Title: Maternity Care and Delivery Services

Policy Number: RP-023

Version Number: 2026.10.01

Medicare Advantage:	Not Applicable	Version Effective:	October 1, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	January 29, 2018
Claim Type:	CMS 1500	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

This policy provides direction for the reimbursement of delivery and newborn care, antepartum and postpartum care, and other related services, for professional provider claims under legacy global obstetric maternity billing structure. It also directs the new maternity billing model effective for deliveries on or after January 1, 2027. This policy is not meant to be all inclusive.

Reimbursement Guidelines:

Delivery Reimbursement Equivalency

The Plan will reimburse all maternity care at a comparable rate regardless of the type of birth. A blended reimbursement for uncomplicated deliveries consists of a single reimbursement for a birth, regardless of delivery method. Reimbursement rates for cesarean delivery are generally higher than those for vaginal deliveries, therefore, the blended reimbursement method will eliminate the financial incentive that may lead to cesarean sections. The codes below will apply blended reimbursement rates for delivery services when paid under the Plan's standard professional fee schedule.

Effective January 1, 2027			
Vaginal Delivery	**VBAC Delivery**	**Cesarean Delivery**	**Cesarean Repeat**
59431	59432	59502	59503
Effective Prior to January 1, 2027			
Obstetrical Care	**Cesarean Delivery**	**VBAC Delivery**	**Attempted VBAC Delivery**
59400	59510	59610	59618
59409	59514	59612	59620
59410	59515	59614	59622

Deliveries Expected on or After January 1, 2027

The American Medical Association (AMA) adopted a new coding and billing model for maternity services utilizing new Current Procedural Terminology Codes (CPT®). According to the AMA, this coding restructure reflects modern team-based obstetric care to allow accurate reporting, reduce care gaps, and provide payers with real-world care delivery visibility. The AMA also believes that the coding restructure improves transparency, data quality, and measurement by creating reliable tracking for quality improvement, risk adjustment, and population-level analysis, especially for maternal morbidity and mortality. Finally, the AMA believes that the coding restructure it supports evidence-based labor and postpartum care by aligning CPT coding with evidence-based practice, improving outcome measurement, and supporting appropriate postpartum follow-up and intervention. For deliveries expected on and after January 1, 2027, providers should utilize this new maternity billing structure which consists of four separate phases: antepartum care, labor management, delivery, and postpartum care.

Effective October 1, 2026, providers shall append modifier TH to evaluation and management (E/M) or maternity service codes to identify the patient visit/service relates directly to maternal or perinatal care.

<u>Antepartum Care</u>

Each prenatal encounter should be reported using the appropriate E/M code that matches where the visit occurred. For example,

- Office and outpatient visits: 99202-99215
- Telemedicine visits: 98000-98015, with 98016 for a virtual check-in
- Home or residence visits: 99341 to 99350
- Inpatient and observation encounters: 99221 to 99236

- Critical Care: 99291, 99292

Standard E/M rules apply which means each is leveled on medical decision making or total time. Providers shall confirm the E/M is maternity-related by reporting the appropriate ICD-10 diagnosis code(s) with the E/M procedure code. If a pregnant patient is admitted as an inpatient or to observation for something other than labor management during an encounter at another site, the service at the initial site can be reported separately, with modifier 25 on the other E/M service when appropriate.

Antepartum procedures (amniocentesis, CVS, fetal testing, etc.) may be separately reported from E/M visits.

Labor Management

Labor management is reported by calendar day using four codes (59080, 59081, 59082, 59083) split in two ways; initial or subsequent and straightforward or complex. A planned cesarean without labor management does not automatically create a labor-management service. Labor management may include activities such as interim examinations, interpretation of physiologic data, and management of labor induction or augmentation. Providers should use the following guidelines when reporting labor management:

1. Report the highest level performed on a calendar date. If labor starts straightforward and turns complex the same day, report complex only.
2. Don't report 59080 to 59083 with 99221 to 99236 on the same date when the same physician or group manages both the hospital care and the labor.
3. Initial day is reported once per facility admission, unless the patient transfers to a new facility or a different specialty assumes care for medical necessity.
4. Multiple gestations, providers should report one labor management code per calendar date, regardless of the number of fetuses.
5. No labor management code should be reported for scheduled cesarean where the patient never labors.
6. A continuous bedside visit spanning midnight is one service, reported on one of the two dates.
7. Face-to-face encounter with the parturient is strictly required for billing all labor management codes and must be documented

Interim exams, partograms, tocometric data, vital signs, pulse oximetry, and induction or augmentation methods are all included in labor management and aren't separately reportable and will not be separately reimbursed.

The Plan uses the criteria in the grid below for determining the complexity level for labor management.

Straightforward (59080, 59082)	Complex (59081, 59083)
> ALL of the following must be met: • Singleton vertex presentation • Routine material/fetal monitoring • Fetal monitoring not requiring physician intervention • Normal progression of labor or routine induction/augmentation • Stable medical conditions not requiring additional management • No previous cesarean delivery	> ANY of the following: • More than one fetus • Fetal heart rate abnormalities requiring intervention • Prolonged first or second stage of labor • Labor complications (infection, preeclampsia) • Severe material morbidity indicators • Maternal conditions requiring additional management • Previous cesarean delivery

Initial Day Labor Management (59080, 59081) may only be reported when:

1. First calendar date the parturient requires labor management or induction begins
2. Physician/QHP has not previously performed labor management during the same admission
3. Parturient is transferred to a new facility
4. A physician of a different specialty assumes care for medical necessity

Subsequent Day Labor Management (59082, 59083) is reported on:

1. Each calendar date the parturient requires labor management or induction begins
2. The calendar date of delivery (if labor management is performed)

Delivery

Delivery services (59431, 59432, 59502, 59503) include delivery care only and do not include antepartum, labor management, or postpartum care. First and second-degree laceration or episiotomy repair is included in 59431 and 59432. Third- and fourth-degree repair is not, and can be reported separately with 59433 and 59434 and the delivery service code. Hysterectomy after cesarean should be reported using 59504 with modifier 51 appended when the same physician performs both. Breech vaginal delivery should be reported with 59431 or 59432 with modifier 22 appended.

For multiple gestations, report one vaginal delivery code per fetus delivered vaginally. For cesarean deliveries, only one cesarean code should be reported regardless of how many fetuses were delivered. A repeat cesarean (59503) is typically planned without labor, so hospital inpatient and observation care on that date is included and should not be separately reported and will not be separately reimbursed. A planned primary cesarean (59502) that happens without labor does allow a separately reported E/M service on the same date.

Postpartum Care

Routine postpartum care on the delivery date is included in the delivery code. Providers should not bill a separate discharge service (99238, 99239) when the patient is discharged to home the same day as the delivery. For a facility birth, every management day after the delivery date can be reported with a subsequent hospital care code (99231 to 99233), then a discharge code on the day of discharge. Critical care days use 99291 and

99292, but these should not be reported on the same day the patient is discharged to home. Outpatient follow-up uses the standard office, telemedicine, virtual check-in, or home visit E/M codes: 99202-99215, 98000-98016, 99341-99350.

Uterine tamponade using a balloon, catheter, vacuum, or packing material (59623) doesn't include pharmacologic management of hemorrhage, only the device or material placement. Do not report 59623 for pharmacologic management of hemorrhage.

Do NOT report postpartum E/M codes on the same calendar date as delivery care. Same-day postpartum care is included in the delivery codes.

Fetal Monitoring

When fetal monitoring is provided on the same day as an E/M service by the same health care professional, the fetal monitoring (59051) is not eligible for separate reimbursement.

Deliveries Expected on or Prior to December 31, 2026

For deliveries expected on, or prior to, December 31, 2026, providers should utilize the legacy obstetric global billing guidelines outlined below. The legacy global obstetric billing structure does not apply for deliveries expected on or after January 1, 2027.

Consistent with the prior coding structure, for deliveries expected prior to December 31, 2026, the Plan reimburses at a single, global contract rate for an uncomplicated maternity case when all services have been provided by one provider or group as further detailed in this section. These services, which include antepartum, delivery, and postpartum care, are not to be reported separately. The four global obstetric codes are 59400, 59510, 59610, and 59618. Physicians will be reimbursed separately for the first visit to confirm pregnancy from the "global maternity care" and should submit a claim for this service at the time of the initial obstetric visit. Claims should include delivery date. All subsequent office visits for maternity care and delivery are considered part of the "global maternity care" package reimbursement and claims should be submitted after delivery and conclusion of postpartum services. Services not included in the global package include (but are not limited to) laboratory tests, amniocentesis, and ultrasounds. These services can be billed separately, and applicable member benefits will be applied.

Newborn Care and Associated Services

Reimbursement is made for routine in-patient care of a newborn. If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services. When reported for provider attendance at a high-risk neonatal delivery, reimbursement may be made to a provider other than the provider who performed the delivery:

For attendance at a cesarean section or attendance at a vaginal delivery, use code 99464.

- Reimbursement may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
- Any specific procedures necessary to care for the sick infant(s) should be reported under the appropriate procedure code (e.g., intubation - 31500, resuscitation - 99465).
- When attendance at delivery (99464) and resuscitation (99465) are reported by the same doctor, the charges should be combined and processed under code 99465. The allowance for the resuscitation includes the allowance for the attendance at the delivery. Modifier 25 may be reported with medical care, such as E/M services, etc.
- If a doctor other than the doctor performing the delivery reports both attendance at the delivery and daily medical care of the newborn, reimbursement may be made for both services.

Note: The guidelines above apply to claims reporting a maternity diagnosis (i.e., twin gestation, cesarean section).

Applicable codes:

31500 99221 99222 99223 99231 99232 99233 99238 99239 99460 99462 99463 99464 99465

Obstetrical Delivery and Associated Services

The following are the reimbursement guidelines for obstetrical:

- For the delivery of a viable infant at any time, regardless of the period of gestation, may be paid as a delivery; **or**
- Interruption of pregnancy after 24 weeks may be processed as a delivery; **or**
- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When re-suturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Reimbursement for obstetrical care includes reimbursement for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), reimbursement can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

Delivery Services Include	
• Admission to hospital • Admission history and physical examination • Management of uncomplicated labor	• Vaginal delivery (with or without episiotomy, with or without forceps); or • Cesarean delivery

Multiple Births

For multiple births, separate delivery reimbursement may be made for each newborn when delivery is performed vaginally. However, multiple cesarean delivery codes should not be reported for the same delivery session. When multiple fetuses are delivered by cesarean section, only one

cesarean delivery code will be reimbursed, regardless of the number of newborns delivered. Antepartum and postpartum care should be included with only one delivery code; reimbursement will be made for only a single antepartum and postpartum period, regardless of the number of newborns delivered. When appropriate, report modifier 59 to identify a distinct vaginal delivery code reported on the same date as another delivery code. Reimbursement for the obstetrical delivery performed on the same date of service includes the allowance for 59400, 59409, 59410, 59414, 59510, 59514. If any of those services are reported on the same day by the same provider or physician group, as obstetrical delivery and the charges are itemized, the Plan will combine the charges and reimburse only the delivery. The following services are considered included in a vaginal delivery or a cesarean section, or delivery after previous cesarean delivery and therefore, are not eligible for reimbursement as distinct and separate services:

- Induction of labor (e.g., PEGGELL insertion, use of Pitocin); **or**
- Augmentation of labor (e.g., use of Pitocin); **or**
- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local). Separate reimbursement may also occur for external cephalic version (59412).

If the services listed above are performed independently, reimbursement can be made under the appropriate code(s) below.

59030 59409 59412 59510 59514 59515 59610 59612 59614 59618 59620 59622 59871 59899
59400 59410

Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability. Reimbursement is allowed for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

Fetal Monitoring

Reimbursement for the delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate reimbursement may be made for fetal monitoring to a physician other than the attending physician when ANY of the following criteria are met (all separately billed procedures must be clearly and separately documented in the medical record):

- For any high-risk pregnancy including multiple gestations with complications; **or**
- For any unusual or abnormal fetal heart rate findings; **or**
- When there is a need for scalp pH; **or**
- For fetal decelerations which are recurrent and of unknown etiology; **or**
- When there are atypical fetal responses with maternal medical diseases; **or**
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

When fetal monitoring is provided on the same day as an E/M service by the same health care professional, fetal monitoring (59050, 59051) is not eligible for separate reimbursement.

When a global obstetrical care service provided exceeds normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual [e.g., as in obstetrical care for high-risk pregnancies]), the service may be given individual consideration. Additional reimbursement for such care may be made when warranted by the patient's medical condition, based on documentation in the medical record. To facilitate the processing of claims for high-risk obstetrical care, the appropriate global obstetrical care code should be reported in conjunction with modifier 22. The charge for additional reimbursement above the global obstetrical fee should reflect the additional medical care provided. Additional medical visits should not be itemized on the claim but should be documented within the patient's medical record and submitted with the claim form.

Antepartum and Postpartum Care

If the provider or physician group who performs a delivery submits itemized charges for antepartum and/or postpartum care and the delivery, the Plan will provide reimbursement for only the procedure code for a delivery (including antepartum and/or postpartum care). The Plan will consider antepartum care (59425, 59426) for reimbursement if the pregnancy is terminated by abortion, provided the delivery would have been eligible. Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of normal prenatal care. When used as a method of treatment, these injections may be reimbursed under the appropriate injection/drug codes.

Applicable codes:

59400 59410 59414 59426 59510 59514 59515 59525 59610 59612 59614 59618 59620 59622
59409 59412 59425 59430

Antepartum Care Services Include	
• Monthly visits to 28 weeks gestation • Biweekly visits to 36 weeks gestation • Weekly visits until delivery	• Routine chemical urinalysis • Obtaining the patient history (including the initial history and any subsequent history)

• Prenatal history and examination and subsequent obstetrical visits	• Obtaining and recording the weight, blood pressure, fetal heart tones
Postpartum Care Services Include	
• Hospital visits	• Office visits following Vaginal or Cesarean delivery

Coding:

Use modifier 25 to identify as service it as significant and separately identifiable from the other service(s) provided on the same day. When modifiers 22, 25 or 59 are reported, the patient's records must support its use in accordance with CPT guidelines. Effective October 1, 2026, providers shall append modifier TH to E/M or maternity service codes to identify the patient visit/service relates directly to maternal or perinatal care.

For deliveries expected on and after January 1, 2027, providers can reference the billing crosswalk in the grid below.

Old code	New Approach for Deliveries Occurring in 2027
59400 (Vaginal global)	Antepartum E/Ms + Labor mgmt (59080-59083) + Delivery (59431 or 59432) + Postpartum E/Ms
59409, 59410 (Vaginal delivery only)	59431 or 59432 + E/M code for Postpartum
59425, 59426 (Antepartum)	Individual E/M codes per visit
59430 (Postpartum only)	Individual E/M codes per visit
59510 (Cesarean global)	Antepartum E/Ms + Labor mgmt (59080-59083 if applicable) + Delivery (59502/59503) + Postpartum E/Ms
59514, 59515 (Cesarean delivery)	Delivery (59502 or 59503) + E/M code for Postpartum
59525 (Cesarean delivery add-on)	Hysterectomy after cesarean delivery (59504 as a stand-alone code)
59610, 59612, 59614 (VBAC global)	Antepartum E/Ms + Labor mgmt (59081/59083) + Delivery (59432) + Postpartum E/Ms
59618, 59620, 59622 (Global delivery-only for cesarean after failed labor)	Antepartum E/Ms + Labor mgmt (59081/59083) + Delivery (59503) + Postpartum E/Ms
59050 (Fetal Monitoring)	59051 (revised descriptor)

Reference the grid below for labor management and delivery scenarios for births occurring on or after January 1, 2027.

Scenario	What to Report
Laboring patient → Vaginal delivery	Labor management (59080-59083) + Vaginal Delivery (59431 or 59432)
Laboring patient → Unplanned C-section	Complex labor management (59081 or 59083) + Cesarean (59502 or 59503)
Scheduled C-section, no labor	Cesarean only (59502 or 59503) → NO labor management code
Scheduled C-section, labor begins	Labor management + Cesarean delivery
Primary planned C-section without labor	E/M service (99221-99233) + Cesarean (59502)
Repeat planned C-section without labor	Cesarean only (59503) → E/M included

For further information on appropriate coding for deliveries prior to January 1, 2027, please consult the Provider Manual Chapter 1 (Units 2 and 4), Chapter 2 (Units 1, 3, and 4), Chapter 4 (Units 1 and 3), Chapter 5 (Units 1, 2, and 6), and Chapter 6 (Unit 3).

Definitions:

Modifier	Definition
22	Unusual services
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day
51	Multiple Procedures
59	Distinct procedural service
TH	Obstetrical treatment/service, prenatal or postpartum

References:

- Rodriguez. C.H. (2019) A New Way of Paying For Maternity Care Aims To Reduce C-Sections.
- Medicaid and CHIP Payment and Access Commission; Medicaid Payments Initiatives to Improve Maternal and Birth Outcomes.
- Washington State Hospital Association; (2015) Reducing Elective Deliveries Prior to 39 weeks
- The American College of Obstetricians and Gynecologists (ACOG)
- AMA CPT® 2027 Maternity Care Services code changes
- American Academy of Professional Coders (AAPC)

Related Plan Policies:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-020: Preventive Medicine and Office or Outpatient Evaluation and Management Services
- RP-035: Correct Coding Guidelines
- RP-037: Emergency Evaluation and Management Coding Guidelines
- RP-046: Telemedicine and Telehealth Services
- RP-057: Evaluation and Management Services
- RP-081: Critical Care with Discharge to Home

Policy Update History:

7 / 2023	Administrative policy review with no changes in policy direction
3 / 2025	Administrative policy review with no changes in policy direction
10 / 2026	Added direction for new maternity billing structure addressing births expected on or after January 1, 2027. Merged direction from Coding Tips section on the Provider Resource Center for deliveries expected prior to January 1, 2027.

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP- 023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	March 3, 2025	**Revised Date:**	March 2025
Date Reviewed:	February 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

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REIMBURSEMENT GUIDELINES:

Newborn Care and Associated Services

The Plan will provide reimbursement for routine in-patient care of a newborn. If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services.

When reported for provider attendance at a high-risk neonatal delivery, reimbursement may be made to a provider other than the provider who performed the delivery:

- For attendance at a cesarean section or attendance at a vaginal delivery, use code 99464.
- Payment may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
- Any specific procedures necessary to care for the sick infant(s) should be reported under the appropriate procedure code (e.g., intubation - 31500, resuscitation - 99465).
- When attendance at delivery (99464) and resuscitation (99465) are reported by the same doctor, the charges should be combined and processed under code 99465. The allowance for the resuscitation includes the allowance for the attendance at the delivery. *Modifier 25 may be reported with medical care, such as evaluation and management (E/M) services, etc., to identify it as significant and separately identifiable from the other service(s) provided on the same day.
- If a doctor other than the doctor performing the delivery reports both attendance at the delivery and daily medical care of the newborn, payment may be made for both services.

***Note:** When modifier 25 is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: The above guidelines apply to claims reporting a maternity diagnosis (i.e., twin gestation, cesarean section).

Applicable codes:

31500	99221	99222	99223	99231	99232	99233	99238	99239
99460	99462	99463	99464	99465				

Obstetrical Delivery and Associated Services

The following are the Plan's reimbursement policies for obstetrical delivery and associated services:

- For the delivery of a viable infant at any time, regardless of the period of gestation, may be paid as a delivery; **or**
- Interruption of pregnancy after 24 weeks may be processed as a delivery; **or**
- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When re-suturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

The following guidelines apply to payment for multiple births:

- If the infants are delivered by the same or different methods (vaginal or cesarean section), payment should be made for one delivery for each newborn.
- Antepartum and postpartum care should be included with only one delivery code e.g., reimbursement will be made only for a single antepartum and postpartum period, regardless of the number of newborns delivered).

Applicable codes:

59400	59409	59410	59414	59510	59514

Note: Report modifier 59 to identify the delivery only code for multiple births as distinct from the global delivery codes reported on the same day. When modifier 59 is reported the patient's records must support its use in accordance with CPT guidelines.

Payment for the obstetrical delivery performed on the same date of service includes the allowance for the services listed above. If any of those services are reported on the same day by the same provider or physician group, as obstetrical delivery and the charges are itemized, the Plan will combine the charges and pay only the delivery.

The following services are considered included in a vaginal delivery or a cesarean section, or delivery after previous cesarean delivery and therefore, are not reimbursement eligible as distinct and separate services:

- Induction of labor (e.g., PEGGELL insertion, use of Pitocin); **or**
- Augmentation of labor (e.g., use of Pitocin); **or**

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- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Note: Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local).

Note: Separate reimbursement may occur for external cephalic version (59412).

If the services listed above are performed independently, payment can be made under the appropriate code(s) below.

59030	59400	59409	59410	59412	59510	59514	59515
59610	59612	59614	59618	59620	59622	59871	59899

Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability.

The Plan will allow reimbursement for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

Fetal Monitoring

Payment for the delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate reimbursement may be made for fetal monitoring to a physician other than the attending physician when ANY of the following criteria are met (all separately billed procedures must be clearly and separately documented in the medical record):

- For any high-risk pregnancy; **or**
- For multiple gestations with complications; **or**
- For any unusual or abnormal fetal heart rate findings; **or**
- When there is a need for scalp pH; **or**
- For fetal decelerations which are recurrent and of unknown etiology; **or**
- When there are atypical fetal responses with maternal medical diseases; **or**
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Note: When fetal monitoring is provided on the same day as an E/M service by the same health care professional, the fetal monitoring is not eligible for separate reimbursement. When fetal monitoring is a benefit, the fetal monitoring is included in the allowance for the E/M service, and therefore, is not separately reimbursed.

When a global obstetrical care service provided exceeds normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual [e.g., as in obstetrical care for high-risk pregnancies]), the service may be given individual consideration. Additional payment for such care may be made when warranted by the patient's medical condition, based on documentation in the medical record. In order to facilitate the processing of claims for high-risk

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obstetrical care, the appropriate global obstetrical care code should be reported in conjunction with modifier 22. The charge for additional payment above the global obstetrical fee should reflect the additional medical care provided. Additional medical visits should not be itemized on the claim; however, the additional visits should be documented within the patient's medical record. All pertinent records should be submitted with the claim form.

Applicable codes: 59050 59051

Antepartum and Postpartum Care

If the provider or physician group who performs a delivery submits itemized charges for antepartum and/or postpartum care and the delivery, the Plan will provide reimbursement for only the procedure code for a delivery (including antepartum and/or postpartum care).

The Plan will consider antepartum care (59425, 59426) for reimbursement if the pregnancy is terminated by abortion, provided the delivery would have been reimbursement eligible.

Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of the normal prenatal care. When used as a method of treatment, these injections may be paid under the appropriate injection/drug codes in accordance with the member's benefits.

Applicable codes:

59400	59409	59410	59412	59414	59425	59426	59430	59510
59514	59515	59525	59610	59612	59614	59618	59620	59622

HISTORY

DEFINITIONS:

Modifier	Definition
22	Unusual services.
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
59	Distinct procedural service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
6 / 2022	Removed MP X-17 Reference
7 / 2023	Administrative policy review with no changes in policy direction
3 / 2025	Administrative policy review with no changes in policy direction

HISTORY

Highmark Reimbursement Policy Bulletin

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Bulletin Number:	RP- 023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	July 24, 2023	**Revised Date:**	July 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA** ☒	**WV** ☒	**DE** ☒	**NY** ☒
Applicable Medicare Advantage Market	**PA** ☐	**WV** ☐	**DE** ☐	**NY** ☐
Applicable Claim Type	**UB** ☐	**1500** ☒		

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

HISTORY

REIMBURSEMENT GUIDELINES:

Newborn Care and Associated Services

The Plan will provide reimbursement for routine in-patient care of a newborn.

If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services.

When reported for provider attendance at a high-risk neonatal delivery, reimbursement may be made to a provider other than the provider who performed the delivery:

- For attendance at a cesarean section or attendance at a vaginal delivery, use code 99464.
- Payment may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
- Any specific procedures necessary to care for the sick infant(s) should be reported under the appropriate procedure code (e.g., intubation - 31500, resuscitation - 99465).
- When attendance at delivery (99464) and resuscitation (99465) are reported by the same doctor, the charges should be combined and processed under code 99465. The allowance for the resuscitation includes the allowance for the attendance at the delivery. *Modifier 25 may be reported with medical care (i.e. visits, consults, etc.) to identify it as significant and separately identifiable from the other service(s) provided on the same day.
- If a doctor other than the doctor performing the delivery reports both attendance at the delivery and daily medical care of the newborn, payment may be made for both services.

***Note:** When modifier 25 is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: The above guidelines apply to claims reporting a maternity diagnosis (i.e., twin gestation, cesarean section).

Applicable codes:

31500	99221	99222	99223	99231	99232	99233	99238	99239
99460	99462	99463	99464	99465				

Obstetrical Delivery and Associated Services

The following are the Plan's reimbursement policies for obstetrical delivery and associated services:

- For the delivery of a viable infant at any time, regardless of the period of gestation, may be paid as a delivery; **or**
- Interruption of pregnancy after 24 weeks may be processed as a delivery; **or**
- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When resuturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

The following guidelines apply to payment for multiple births:

- If the infants are delivered by the same or different methods (vaginal or cesarean section), payment should be made for one delivery for each newborn.
- Antepartum and postpartum care should be included with only one delivery code e.g. reimbursement will be made only for a single antepartum and postpartum period, regardless of the number of newborns delivered).

Applicable codes:

59400	59409	59410	59414	59510	59514

Note: Report modifier 59 to identify the delivery only code for multiple births as distinct from the global delivery codes reported on the same day. When modifier 59 is reported the patient's records must support its use in accordance with CPT guidelines.

Payment for the obstetrical delivery performed on the same date of service includes the allowance for the services listed above. If any of those services are reported on the same day by the same provider or physician group, as obstetrical delivery and the charges are itemized, the Plan will combine the charges and pay only the delivery.

The following services are considered included in a vaginal delivery or a cesarean section, or delivery after previous cesarean delivery and therefore, are not reimbursement eligible as distinct and separate services:

HISTORY

- Induction of labor (e.g., PEGGELL insertion, use of pitocin); **or**
- Augmentation of labor (e.g., use of pitocin); **or**
- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Note: Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local).

Note: Separate reimbursement may occur for external cephalic version (59412).

If the services listed above are performed independently, payment can be made under the appropriate code(s) below.

59030	59400	59409	59410	59412	59510	59514	59515
59610	59612	59614	59618	59620	59622	59871	59899

Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability.

The Plan will allow reimbursement for fetal non-stress testing (59025) or fetal contraction stress testing (59020) as distinct and separate services from the global obstetrical allowance.

Fetal Monitoring

Payment for the delivery or total obstetrical care includes the allowance for fetal monitoring during labor. However, separate reimbursement may be made for fetal monitoring to a physician other than the attending physician when ANY of the following criteria are met (all separately billed procedures must be clearly and separately documented in the medical record):

- For any high risk pregnancy; **or**
- For multiple gestations with complications; **or**
- For any unusual or abnormal fetal heart rate findings; **or**
- When there is a need for scalp pH; **or**
- For fetal decelerations which are recurrent and of unknown etiology; **or**
- When there are atypical fetal responses with maternal medical diseases; **or**
- When there is a pattern indicating fetal distress and the possible need for a cesarean section.

Note: When fetal monitoring is provided on the same day as a consultation by the same health care professional, the fetal monitoring is not eligible for separate reimbursement. When fetal monitoring is a benefit, the fetal monitoring is included in the allowance for the consultation, and therefore, is not separately reimbursed.

When a global obstetrical care service provided exceeds normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual [e.g. as in obstetrical care for high risk pregnancies]), the service may be given individual consideration. Additional payment for such care may be made when warranted by the patient's medical condition, based on

HISTORY

documentation in the medical record. In order to facilitate the processing of claims for high risk obstetrical care, the appropriate global obstetrical care code should be reported in conjunction with modifier 22. The charge for additional payment above the global obstetrical fee should reflect the additional medical care provided. Additional medical visits should not be itemized on the claim, however the additional visits should be documented within the patient's medical record. All pertinent records should be submitted with the claim form.

Applicable codes: 59050 59051

Antepartum and Postpartum Care

If the provider or physician group who performs a delivery submits itemized charges for antepartum and/or postpartum care and the delivery, the Plan will provide reimbursement for only the procedure code for a delivery (including antepartum and/or postpartum care).

The Plan will consider antepartum care (59425, 59426) for reimbursement if the pregnancy is terminated by abortion, provided the delivery would have been reimbursement eligible.

Injections given during the prenatal period for the treatment of threatened abortions or complications of pregnancy should not be considered part of the normal prenatal care. When used as a method of treatment, these injections may be paid under the appropriate injection/drug codes in accordance with the member's benefits.

Applicable codes:

59400	59409	59410	59412	59414	59425	59426	59430	59510
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DEFINITIONS:

Modifier	Definition
22	Unusual services.
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
59	Distinct procedural service.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

HISTORY

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
6 / 2022	Removed MP X-17 Reference
7 / 2023	Administrative policy review with no changes in policy direction

HISTORY

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	July 11, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA** ☒	**WV** ☒	**DE** ☒	**NY** ☒
Applicable Medicare Advantage Market	**PA** ☐	**WV** ☐	**DE** ☐	**NY** ☐
Applicable Claim Type	**UB** ☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

HISTORY

REIMBURSEMENT GUIDELINES:

Newborn Care and Associated Services

The Plan will provide reimbursement for routine in-patient care of a newborn.

If the doctor who performs the delivery also provides routine care for the newborn after delivery, reimbursement may be made for both services.

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- Payment may be made for one attendance (99464) for each newborn per delivery session (e.g., multiple births).
- Any specific procedures necessary to care for the sick infant(s) should be reported under the appropriate procedure code (e.g., intubation - 31500, resuscitation - 99465).
- When attendance at delivery (99464) and resuscitation (99465) are reported by the same doctor, the charges should be combined and processed under code 99465. The allowance for the resuscitation includes the allowance for the attendance at the delivery. *Modifier 25 may be reported with medical care (i.e. visits, consults, etc.) to identify it as significant and separately identifiable from the other service(s) provided on the same day.

- If a doctor other than the doctor performing the delivery reports both attendance at the delivery and daily medical care of the newborn, payment may be made for both services.

***Note:** When modifier 25 is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: The above guidelines apply to claims reporting a maternity diagnosis (i.e., twin gestation, cesarean section).

Applicable codes:

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Obstetrical Delivery and Associated Services

The following are the Plan's reimbursement policies for obstetrical delivery and associated services:

- For the delivery of a viable infant at any time, regardless of the period of gestation, may be paid as a delivery; **or**
- Interruption of pregnancy after 24 weeks may be processed as a delivery; **or**
- Attendance at labor (59899) by the same physician who performs the delivery is considered part of the global delivery fee and is not separately payable; **or**
- When resuturing of an episiotomy is required due to complications following a delivery, the case should be referred for medical review.

Payment for obstetrical care includes payment for vaginal delivery of the infant and delivery of the placenta. However, if the obstetrician is not present for the delivery (e.g., the infant is delivered en route to the hospital), payment can be made to the attending obstetrician for the delivery of the placenta, as well as for antepartum care and/or postpartum care, as appropriate.

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Note: Report modifier 59 to identify the delivery only code for multiple births as distinct from the global delivery codes reported on the same day. When modifier 59 is reported the patient's records must support its use in accordance with CPT guidelines.

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HISTORY

The following services are considered included in a vaginal delivery or a cesarean section, or delivery after previous cesarean delivery and therefore, are not reimbursement eligible as distinct and separate services:

- Induction of labor (e.g., PEGGELL insertion, use of pitocin); **or**
- Augmentation of labor (e.g., use of pitocin); **or**
- Removal of cervical cerclage sutures prior to delivery under local anesthesia or without anesthesia; **or**
- Methods used to alter presentation of the fetus such as internal rotation, use of forceps, etc.; **or**
- Suturing of episiotomy; **or** Fetal scalp blood sampling; **or** Fetal monitoring

Note: Separate reimbursement may occur for the removal of cerclage suture under anesthesia (other than local).

Note: Separate reimbursement may occur for external cephalic version (59412).

If the services listed above are performed independently, payment can be made under the appropriate code(s) below.

59030	59400	59409	59410	59412	59510	59514	59515
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HISTORY

Fetal Testing

The fetal non-stress test does not require the use of a pharmacologic agent. The contraction stress test requires the use of a pharmacologic agent (e.g., oxytocin) and is generally intravenously administered. These tests are used to determine fetal status and viability.

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Fetal Monitoring

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HISTORY

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
6 / 2022	Removed MP X-17 Reference

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-023		
Subject:	Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA** ☒	**WV** ☒	**DE** ☒	**NY** ☒
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59514	59515	59525	59610	59612	59614	59618	59620	59622

HISTORY

RELATED MEDICAL POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- X-17: Obstetrical Ultrasound

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy