified as follows:

Straightforward *All* the following criteria must be met for straightforward labor management	**Complex** Any labor management that does not meet every criterion for straightforward labor management. Examples:
• Singleton vertex presentation	• More than one fetus
• Routine maternal/fetal monitoring	• Fetal monitoring (e.g., 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 (e.g., 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) (e.g., acute renal failure, eclampsia)
• No previous cesarean delivery	• Maternal medical conditions (e.g., hypertension, diabetes, morbid obesity) requiring additional medical management during labor
	• Previous cesarean delivery

4. Straightforward and complex labor management procedure codes:

Code	Code Description
59080	Initial day labor management; straightforward, per day
59081	Initial day labor management; complex, per day
59082	Subsequent day labor management; straightforward, per day
59083	Subsequent day labor management; complex, per day

I. Labor Procedures

The following procedures may be reported separately in addition to labor management:

Code	Code Description
59030	Fetal scalp blood sampling
59051	Fetal monitoring during labor by consulting physician (i.e., non-attending physician) or other qualified health care professional, with interpretation and report

If ongoing concerns about fetal distress or abnormal heart rate patterns require repeated fetal scalp blood sampling in the same day, append modifier 76 or 77 as appropriate and document the medical necessity rationale.

J. Delivery Care Overview

1. Delivery care begins when labor is either:
   a. Complete: Presenting part of the fetus is visible and firmly rimmed by the vaginal introitus.
   b. Interrupted (e.g., arrest of labor is diagnosed and a subsequent decision for cesarean delivery is made).
2. Delivery care includes management of the pregnant mother and fetus(es).
3. Delivery of multiple gestations:
   a. When submitting claims for deliveries of more than one newborn, we require that all delivery charges, any global services, and any additional surgical services from the date of delivery (e.g., 58611 tubal at time of cesarean delivery) be submitted on the same claim and use the same date of delivery (due to multiple procedure reduction rules).
   b. For billing purposes, use the date of birth of the first infant as the date of service for all procedure codes associated with the delivery, even if the delivery of multiple infants spans midnight.[43, 44, 45]
4. Immediate postpartum care on the same calendar date as delivery is included in delivery care services; do not report separately. When a patient is discharged on the same calendar date as delivery care, do not separately report hospital inpatient or observation discharge day management (99238, 99239).
5. When postpartum care takes place on a calendar date after the reported delivery care date, report the appropriate E/M code.
6. Vaginal and cesarean delivery care do not include the work of labor management.
7. Outcome of Delivery Diagnosis.
   a. For each birth, include an outcome of delivery diagnosis code (category Z37) as a secondary diagnosis on the claim. [54, 55]
      i. Report outcome of delivery diagnosis codes only on the maternal claim, never on the infant's claim.
      ii. The outcome of delivery diagnosis code identifies the number of infants delivered and whether or how many were liveborn or stillborn.
   b. The ICD-10 outcome of delivery coding instruction applies to:
      i. Professional claims that report a delivery service.
      ii. Inpatient facility claims when a delivery occurs, including before admission (for example in the parking lot).
      iii. Birthing center maternal claims when a delivery occurs.
   c. Inpatient facility claims that include specified ICD-10-PCS procedure codes but do not include an outcome of delivery diagnosis code (category Z37), will deny for a missing secondary diagnosis code.
      i. Do not contact Customer Service, or your Medical Professional Relations representative, or submit a written appeal with records. These actions will not resolve the denial.
      ii. Submit a corrected claim with the addition of the appropriate outcome of delivery diagnosis code (category Z37) as a secondary diagnosis code.

K. Vaginal Delivery Care

1. Vaginal delivery begins when the fetal presenting part is visible and firmly rimmed by the vaginal introitus.
2. Vaginal delivery includes:
   a. Delivery of the fetus and placenta

b. Repair of any first- or second-degree episiotomy or spontaneous lacerations.

3. If an attempted vaginal delivery results in cesarean delivery, report only the appropriate cesarean delivery code.
4. A breech vaginal delivery may be reported with a vaginal delivery code (59431, 59432) with modifier 22.
5. For successful vaginal delivery after a previous cesarean delivery (i.e., VBAC), report 59432. If the vaginal delivery attempt is unsuccessful and repeat cesarean delivery is performed, report 59503.
6. Multiple gestations.
   a. For multiple gestations delivered vaginally, report one delivery code per fetus.
   b. Reminder: Use the first infant's date of birth as the DOS for all delivery-related procedure codes.
   c. To report a fetus(es) delivered vaginally and a fetus(es) delivered via cesarean delivery for the same pregnant mother,
      i. Use the appropriate vaginal delivery code (59431, 59432) per fetus delivered vaginally, and
      ii. Use the appropriate cesarean delivery code (59502, 59503) ***once*** regardless of the number of fetuses delivered via cesarean delivery.
   d. The appropriate multiple gestation outcome of delivery diagnosis code (Z37.2-Z37.7) must be reported.
   e. Multiple procedure fee reductions apply to multiple delivery services for multiple gestations.
      i. For each secondary delivery code, append modifiers 51 and 59 to indicate a separate newborn.
      ii. In most cases the delivery of the first newborn is considered primary and allowed at 100% and the delivery of all subsequent newborns are considered secondary and reimbursed at 50% of the contracted allowable. An exception to this rule occurs if one or more newborns are delivered vaginally and then a cesarean delivery is needed for the remaining newborn(s); in this case the cesarean delivery is more comprehensive and becomes the primary delivery procedure (100%) and the vaginal delivery(ies) are secondary and allowed at 50%.[28]
   f. Reminder: For labor management of multiple gestations, report labor management only once per calendar date, regardless of the number of fetuses.
7. Episiotomy or laceration (tear) repairs.
   a. Vaginal delivery care codes (59431, 59432) include repair of first- or second-degree episiotomy or lacerations (tears).
   b. Repair of a first- or second-degree laceration or episiotomy performed by a physician or other qualified health care professional (QHP) *not performing the vaginal delivery* may be reported with 59300.
   c. Do not report 59300 when a vaginal delivery code is also being reported by a physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice.
   d. Vaginal delivery care codes (59431, 59432) do not include repair of third- or fourth-degree episiotomy or lacerations; if performed, separately report 59433 or 59434 as applicable.
8. Delivery of placenta for vaginal deliveries

a. Do not report delivery of placenta if a vaginal delivery code is also being reported by a physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice.
b. Report delivery of placenta (59414) when it is performed by a physician or other QHP not performing the vaginal delivery and not part of the same group practice of the practitioner performing the vaginal delivery.

L. Cesarean Delivery Care

1. Cesarean delivery includes delivery of the fetus(es) and placenta(s) through the incised abdominal wall and uterus, followed by closure of the uterine and abdominal incisions.
2. Report a primary cesarean delivery (59502) for a woman who has not previously had a cesarean delivery.
3. Report a repeat cesarean delivery (59503) for a woman who has previously had a cesarean delivery.
4. Unplanned cesarean delivery - When a laboring mother (i.e., expected vaginal delivery) needs an unscheduled or unplanned cesarean delivery (primary or repeat):
   a. The cesarean delivery service begins at the decision for cesarean delivery.
   b. Both labor management and a cesarean delivery code may be reported together on the same date.
5. Planned cesarean delivery:
   a. When a patient presents for a scheduled or planned cesarean delivery and is not in labor, a labor management code is not reported.
   b. Delivery After Previous Cesarean Delivery
      i. A repeat cesarean delivery (59503) is typically a planned event and occurs without labor.
      ii. Initial or subsequent hospital inpatient or observation care services are included in a cesarean delivery. Do not separately report an E/M (99221, 99222, 99223, 99231, 99232, 99233) on the same calendar date as a repeat cesarean delivery (59503).
6. Multiple gestations.
   a. Report only ***one*** cesarean delivery code (59502, 59503) regardless of the number of fetuses delivered via cesarean delivery.
   b. When any fetus(es) are also delivered vaginally, report the appropriate delivery code (59431, 59432) for each fetus delivered vaginally in addition to the ***one*** appropriate cesarean delivery code (59502, 59503).
   c. Use the first infant's date of birth as the DOS for all delivery-related procedure codes .
   d. The appropriate multiple gestation outcome of delivery diagnosis code (Z37.2-Z37.7) must be reported.
   e. Multiple procedure fee reductions apply to multiple delivery services for multiple gestations.
      i. For each secondary delivery, append modifiers 51 and 59 to indicate a separate newborn.
      ii. In most cases the delivery of the first newborn is considered primary and allowed at 100% and the delivery of all subsequent newborns are considered secondary and reimbursed at 50% of the contracted allowable. An exception to this rule occurs if one or more newborns are delivered vaginally and then a cesarean delivery is needed for the remaining newborn(s); in this case the cesarean delivery is more comprehensive and becomes the primary delivery procedure (100%) and the vaginal delivery(ies) are secondary and allowed at 50%.[28]
   f. Reminder: For labor management of multiple gestations, report labor management only once per calendar date, regardless of the number of fetuses.

M. Other Procedures During the Same Operative Session as a Cesarean Delivery

1. Hysterectomy.
   a. Report 59504 when a subtotal or total hysterectomy is performed during the same operative session as a cesarean delivery.
   b. The hysterectomy may be performed by the same or different physician performing the cesarean delivery.
2. Report 58611 when a ligation or transection of fallopian tube(s) is performed during the same operative session as a cesarean delivery.
3. Multiple procedure reductions apply.

N. Maternal Postpartum Care

Maternal postpartum care includes ongoing, patient-specific assessments.

1. When the mother delivers during 2026 and some or all of the postpartum care occurs on or after January 1, 2027:
   a. Maternity care (global maternity or delivery-only codes) are billed on the date of delivery and include reimbursement for postpartum care.
      i. 2026 vaginal delivery codes include 49 days of all postpartum care that does not require a return to the operating room.
      ii. 2026 cesarean delivery codes include 90 days of all postpartum care that does not require a return to the operating room.
   b. All E/M codes billed by the delivering provider's TIN and specialty group within the global period of a 2026 delivery date will be denied as included in the global maternity package.
      i. This will apply to:
         1) Vaginal deliveries between November 13, 2026 and December 31, 2026.
         2) Cesarean deliveries between October 3, 2026 and December 31, 2026.
      ii. E/M services during the postpartum period that are unrelated to the delivery:
         1) Must be reported with modifier -24.
         2) E/M service during the postoperative period that is unrelated to the delivery.
         3) Any postpartum-related diagnosis code that appears on the E/M visit procedure code will result in denial of the E/M as included in the delivery.
         4) Appeals of these denials must include the full medical records from the E/M visit in question.
2. When the mother delivers on or after January 1, 2027:
   a. Report postpartum care s an evaluation and management (E/M) service.
   b. Vaginal and/or cesarean delivery care include postpartum care on the same calendar date as the delivery. Do not report a separate E/M code.
   c. Inpatient maternal postpartum care on a date following the date of delivery may be reported with the appropriate E/M code; for example, subsequent hospital inpatient or observation care service (99231, 99232, 99233), hospital inpatient or observation discharge service (99238, 99239).

O. Spontaneous Abortion (Miscarriage)

1. For medical treatment of a spontaneous abortion, any trimester, see E/M codes 98000-98015, 99202-99233.
2. For surgical treatment of a spontaneous abortion, any trimester, see 59200, 59812.

P. Induced Abortion

1. For induced abortion procedures, see 59840 – 59857.
2. For medical treatment related to an induced abortion, see E/M codes 98000-98015, 99202-99233.

Q. Midwife Care

1. Eligible providers

a. Commercial plans:
   Our Standard Commercial Plans consider midwives to be eligible providers when they are who are licensed and certified in the state where they practice, including, but not limited to:
   i. Certified Nurse Midwife (CNM)
   ii. Nurse Practitioner Midwife (NPM, NMNP)
   iii. Certified Professional Midwife (CPM)
   iv. Certified Midwife (CM)
   v. Licensed Direct-Entry Midwife (LDM, LDEM)

b. Medicare Advantage covered midwives:[26]
   i. Certified Nurse Midwife (CNM)
   ii. Nurse Practitioner Midwife (NPM, NMNP)

c. Medicaid covered midwives:[27]
   i. Certified Nurse Midwife (CNM)
   ii. Nurse Practitioner Midwife (NPM, NMNP)
   iii. Licensed Direct-Entry Midwife (LDM, LDEM)
   Note: For questions about out-of-hospital/community births, verify benefits with the Medicaid Customer Service team.[27]

d. Medicaid also covers doula services.[31, 32, 33, 35]

2. Providers not eligible

Other types of non-licensed, non-certified midwives and/or birth support providers are not eligible providers, including, but not limited to:

a. Practical midwife.
b. Lay midwife.
c. Trained birth attendant.
d. Doulas are not eligible for standard Commercial plans or Medicare Advantage plans.[34] Some self-funded or specific employer groups may offer coverage for doula services; verify benefits online using Medical Benefit Tracker or by contacting Customer Service.

3. Provider Taxonomy and Specialty for Midwives

For billing, coding, and claims processing, all providers who furnish maternity and obstetrics care are considered to be in the same specialty, regardless of licensure level.

a. Midwives are in the exact same specialty as an MD who is also providing antepartum, labor and delivery, and postpartum care.
b. Taxonomy codes 207V00000X – Obstetrics and Gynecology (for an MD/DO) and 367A00000X – Advanced Practice Midwife are both considered to be the exact same specialty. The difference in taxonomy codes is created by a different licensure level between a midwife and a physician, not a different specialty.
c. For example, per CPT coding guidelines, when a patient is seen in the office and subsequently admitted to the hospital, all the office evaluation is included in the initial hospital visit E/M code and may not be billed separately. If the midwife saw the patient at home or in the office and determined a hospital admit to an MD care in the same Obstetric clinic was needed, the physician's E/M service

includes the midwife's E/M services in the pre-hospital setting; these are two practitioners of the same clinic and same specialty, and do not qualify for billing separate visit codes.

4. Labor Care by Midwife When Care Transferred to MD for Delivery

   A patient may labor with a midwife in attendance and then transfer to a physician for additional care and delivery, whether vaginal or cesarean.

   a. If the midwife and physician are in the same group practice (TIN), then only the physician reports labor management that day. Payment for the midwife's work that day is handled internally by the practice group's accounting.
   b. If the midwife and physician are in different group practice (different clinic name, different tax ID numbers), both the midwife and the physician report the applicable labor management code for that day.

5. Home Visits

   Report home visits for antepartum care or for postpartum care with the appropriate E/M code for the setting.

6. Home Births

   Eligible professional fees by the Certified Nurse Midwife or Nurse Practitioner Midwife are eligible for coverage. Other home birth expenses are not eligible for reimbursement and are generally excluded by the member's contract. This includes but is not limited to: travel, portable hot tubs, supplies, and transportation of equipment, etc.

R. Assistant Surgeon Charges (Single or Multiple Births)

Assistant surgeon charges are eligible for delivery codes with a CMS assistant surgeon indicator of "2" on the Medicare Physician Fee Schedule Database (MPFSDB). A maximum of one assistant surgeon is eligible for reimbursement.

When billing assistant surgeon charges, append the appropriate modifier(s) for each delivery. Assistant surgeon reimbursement is a percentage of the primary physician's contracted rate, subject to the member's contract benefits.

S. Anesthesia for unplanned cesarean delivery or hysterectomy (01967 / 01968, 01969)

When neuraxial analgesia/anesthesia (e.g., spinal, epidural) is provided for a planned vaginal delivery which ultimately results in a cesarean delivery or an emergency cesarean hysterectomy, two anesthesia procedure codes must be reported. 01967 is the primary/"parent" code, and 01968 or 01969 are the related add-on codes.

Generally, the same provider must bill add-on codes on the same DOS as the primary (parent) procedure code. However, for unplanned cesarean deliveries 01968 and 01969 are allowed when 01967 was billed on the preceding DOS or by a different provider or provider group.

Rationale:

When the neuraxial labor analgesia/anesthesia is initiated prior to midnight, and the cesarean delivery or cesarean hysterectomy is performed after midnight, the total anesthesia service is provided as a continuous service, but the two portions occur on different, sequential dates. Thus, the primary/"parent code 01967 may legitimately be billed for a different DOS immediately preceding the date for the add-on code(s).
When a cesarean delivery is performed after a lengthy vaginal labor, the vaginal neuraxial analgesia/anesthesia (01967) and the cesarean anesthesia (01968, 01696) may be performed and billed by two separate anesthesia providers.

T. Nitrous Oxide for Pain Management During Labor

1. Nitrous oxide inhaled gas for labor pain management during labor is separately reimbursable when:
   a. Performed by a physician anesthesiologist or certified registered nurse anesthetist (CRNA).
   b. Submitted with CPT code 01999 (Unlisted anesthesia procedure).[23]
   c. Maintain medical record documentation of the anesthetic procedure and services performed for review upon request.

2. Nitrous oxide during labor is not eligible for reimbursement and will be denied to provider responsibility when any of the following occur:
   a. Submitted with CPT codes:
      i. 01960 (Anesthesia for vaginal delivery only).
      ii. 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor).
      iii. 99151-99157 (Moderate conscious sedation codes).
   b. Performed by:
      i. Naturopathic physicians (NDs).
      ii. Registered nurses (RNs who are not CRNAs).
      iii. Other provider types outside of anesthesiologist or CRNA.

3. These decisions reflect published resources and consultation with a same-specialty physician. [14, 15, 16, 17, 18, 19, 20, 21, 22]

U. Birthing Centers

1. For Medicare Advantage plans, birthing centers are not an eligible provider.[29] Therefore, birthing center claims will be denied indicating not an eligible provider. Claims for a nurse midwife's professional services are eligible for coverage, even if performed at a birthing center (POS 25). [30]

2. Birthing centers cannot bill hourly charges for their facility fees. The coding described below includes immediate postpartum care for both the mother and the baby.

   Note, Medicare documentation and guidelines do not address birthing center coding and billing. Therefore in lieu of Medicare CMS guidelines, we reference Medicaid guidelines as our source for birthing center billing and coding.[13, 24]
   a. Single gestations – Report procedure code 59431 or 59432 only once for a single vaginal delivery, regardless of the number of days that the client was in the facility.
   b. For delivery of twins or multiple gestations –
      i. Oregon & Alaska plans:
         1) Report procedure code 59431 or 59432 for the delivery of the first twin.
         2) On a separate line item, report procedure code 59431 or 59432 with a modifier indicating a separate and distinct procedure (e.g. -XS, -59) for the delivery of the second twin.
         3) Do not report additional codes or units, regardless of the number of days that the client was in the facility.
      ii. Texas plans:
         1) Report procedure code 59431 for the delivery of all babies. No provision is made for billing additional units for the delivery of multiple gestations in the Texas Medicaid guidelines for birthing centers.[24]
         2) Do not report additional codes or units , regardless of the number of days the client was in the facility.

c. For management of labor only –
When labor was managed in the birthing center but delivery did not result (e.g., mother was transferred to the hospital for cesarean delivery, etc.), report 59080 or 59081 for the first day, and 59082 or 59083 if labor extended to a second calendar date. Attach medical records documenting the circumstances.
d. Postpartum care. The birthing center may not submit separate charges for postpartum care. These services are included in the facility fee for the labor and delivery.
e. Newborn care. Do not submit separate charges for newborn care. These services are included in the facility fee for the delivery stay.

3. If the facility employs the midwife, a separate claim may be submitted for the midwife's professional services. List the midwife as the rendering provider (not the birthing facility) on the claim for professional services.

V. Lactation Services

1. Lactation counseling is a covered benefit for mothers on our plans. [36]
2. While the lactation counselor often interacts with the mother and baby together, and the baby does benefit from improved breastfeeding, the mother is the patient for lactation counseling or breast-feeding support services. [37]
   a. Report lactation services under the mother's name and plan, not the infant's coverage.
   b. Claims for lactation services billed under the infant's name and plan are denied, most often for a procedure to patient age conflict.
3. Lactation counselors, regardless of their type of certification, are not eligible to report evaluation and management visit procedure codes for lactation counseling services. Their licensure or certification does not include medical decision making, which must be performed as part of an E/M service, even if an E/M code selection is based upon time spent with the patient. [J]
   a. S9443 *(Lactation classes, nonphysician provider, per session*) is a specific lactation procedure code accepted on our Commercial plans. This code may be reported for one-to-one lactation counseling. A "class" can be provided to an individual or a group.
   b. For Medicaid members, consider 98960 *(Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient)*.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
AROM	Artificial Rupture Of Membranes
CM	Certified Midwife
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CPM	Certified Professional Midwife
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DO	Doctor of Osteopathic Medicine
DOB	Date of Birth

Acronym	Definition
DOS	Date of Service
HER	Electronic Health Record
E/M E&M E & M	Evaluation and Management (services, visit) (Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)
FQHC	Federally Qualified Health Center(s)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HEDIS	Healthcare Effectiveness Data and Information Set
LDEM	Licensed Direct-Entry Midwife
LDM	Licensed Direct-Entry Midwife
MD	Medical Doctor
MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MRI	Magnetic Resonance Imaging
ND	Doctor of Naturopathy (aka Naturopathic Physician)
NMNP	Nurse Midwife Nurse Practitioner (see also NPM)
NPI	National Provider Identifier
NPM	Nurse Practitioner Midwife (see also NMNP)
NST	Non-stress test, fetal
OB	Obstetric, Obstetrics, Obstetrician
OHA	Oregon Health Authority
POS	Place of Service
QHP	Qualified Healthcare Professional
RHC	Rural Health Clinic(s)
RHEA	Reproductive Health Equity Act (ORS 743A.067) [36]
RN	Registered Nurse (not advanced practice nurse license)
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
RVU	Relative Value Unit
TAC	Texas Administrative Code
VBAC	Vaginal Birth After Cesearean

Definition of Terms

Term	Definition
Antepartum Care	Antepartum care includes pregnancy management before labor begins. [50]
Delivery Care	Delivery care begins when labor is complete (presenting part of the fetus is visible and firmly rimmed by the vaginal introitus) or interrupted (e.g., arrest of labor is diagnosed and a subsequent decision for cesarean delivery is made). Delivery care includes management of the pregnant mother and fetus(es). Delivery care ends when the placenta is delivered and any incisions, episiotomies, or lacerations have been closed. [50]
High-Risk Maternity	Maternity care complicated by a documented condition during the patient’s pregnancy requiring direct face-to-face practitioner care beyond the usual service.
Labor Management	Labor management includes integrated decision making to assess and support the pregnant mother and fetus(es), manage medical conditions or complications, and optimize outcomes through delivery. [50]

Term	Definition
Lactation Consultant	A health professional who specializes in breastfeeding and in offering breast milk to infants. (paraphrased from [38])
Lactation Counseling	Education and coaching provided to the mother on a variety of topics and skills to help her more successfully breast feed her baby and navigate a variety of possible challenges. Lactation counseling can occur during later pregnancy, shortly after birth, or even several months into breast feeding. (paraphrased from [38])
Maternity Global	Services provided in uncomplicated maternity cases including antepartum care, delivery and postpartum care. (Note: applies to deliveries occurring in 2026 only.)
Maternity Period	For billing purposes, the obstetrical period begins on the date of the initial visit in which pregnancy was confirmed and extends through the end of the postpartum period (45 days after vaginal delivery; this time period only applies to deliveries occurring in 2026).
Postpartum Care	Postpartum care begins when the placenta is delivered and any incisions, episiotomies, or lacerations have been closed. Maternal postpartum care includes ongoing assessments and care tailored to the individual patient. [50]
Precipitous Delivery	The patient delivers the baby vaginally prior to admission (ambulance, parking lot, etc.) or prior to the physician/midwife's arrival.

Procedure codes (CPT & HCPCS)

Code	Code Description
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
59080	Initial day labor management; straightforward, per day
59081	Initial day labor management; complex, per day
59082	Subsequent day labor management; straightforward, per day
59083	Subsequent day labor management; complex, per day
59100	Hysterotomy, abdominal (e.g., hydatidiform mole, abortion)
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy
59130	Surgical treatment of ectopic pregnancy; abdominal pregnancy
59136	Surgical treatment of ectopic pregnancy; interstitial uterine pregnancy with partial resection of uterus
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
59160	Curettage, postpartum
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)
59300	Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)
59350	Hysterorrhaphy of ruptured uterus
59412	External cephalic version, with or without tocolysis

Code	Code Description
59414	Delivery of placenta (separate procedure)
59431	Vaginal delivery, with or without episiotomy;
59432	Vaginal delivery, with or without episiotomy; after previous cesarean delivery
59433	Repair of episiotomy or laceration; third-degree laceration
59434	Repair of episiotomy or laceration; fourth-degree laceration
59502	Cesarean delivery; primary
59503	Cesarean delivery; repeat
59504	Subtotal or total hysterectomy after cesarean delivery
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59623	Uterine tamponade (e.g., balloon, catheter, vacuum, packing material)
59812	Treatment of incomplete abortion, any trimester, completed surgically
59820	Treatment of missed abortion, completed surgically; first trimester
59821	second trimester
59830	Treatment of septic abortion, completed surgically
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
59851	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
59852	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)
59855	Induced abortion, by 1 or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856	Induced abortion, by 1 or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
59857	Induced abortion, by 1 or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)
59870	Uterine evacuation and curettage for hydatidiform mole

Modifier Definitions

Modifier	Modifier Description & Definition
Modifier 22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.
Modifier 78	**Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period:** It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of the operating/procedure room, it may be reported by adding the modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76).

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.
C. "Modifier 22 – Increased Procedural Services." Moda Health Reimbursement Policy Manual, RPM007.
D. "Therapeutic Drug Monitoring." Moda Health Medical Necessity Criteria.
E. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.
F. "Add-on Codes." Moda Health Reimbursement Policy Manual, RPM025.
G. "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003.
H. "Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures." Moda Health Reimbursement Policy Manual, RPM010.
I. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service," Moda Health Reimbursement Policy Manual, RPM027.
J. "Scope Of License For Evaluation & Management Codes," Moda Health Reimbursement Policy Manual, RPM080.
K. "Maternity Care, 2026 Guidelines," Moda Health Reimbursement Policy Manual, RPM020-B.

Resources

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45. CMS. *Medicare Benefit Policy Manual* (Pub. 100-2). Chapter 15 – Covered Medical and Other Health Services, § 20.1.A. “All expenses for surgical and obstetrical care, including preoperative/prenatal examinations and tests and post-operative/postnatal services, are **considered incurred on the date of surgery or delivery**, as appropriate. This policy applies whether the physician bills on a package charge basis, or itemizes the bill separately for these items.”
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Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
10/21/2026	Added clarification for Outcome of Delivery diagnosis. Resources updated. No policy changes.
9/9/2026	Policy split into 2026 & 2027 versions & Title updated. Added OHA Medicaid performance measurement tracking requirements. Policy fully revised for 2027 guidelines & includes pregnancies spanning 2026-2027. Link to 2026 policy added. Acronyms & Resources updated.
2/11/2026	Clarified treatment of complications during delivery, additional reimbursement for high-risk pregnancy during delivery, when Intrapartum/delivery changes to Postpartum care, defined date of delivery, DOS for multiple gestations. Acronyms & Resources updated. No policy changes.
7/14/2025	Clarification of lactation counseling services coverage under mother’s plan, scope of license, & general coding options added. Acronyms, Definition of Terms, Related Policies, & Resources updated. Minor rewording. Formatting updates. No policy changes.
8/14/2024	Updated Commercial plan coverage information for doulas/doula services. Clarified 1) reimbursement of laceration repair; 2) billing when antepartum care transfers within a group practice at some point during antepartum care; 3) diagnosis code requirements for additional antepartum visits; 4) E/M visits for treatment of postpartum complications; 5) reimbursement for surgeries during postpartum period. Updated Cross References. Formatting updates.
5/8/2024	Clarified birthing center management of labor only coding instruction are non-optional, changed “may” to “is to.” Updated information on coverage of doulas/doula services, with footnotes. Resources updated.

Date	Summary of Update
6/14/2023	Clarified coding instructions for Delivery of Multiple Gestations with various combinations of delivery methods; typos corrected. Added information re: birthing centers for Medicare Advantage claims. Resources updated.
11/9/2022	Clarified diagnosis coding requirements for additional antepartum visits, and eligible midwife providers for various lines of business. Acronyms, Related Policies, & Resources updated.
10/12/2022	Clarified reimbursement for postpartum complications and postpartum care after a high-risk pregnancy. Idaho added to Scope. Acronyms & Modifiers updated. Formatting updates. No policy changes.
4/10/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on AMA/CPT guidelines.