



Reimbursement Policy:

Obstetrical/Maternity Care Services – Professional Reimbursement Policy (Commercial, Medicare, Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RP20260030	1/01/2027	RPC (Reimbursement Policy Committee)

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. EmblemHealth will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpage on emblemhealth.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in EmblemHealth's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, EmblemHealth strives to minimize these variations.

EmblemHealth follows coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. EmblemHealth uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, EmblemHealth may deny the claim and/or recoup claim payment.

Note: EmblemHealth Medicaid plans only reimburse codes if they are found on the Medicaid fee schedules. *Codes that are not included on the Medicaid fee schedule(s) will be denied.*

Overview:

This policy outlines updated American Medical Association (AMA) coding guidelines for maternity care services, including the use of evaluation and management (E/M) codes for antepartum and postpartum care, new labor management codes, and clearer distinctions among delivery types and related procedures. Providers should review these changes to support accurate reporting and compliance for dates of service on or after January 1, 2027.

Policy Statement:

Maternity care services include care provided throughout the pregnancy-related episode of care, including antepartum care, labor management, delivery services, and postpartum care. Historically, maternity care has been reported primarily through global obstetrical codes that represent multiple components of care within a single bundled service.

Effective January 1, 2027, EmblemHealth will align reimbursement for maternity care services with applicable American Medical Association (AMA) CPT guidelines, which replace the prior global obstetric package structure with phase-based reporting for antepartum care, labor management, delivery care, and postpartum care. Reimbursement will be based on the code reported, the date of service, the provider's role in the member's care, and supporting documentation.

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Guidelines:

Maternity care services include outpatient and inpatient **antepartum care**, **labor management**, inpatient and outpatient **delivery care**, and **postpartum care**. Professional claims must be reported using the code that accurately reflects the phase of care, date of service, setting, provider role, and documented service.

Pregnancy confirmation may be reported with the appropriate evaluation and management code for the applicable setting when the service is separately supported by documentation. Services furnished by qualified nonphysician professionals who may not report evaluation and management services should be reported with the applicable service-specific code when appropriate.

Modifier TH should be appended to applicable outpatient evaluation and management services directly related to prenatal or postpartum care. Modifier TH should not be appended to labor management codes, delivery services, inpatient antepartum or postpartum days, facility fee claims, or services unrelated to pregnancy care.

Antepartum Care (Prenatal)

Antepartum care refers to pregnancy-related care provided before labor begins. These services should be reported using the appropriate evaluation and management (E/M) code based on the type and setting of the encounter. This may include office or other outpatient visits (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215), telemedicine services (98000–98015), virtual check-ins (98016), home or residence services (99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350), initial or subsequent hospital inpatient or observation services (99221, 99222, 99223, 99231, 99232, 99233), hospital inpatient or observation care that includes admission and discharge on the same date (99234, 99235, 99236), and critical care services (99291, 99292), when applicable.

Providers should append Modifier TH (*obstetrical treatment/services, prenatal, or postpartum*) only to outpatient E/M services that are directly related to prenatal care. Modifier TH should not be appended to labor management codes, delivery services, and inpatient antepartum services unrelated to pregnancy.

Antepartum fetal invasive procedures may be reported separately from antepartum E/M visits when supported by the service performed and documentation. Diagnostic imaging services, such as obstetrical ultrasound evaluation of the fetus or fetuses, including the maternal pelvis and placenta (76801–76828), and fetal magnetic resonance imaging (74712, 74713), may also be reported separately in addition to antepartum E/M services when appropriate.

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When the pregnant person is admitted to the hospital for other than labor management, as an inpatient or to observation status in the course of an encounter in another (initial) site of service (eg, hospital emergency department, office), the services in the initial site may be separately reported.

Antepartum Fetal Invasive Procedure Codes

Code	Definition
59000	Amniocentesis; diagnostic (For radiological supervision and interpretation, use 76946)
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012	Cordocentesis (intrauterine), any method (For radiological supervision and interpretation, use 76941)
59015	Chorionic villus sampling, any method (For radiological supervision and interpretation, use 76941)
59020	Fetal contraction stress test
59025	Fetal non-stress test
59070	Transabdominal amnioinfusion, including ultrasound guidance
59072	Fetal umbilical cord occlusion, including ultrasound guidance
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59076	Fetal shunt placement, including ultrasound guidance
59320	Cerclage of cervix, during pregnancy; vagina
59325	Cerclage of cervix, during pregnancy; abdominal
59412	External cephalic version
59866	Multifetal pregnancy reduction(s) (MPR)
59871	Removal of cerclage suture under anesthesia (other than local)

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Medicaid Antepartum Billing Requirements

New York State (NYS) Medicaid requires NYS Medicaid-enrolled providers that render antepartum, postpartum, labor, and delivery services to follow the guidance below for services provided to individuals **who begin prenatal care on or after June 1, 2026, and/or have an estimated due date on or after January 1, 2027:**

- Report Evaluation and Management (E/M) CPT codes with Modifier TH;
- Include pregnancy-related **O** or **Z** ICD-10 diagnostic codes for all prenatal visits; *and*
- Report Category II CPT code 0500F for the initial prenatal visit.

A TH modifier must be appended to CPT E/M codes used to report routine antepartum care for dates of service on or after June 1, 2026, as shown in the table below:

CPT Code	CPT Description
99202	Office Or Other Outpatient Visit for New Patient
99203	Office Or Other Outpatient Visit for New Patient
99204	Office Or Other Outpatient Visit for New Patient
99205	Office Or Other Outpatient Visit for New Patient
99211	Office Or Other Outpatient Visit for Established Patient
99212	Office Or Other Outpatient Visit for Established Patient
99213	Office Or Other Outpatient Visit for Established Patient
99214	Office Or Other Outpatient Visit for Established Patient
99215	Office Or Other Outpatient Visit for Established Patient
99341	Residence Visit For New Patient With Straightforward
99342	Residence Visit For New Patient With Low Level
99344	Residence Visit For New Patient With Moderate Level
99345	Residence Visit For New Patient With High Level
99347	Residence Visit For Established Patient With Straightforward
99348	Residence Visit For Established Patient With Low Level
99349	Residence Visit For Established Patient With Moderate Level
99350	Residence Visit For Established Patient With High Level
99417	Prolonged Outpatient Service, Each 15 Minutes

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Bundled/Global CPT codes that will be deleted and unavailable when service dates include dates on or after January 1, 2027:

CPT Code	CPT Description
59400	Vaginal delivery with antepartum and postpartum care
59425	Antepartum care only; four to six visits
59426	Antepartum care only; seven or more visits
59510	Cesarean delivery with antepartum and postpartum care
59610	Vaginal birth after cesarean delivery with antepartum and postpartum care
59618	Cesarean delivery after attempted vaginal delivery with antepartum and postpartum care

Labor Management

Labor management includes the clinical care and decision-making needed to support the pregnant patient and fetus(es) during labor or when preparing for birth. Providers should report labor management codes once per calendar date, based on whether the service is for the initial day or a subsequent day and whether the documented level of care is straightforward or complex.

- For each calendar date, a physician or providers within the same group practice may report only one labor management code for the same patient.
- When labor management progresses from straightforward to complex on the same calendar date, the complex labor management code is the only code that should be billed for that date.
- Hospital inpatient or observation E/M services should not be billed separately on a calendar date when the same physician, QHP, or same group practice is also responsible for both the hospital care and labor management.
- Labor management should not be billed separately for a planned or scheduled cesarean delivery if the member has not entered labor.
- A subsequent-day labor management code should not be submitted unless an initial-day labor management service was previously reported for the same patient during the applicable admission or setting, unless CPT guidelines support reporting a new initial service.

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Labor Management Level	General Description
Straightforward	Generally applies when labor involves a singleton vertex presentation, routine maternal and fetal monitoring, normal labor progression or routine induction/augmentation, stable medical conditions that do not require additional management during labor, and no previous cesarean delivery.
Complex	Applies when labor does not meet the straightforward criteria, including circumstances such as multiple gestation, fetal monitoring abnormalities requiring intervention, prolonged labor, labor complications, severe maternal morbidity indicators, medical conditions requiring additional management during labor, or previous cesarean delivery.

Labor Management Codes

Code	Description
59030	Fetal scalp blood sampling
59051	Fetal monitoring during labor by consulting physician or other QHP, with interpretation and report
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

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Delivery Care

Delivery care begins when labor is complete or interrupted and includes management of the patient and fetus(es) during the delivery service. Delivery care is reported separately from labor management. Immediate postpartum care provided on the same calendar date as delivery is included in the delivery service and should not be separately reported.

Vaginal Delivery

- Vaginal delivery codes encompass delivery of the fetus and placenta, as well as repair of a first- or second-degree episiotomy or spontaneous laceration when completed by the delivering physician or QHP.
- When clinically documented and otherwise supported, repair of a third- or fourth-degree episiotomy or laceration may be eligible for separate reporting with the appropriate repair code.
- When a vaginal delivery code is billed, separate reporting of placental delivery or repair of a first- or second-degree laceration is not appropriate by a physician or QHP in the same specialty and group practice.
- The same physician or same group practice should not report both vaginal and cesarean delivery for the same calendar date unless the circumstances involve multiple gestation and support use of both delivery methods.

Vaginal Delivery Codes

Code	Description
59300	Repair of first- or second-degree episiotomy or laceration by a physician or QHP other than the attending physician or QHP performing vaginal delivery care
59414	Delivery of placenta only
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

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Cesarean Delivery

- Primary cesarean delivery is reported for a patient who has not previously had a cesarean delivery.
- Repeat cesarean delivery is reported for a patient who has previously had a cesarean delivery.
- For a planned or scheduled cesarean delivery without labor, labor management is not separately reportable.
- For cesarean delivery of multiple gestations, report one cesarean delivery code regardless of the number of fetuses delivered by cesarean.
- Subtotal or total hysterectomy performed during the same operative session as cesarean delivery should be reported with the applicable hysterectomy-after-cesarean code.

Cesarean Delivery Codes

Code	Description
59502	Cesarean delivery; primary
59503	Cesarean delivery; repeat
59504	Subtotal or total hysterectomy after cesarean delivery

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Postpartum Care

Postpartum care consists of medically necessary follow-up services provided to the patient after delivery. Services furnished after the delivery date should be billed with the appropriate evaluation and management (E/M) code according to the setting and type of service rendered, including inpatient hospital care, observation care, discharge services, critical care, office or outpatient visits, telemedicine, virtual check-ins, or home/residence visits, when supported by documentation.

- Routine postpartum services furnished on the same calendar date as the delivery are considered part of the delivery care and are not reimbursed separately.
- Postpartum services reported in 2027 may not qualify for separate reimbursement when the delivery and related global maternity care were performed and billed under a 2026 global obstetric code, unless the postpartum service is unrelated and independently documented.
- Uterine tamponade may be reported separately when the service is performed and supported by documentation; it should not be billed for medication-only treatment of hemorrhage.

Postpartum Codes

Code/Code Range	Description
59160	Curettage, postpartum
59350	Hysterorrhaphy of ruptured uterus
59623	Uterine tamponade
99202-99205, 99211-99215	Office or other outpatient E/M services
98000-98015, 98016	Telemedicine and virtual check-in services
99341-99345, 99347-99350	Home or residence E/M services
99231-99233, 99238-99239, 99291-99292	Subsequent hospital, discharge, and critical care services

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2026-2027 Maternity Care Split-Year Coding/Billing Scenarios

Scenario	Clinical Summary	2026 Billing	2027 Billing	Key Adjudication Rule
1. Antepartum Care in 2026; Delivery in 2027	Same provider performs 7 prenatal visits in 2026, 1 prenatal visit, labor management, vaginal delivery, and 2 postpartum visits in 2027	59426 (Antepartum Care Only; 7+ visits)	99XXX-TH (Prenatal E/M) + 5908X (Labor Management) + 5943X (Vaginal Delivery) + 99XXX-TH (Postpartum E/M Visits)	Split billing based on date of service; global maternity package deleted for 2027.
2. Antepartum Care Spans Both Years; No Delivery Yet	Same provider performs 6 prenatal visits in 2026 and 1 additional prenatal visit in 2027	59425 (Antepartum Care Only; 4-6 visits)	99XXX-TH (Prenatal E/M Visit)	2026 antepartum bundle may be billed; 2027 prenatal visits transition to E/M reporting.
3. High-Risk Pregnancy Ending in Cesarean Delivery	More than 7 prenatal visits in 2026; high-risk pregnancy continues in 2027 with preterm labor evaluations, cesarean delivery, and postpartum care	59426	99XXX-TH (Antepartum E/M Services) + 59083 (Complex Labor Management) + 5950X (Cesarean Delivery) + 99XXX-TH (Postpartum E/M Visits)	Clinical complexity is reflected through E/M levels and labor-management coding.
4. Entire Global Episode Completed in 2026	Antepartum care, delivery, and postpartum care are completed under the 2026 global package even though a routine postpartum encounter occurs after January 1, 2027	59510 (Global Cesarean Package) or applicable global code	None	Postpartum care remains included in the 2026 global package. No separate 2027 billing.
5. Group Practice Labor Management Across Multiple Dates	Provider #1 performs antepartum care; labor spans two calendar dates with providers from the same group; cesarean delivery by Provider #1; postpartum care by Provider #2	59425	59080 (Initial Day Labor Management) + 59082 (Subsequent Day Labor Management) + 5950X (Cesarean Delivery) + 99XXX-TH (Postpartum E/M)	Same-group physicians are treated as one reporting entity
6. Limited Prenatal Care in Both Years	Three prenatal visits in 2026 and three prenatal visits in 2027; delivery has not yet occurred	99XXX-TH (Individual prenatal visits-less than four visits)	99XXX-TH (Prenatal E/M Visits)	59425/59426 thresholds not met; report individual visits.

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Revision history

DATE	REVISION
9/2026	New Policy