

Reimbursement Policy

Policy: RP-202701

Initial Effective Date: 01/01/2027

SUBJECT: Maternity Care Services

Applicability: This Reimbursement Policy will be applicable to the following Medical Mutual companies (each individually, and collectively, “Medical Mutual”) and products:

- ☒ Medical Mutual of Ohio, Medical Mutual Services, LLC (except Mutual Health Services), Medical Health Insuring Corporation of Ohio, MedMutual Life Insurance Company
 - ☒ Commercial and Marketplace (Fully-Insured and Self-Funded)
 - ☒ Medicare Advantage
- ☒ Mutual Health Services
 - ☒ Commercial (Self-Funded)

Definition:

Maternity Care Services

Maternity care services include outpatient and inpatient antepartum care, labor management, delivery care, and inpatient and outpatient postpartum care.

Antepartum Care

Antepartum care includes prenatal visits and the management of pregnancy prior to the onset of labor.

Labor Management

Labor management includes integrated decision-making and management of labor to assess, support, and balance the well-being of the pregnant person and fetus(es).

Delivery Care

Delivery care begins when labor is complete or interrupted and a delivery decision is made. Delivery care includes management of the pregnant person and fetus or fetuses during the delivery event.

Postpartum Care

Maternal postpartum care includes ongoing assessments tailored to the individual patient after delivery. Postpartum care occurring on a calendar date after the date of delivery is reported using the appropriate evaluation and management code.

Background:

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Reimbursement Policy

The purpose of this policy is to establish Medical Mutual's reimbursement requirements for maternity care services following the American Medical Association (AMA) CPT 2027 maternity care services restructure. The revised CPT framework is intended to allow maternity care to be reported more granularly across the full pregnancy episode, including antepartum care, labor management, delivery care, and postpartum care. Effective for dates of service on or after Jan. 1, 2027, Medical Mutual will reimburse maternity care services based on the separately reported component of care furnished, including antepartum care, labor management, delivery care, and postpartum care. Deleted legacy global maternity care codes will not be eligible for reimbursement for dates of service on or after Jan. 1, 2027. Pregnancies that begin prior to January 1, 2027, and continue beyond January 1, 2027, are subject to the reimbursement requirements applicable to the date each service is rendered, not the billing date for the service.

Reimbursement Policy:

Confirmation of Pregnancy

Pregnancy confirmation is reimbursable when reported with the appropriate evaluation and management (E/M) or preventive medicine code for the setting and service performed. 0500F should be billed on the initial visit in conjunction with the appropriate E/M code with the TH modifier (obstetrical treatment/services, prenatal or postpartum), plus a pregnancy-related ICD-10 diagnosis code. The use of HCPCS code 0500F is needed for quality measurements, tracking and care coordination efforts; however, it is not separately reimbursable and will not be considered for payment.

Antepartum Care

For dates of service on or after Jan. 1, 2027, antepartum care must be reported using the appropriate E/M code for the setting and level of service performed. Medical Mutual will not reimburse deleted legacy antepartum care codes for dates of service on or after Jan. 1, 2027. Modifier TH (obstetrical treatment/services, prenatal or postpartum) must be appended to E/M codes to designate pregnancy-related E/M services.

For the initial prenatal visit, CPT code 0500F should be billed in conjunction with the appropriate E/M code, along with the TH modifier and a pregnancy-related ICD-10 diagnosis code. The use of HCPCS code 0500F is needed for quality measurement, tracking, and care coordination efforts. As a reporting code, 0500F is not separately reimbursable, and reimbursement is considered included in the payment for the associated prenatal evaluation and management service.

When a pregnant patient is admitted as an inpatient or to observation status for reasons other than labor management, separately reported E/M services are reimbursable only when the service is significant and separately identifiable from other services performed on the same calendar date, and the medical record documentation supports that the service was significant and separately identifiable.

Medical records may be requested to ensure that the appropriate level of CPT E/M code is reimbursed based on the health care services provided. The E/M code(s) reported by Practitioners should best represent the services provided based on AMA documentation guidelines. Medical Mutual may deny or adjust reimbursement of the professional E/M level submitted on the claim if the documentation does not support the E/M level submitted. The Practitioner may resubmit the claim with a revised E/M code for denied claims.

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Reimbursement Policy

Labor Management

Labor management services are reimbursable when reported with the appropriate labor management code based on whether the service represents initial day or subsequent day labor management and whether the documented labor management is straightforward or complex. Labor management may be reported once per calendar date by the same physician or other qualified health care professional, or by providers of the same specialty and subspecialty within the same group practice. For multiple gestations, labor management is reported once per calendar date regardless of the number of fetuses.

Initial day labor management is eligible for reimbursement once per applicable facility admission or qualifying care transition. Medical Mutual will not separately reimburse multiple initial day labor management services during the same facility admission by the same physician or other qualified health care professional, same specialty or subspecialty, or same group practice.

Subsequent day labor management is reimbursable once per calendar date after the initial labor management date when labor management services are performed and documented. Subsequent day labor management is not separately reimbursable on the same calendar date as the initial day labor management service.

The level of labor management must be reported in accordance with AMA guidelines and supported by the patient's condition, fetal status, complexity of medical decision-making, and associated services documented in the medical record. The highest level of labor management performed may be reported once per calendar date. Medical Mutual may adjust or deny labor management services when the reported level is not supported by documentation.

Interim physical examinations, collection and interpretation of physiologic data, and labor induction or augmentation are included in labor management and are not separately reimbursable.

Hospital inpatient or observation E/M services are not separately reimbursable on the same calendar date as labor management when both services are provided by the same physician or other qualified health care professional, or by providers of the same specialty/subspecialty within the same group practice.

Labor management is not separately reimbursable when the patient presents for a scheduled or planned cesarean delivery and labor does not occur.

Delivery

Vaginal delivery services are reimbursable when reported with the appropriate delivery-only code and supported by documentation.

For multiple gestation vaginal delivery, Medical Mutual will consider reimbursement of one appropriate vaginal delivery code per fetus.

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Reimbursement Policy

Cesarean delivery services are reimbursable when reported with the appropriate cesarean delivery code. For multiple gestation cesarean delivery, only one cesarean delivery code is eligible for reimbursement, regardless of the number of fetuses delivered by cesarean section.

When one or more fetuses are delivered vaginally and one or more fetuses are delivered by cesarean delivery for the same patient, Medical Mutual will consider reimbursement of the appropriate vaginal delivery code per fetus delivered vaginally and one cesarean delivery code for the cesarean delivery.

First- and second-degree laceration repairs, episiotomy repairs, and delivery of the placenta are included in the vaginal delivery code and are not separately reimbursable when performed by the physician or other qualified health care professional reporting the vaginal delivery, or by a physician or other qualified health care professional of the same specialty or subspecialty within the same group practice.

Postpartum Care

Immediate maternal postpartum care performed on the same calendar date as delivery is included in the delivery care service and is not separately reimbursable.

Hospital inpatient or observation discharge management is not separately reimbursable when discharge occurs on the same calendar date as delivery care.

General Guidelines

Modifier 25 must be appended only when the documentation supports a significant, separately identifiable E/M service performed on the same calendar date as another procedure or service. Modifier 25 must not be used routinely or automatically. Incorrect use of Modifier 25 may result in adjustments or denials.

Medical Mutual may apply coding edits, bundling edits, frequency edits, modifier edits, duplicate claim edits, provider specialty edits, place-of-service edits, claim form edits, and documentation review to determine reimbursement. Medical Mutual may request medical records, itemized bills, operative reports, labor and delivery records, progress notes, discharge documentation, and other documentation necessary to verify the services billed.

Documentation Requirements:

Medical Mutual reserves the right to request additional documentation as part of its reimbursement process and for adherence to this Policy. Medical Mutual may deny reimbursement when it has determined that the services performed/billed are not separately payable or reimbursable regardless of coding used, a pattern of billing or other practice which has been found to be either inappropriate or excessive. Additional documentation must be made available upon request to Medical Mutual. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service as well as itemized bills. Medical Mutual also reserves the right to modify, revise, change, apply, and interpret this Policy at its sole discretion, and the exercise of this discretion shall be final and binding.

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Reimbursement Policy

NOTE: After reviewing the relevant documentation, Medical Mutual reserves the right to apply this Policy to the service, procedure, supply, product, or accommodation performed or furnished regardless of how the service, procedure, supply, product, or accommodation was coded by the Provider.

Sources of Information:

American Medical Association Publications

Revised:

01/01/2027

Policy Created

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