REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Obstetrical Care-OH MCD-PY-1843	01/01/2027
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 3
E. Conditions of Coverage 6
F. Related Policies/Rules 7
G. Review/Revision History 7
H. References 7

A. Subject
Obstetrical Care

B. Background
The American Medical Association (AMA) 2027 *Current Procedural Terminology (CPT) Manual* introduced substantial changes to the reporting of maternity care services. The revised coding framework established new codes and reporting guidelines that separately describe antepartum care, labor management, delivery services, and postpartum care while providing greater specificity regarding the services included in and excluded from each component of maternity care.

These changes reflect the increasing complexity of maternity care that is individualized to member needs based on risk factors, medical comorbidities, pregnancy complications, and care transitions throughout the course of pregnancy and childbirth. The revised CPT structure is intended to more accurately represent the varying levels of care provided throughout the antepartum, labor, delivery, and postpartum periods.

This policy provides billing and reimbursement guidance for maternity care services reported under the revised CPT framework. Services should be reported using industry-standard compliant codes that accurately report the services performed and are fully supported in the medical record. Services should be appropriate to the specific medical needs of the member. Submission of claims for reimbursement will serve as the provider's certification of medical necessity for these services.

C. Definitions
- **Antepartum Care** – The management of pregnancy prior to the onset of labor.
- **Cesarean Delivery** – Delivery of the fetus and placenta through the incised abdominal wall and uterus and closure of the uterine and abdominal incisions.
- **Delivery Care** – Begins when labor is complete or interrupted (eg, arrest of labor is diagnosed and a decision for cesarean delivery is made) and includes management of a member and fetus(es) and same calendar day postpartum care.
  - **Early Term Delivery** – 37 weeks through 38 weeks of gestation.
  - **Full Term Delivery** – 39 weeks through 40 weeks of gestation.
  - **Late Term Delivery** – 41 weeks of gestation.
  - **Post Term Delivery** – 42 weeks of gestation and beyond.
- **Labor Management** – Integrated decision making to assess, support, and balance the well-being of a member in labor or preparing for birth and includes the management of medical conditions or complications (eg, cardiac or neurological conditions, diabetes, hypertension, preeclampsia, abnormal fetal heart tracings, labor dystocia).
- **Postpartum Care** – Includes ongoing assessments tailored to the member during the postpartum period of coverage as described in 42 U.S.C 139a(e) as in effect October 1, 2022.
- **Vaginal Delivery** – Begins when the presenting part of the fetus is visible and firmly rimmed by the vaginal introitus and includes delivery of the fetus and placenta, repair of first- or second-degree episiotomy or spontaneous lacerations.

D. Policy

Maternity care includes outpatient and inpatient antepartum care, labor, delivery, and postpartum care.

I. Risk Appraisal and Case Management Referral

A. The Pregnancy Risk Assessment Form (PRAF) is eligible for separate reimbursement when reported by code H1000 and appended by modifier 33 or TH to indicate that an assessment form was submitted. The PRAF may be submitted any time there is a change in condition during the pregnancy during the antepartum, labor, delivery, and postpartum stages.

B. Eligible members meeting any of the risk factors listed on the PRAF are qualified for case management services and should be referred to CareSource for further screening for those case management services.

II. Antepartum Care

A. Antepartum care is reported with the appropriate evaluation and management (E/M) codes, diagnosis codes Z34.XX, including the weeks of gestation, and modifier TH. The complexity of medical decision making (MDM) is based on the number and complexity of problems supporting the change and challenges of pregnancy.

B. Antepartum procedures, fetal invasive procedures, and diagnostic imaging may be separately reported from antepartum E/M visits.

C. If a member is admitted for labor management in the course of an E/M visit at another site (eg, emergency department office), the E/M service at the initial site may be reported with modifier 25.

III. Labor Management

Labor management is reported once per day based on length (initial day or subsequent day) and complexity (straightforward or complex) and requires a face-to-face encounter with the member. Labor management includes multiple visits by the same provider, same provider group, or on-call provider in the same setting.

NOTE: A continuous visit over the course of 2 calendar days is reported as a single service on 1 of the calendar days. For example, a visit from 11:45 pm to 12:15 am is reported as 1 unit on either the first or the second calendar day, not 1 unit on each of both days.

A. Initial day labor management is reported when **ANY** of the following is met:

1. first calendar date the member requires labor management services or induction begins
2. labor management services not previously performed by the provider or same group practice during the same facility admission and stay
3. member transfers to a new facility after receiving labor management services at a previous facility
4. provider of a different specialty assumes care for reasons other than covering for another provider (eg, escalation of care for medical necessity)

B. Subsequent day labor management is reported when labor management services are performed each additional calendar day.
C. Labor complexity is based on the highest level of service performed once per calendar day.
    1. Straightforward labor management meets **ALL** of the following:
        a. single vertex presentation
        b. routine maternal/fetal monitoring
        c. fetal monitoring (eg, heart rate) does not require physician, certified nurse midwife (CNM), APRN, or PA intervention
        d. normal progression of labor or routine labor induction or augmentation
        e. stable medical conditions (eg, well-controlled hypertension, diet-controlled diabetes) not requiring additional management during labor
        f. no previous cesarean delivery
    2. Complex labor management is reported when none of the above are met. Examples include, but are not limited to:
        a. more than 1 fetus
        b. fetal monitoring (eg, heart rate) abnormalities requiring a change in management requiring physician, CNM, APRN, or PA intervention
        c. prolonged first or second stage of labor
        d. labor complications (eg, intraamniotic infection and/or inflammation, preeclampsia)
        e. severe maternal morbidity indicator(s) (eg, acute renal failure, eclampsia)
        f. maternal medical conditions (eg, hypertension, diabetes, morbid obesity) requiring additional medical management during labor
        g. previous cesarean delivery
D. Services included and excluded in labor management (not all-inclusive):

Services included in labor management that may NOT be billed separately	Services excluded from labor management and may be billed separately
Admission history and physical	Provider consultation when that provider does not assume care for member or fetus
Admission to hospital including evaluation and management	Fetal blood scalp sampling
Medical decision making and management of medical conditions or complications	Fetal monitoring by consulting provider with interpretation and report
Interim physical examination	Complications of pregnancy unrelated to labor management
Collection and interpretation of physiologic data (eg, partograms, tocometric data, vital signs, pulse oximetry)	Surgical complications or other problems related to pregnancy
Obstetrical ultrasound when used to diagnose and/or manage conditions	Hospital and observation care visits for early term labor prior to 36 weeks gestation

under complex labor management, see D.III.C.2	
Multiple visits by the same provider, provider group, or on-call provider on the same calendar day	Conditions unrelated to pregnancy or labor management
Hospital inpatient and observation care services on the same date as labor management when the same provider or provider group is managing both the hospital care and labor	
Labor management of multiple gestations	

IV. Delivery

Delivery care begins when labor is complete or interrupted and includes management of the member and the fetus.

A. Vaginal delivery and vaginal delivery after previous cesarean (VBAC) include delivery of the fetus and placenta and the repair of first- or second-degree episiotomy or spontaneous lacerations.

B. Planned cesarean delivery reported without labor management may be reported with an E/M service on the same calendar date.

C. Unplanned cesarean delivery begins at the decision for cesarean delivery and may be reported on the same date as labor management.

D. If a vaginal delivery is attempted and cesarean delivery occurs, report only the cesarean delivery.

E. Multiple gestations
   1. For vaginal delivery, report 1 delivery code per fetus.
   2. For cesarean delivery, report 1 delivery code regardless of the number of fetuses delivered.
   3. For a fetus delivered vaginally and a fetus delivered via cesarean, report the vaginal delivery code for each fetus delivered vaginally and 1 cesarean code regardless of the number of fetuses delivered via cesarean.

F. Services included and excluded in delivery care (may not be all-inclusive):

Services included in delivery care that may NOT be billed separately	Services excluded from delivery care and may be billed separately
Vaginal delivery with or without episiotomy or forceps	Uterine tamponade
Delivery of placenta	Curettage, postpartum
Repair of second-degree episiotomy or laceration	Hysterorrhaphy of ruptured uterus
Physical examinations	Delivery of placenta only, when not reported with delivery
Recording of weight or blood pressure	Repair of third- or fourth-degree episiotomy or laceration
Routine chemical urinalysis	Rh immune globulin administration

Routine postpartum care on same day of delivery	Hysterorrhaphy
Inpatient and observation discharge day management on day of discharge	

V. Postpartum Care
Postpartum care includes ongoing visits individualized to a member's medical needs and is reported with the appropriate E/M codes, ICD-10-CM codes, and modifier TH.
A. Postpartum care on same date of service as delivery is included in the delivery and not separately reported/billed.
B. Inpatient services provided to a newborn should be reported under the appropriate newborn care E/M codes.

VI. Modifiers
A. Modifier TH is required to be appended to prenatal and postpartum E/M services.
B. Modifier UB, UC, or UD is required to be appended to the delivery code, or the claim will be denied. Deliveries with modifier UB or UD must show medical necessity, and medical documentation may be requested.
C. Modifier 25 may be appended to the initial E/M site if the member is admitted for labor management in the course of an encounter in another, initial, site of service (eg, emergency department, office).
D. Modifier 22 may be appended to the delivery code to support substantial additional work, such as a breech vaginal delivery. Documentation must be submitted with the claim demonstrating the reason and the additional work provided.

VII. Member Eligibility
If a member was not eligible for Medicaid prior to delivery and became eligible due to a live birth, only delivery and postpartum care is reimbursable. Antepartum care (including laboratory services), hospital admission services, normal hospital E/M visits, and labor management services are not reimbursable.

E. Conditions of Coverage

Reimbursement policies are designed to assist providers when submitting claims to CareSource and are routinely updated to promote accurate coding and policy clarification. Reimbursement will be established based on a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify members' eligibility.

Submission of claims for reimbursement will serve as the provider's certification of medical necessity for these services. Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Codes referenced in this policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Please refer to the individual fee schedule for appropriate codes.

The following list of codes is provided as a reference. This list may not be all-inclusive and is subject to updates.

CPT Code	Description
E/M	Antepartum and postpartum care
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
59431	Vaginal delivery, with or without episiotomy
59502	Cesarean delivery, primary
59503	Cesarean delivery, repeat
Modifiers	**Description**
22	Increased procedural service
25	Significant, separately identifiable E/M service by the same provider on the same day of the procedure or other service
UB	Medically necessary delivery prior to 39 weeks of gestation
UC	Delivery at 39 weeks of gestation or later
UD	Non-medically necessary delivery prior to 39 weeks of gestation
TH	Obstetrical treatment services, prenatal or postpartum

F. Related Policies/Rules

Obstetrical Care-Hospital Inpatient Admissions

G. Review/Revision History

	DATE	ACTION
Date Issued	09/23/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2027	
Date Archived		

H. References

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Approved by ODM 10/16/2026