

Subject:	Obstetric Billing Guidelines		
Policy Number:	PO-RE-132v5		
Effective Date:	10/01/2025	Last Approval Date:	10/19/2026

I. Policy Description

This policy describes the reimbursement of obstetrical (OB) codes and the itemization of maternity care services. It also identifies which services are and are not separately reimbursable in relation to other maternity services. Please refer to your provider contract with Healthfirst for additional details.

The policy incorporates updated national coding standards and New York State (NYS) Medicaid billing guidance for maternity care. Billing will transition from the historical global obstetrical payment model to a service-level, encounter-based framework. These changes will apply for certain pregnancies beginning June 1, 2026.

Revised Structure Overview:

- Beginning June 1, 2026: Transition to encounter-based billing for certain pregnancies
- Starting January 1, 2027:
 - Global obstetrical package codes will no longer be recognized for reimbursement.
 - New obstetrical management procedure codes will be introduced.
- Antepartum and postpartum services must be reported using Evaluation and Management (E/M) codes.
- Maternity care must be reported across distinct phases:
 - Antepartum care
 - Labor management
 - Delivery
 - Postpartum care

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicaid Managed Care (MMC)	• Qualified Health Plan (QHP)
• Personal Wellness Plan (HARP)	• Medicare Advantage

Policy Scope

This reimbursement policy applies to professional obstetrical services rendered to Healthfirst members for maternity care and delivery services, reported on a CMS-1500, UB-04, or electronic equivalent.

Providers are responsible for:

- Verifying member-specific benefits
- Obtaining prior authorization or reauthorization when required

Applicability of Updated Requirements

Healthfirst providers must follow updated prenatal billing requirements for:

- Routine prenatal visits initiated on or after June 1, 2026
and/or
- Pregnancies with an estimated due date (EDD) on or after January 1, 2027. Please see [billing scenarios](#) below.

General Rule for Global Billing

Healthfirst considers the postpartum/postnatal period to be 12 weeks (84 days) following the date of vaginal or cesarean delivery. After the initial postpartum period, subsequent care should be billed with the appropriate Evaluation and Management (E/M) or procedure code, when applicable.

Category II Reporting Requirement (MMC and HARP Only)

To capture HEDIS data, providers must report the applicable Category II CPT code for the initial prenatal visit and postpartum visit.

CPT Code	Code Description
0500F	Initial Prenatal Visit
0503F	Postpartum Visit

* These codes should correspond to each visit provided within the obstetric global period being billed.

Key Requirements:

- Category II CPT codes are informational only and are not separately reimbursed.
- With the transition to individual E/M billing, Category II CPT codes **may be reported on the same claim as the E/M visit representing the applicable service.**
- A separate no-charge informational claim is **not required** when the applicable Category II CPT code is reported on the same claim as the corresponding E/M service.
- Category II CPT codes should be reported in connection with the applicable initial prenatal or postpartum visit, as appropriate.

For all other lines of business, these codes are **not required**.

Prenatal Billing Transition (Effective June 1, 2026)

Modifier TH Requirement

For routine prenatal visits billed separately using E/M codes, providers must report the appropriate E/M code with **modifier TH** and use applicable pregnancy-related O or Z ICD-10 diagnosis codes.

For pregnancies subject to the prenatal billing transition beginning June 1, 2026, routine prenatal visits that would otherwise have been incorporated into legacy bundled antepartum or global obstetric billing must be reported separately using the appropriate E/M code with modifier TH.

Modifier TH is required on all separately billed routine prenatal E/M visits and will continue to be required for applicable dates of service on and after January 1, 2027. Providers must append modifier TH to each separately billed routine prenatal E/M service line.

Diagnosis Coding Requirements

Pregnancy-related diagnosis coding must be complete, specific, and sequenced appropriately on prenatal claims. The primary diagnosis should reflect the maternity status, supervision of pregnancy, or other pregnancy-related conditions that support the routine prenatal service.

Additional diagnosis codes should be reported, as applicable, to identify trimesters, high-risk factors, pregnancy complications, comorbid conditions, or other clinically relevant circumstances supported by the medical record.

Modifier TH does not replace the requirement for proper diagnosis coding. Claims must include pregnancy-related **O or Z ICD-10 diagnosis codes** in the appropriate claim positions, supported by documentation.

Deleted or Unavailable Bundled and Global CPT Codes for Dates of Service on or After January 1, 2027

The following bundled and global CPT codes must not be billed for service dates on or after January 1, 2027:

CPT Code	Description
59400	Global vaginal delivery (antepartum, delivery, and postpartum care)
59510	Global cesarean delivery (antepartum, delivery, and postpartum care)
59610	Global VBAC (vaginal birth after previous cesarean)

59618	Global cesarean delivery following attempted VBAC
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59410	Vaginal delivery and postpartum care only
59515	Cesarean delivery and postpartum care only
59614	VBAC delivery and postpartum care only
59622	Cesarean delivery after attempted VBAC and postpartum care only
59430	Postpartum care only (separate procedure)
59409	Vaginal delivery only (without postpartum care)
59514	Cesarean delivery only (without postpartum care)
59612	VBAC delivery only (without postpartum care)
59620	Cesarean delivery only after attempted VBAC (without postpartum care)
59050	Fetal monitoring during labor by attending physician
59525	Subtotal or total hysterectomy after cesarean delivery

Additional obstetric CPT coding changes become effective January 1, 2027. Providers must follow current Healthfirst billing guidance and any subsequent coding updates that apply to dates of service in 2027 and after.

E/M Codes for Routine Antepartum Care

For separately billed routine prenatal visits, including visits subject to the June 1, 2026 transition requirements and applicable visits on or after January 1, 2027, the following CPT E/M codes may be reported with modifier TH, based on the setting, patient status, and level of service documented in the medical record.

CPT Codes	Use
99202-99205	Office or other outpatient visit codes for new patients
99211-99215	Office or other outpatient visit codes for established patients
99341, 99342, 99344, 99345	Residence visits codes for new patients
99347, 99348, 99349, 99350	Residence visits codes for established patients
99417	Prolonged outpatient service, each 15 minutes

Antepartum Care Only

For pregnancies not subject to June 1, 2026, prenatal billing transition, if the patient is treated for antepartum services only, one antepartum care-only CPT code should be reported based on the total number of antepartum visits rendered during the pregnancy:

- CPT 59425 for 4-6 visits.
- CPT 59426 for 7 or more visits.
- For 1-3 antepartum visits, report the appropriate E/M CPT code instead.

Only one antepartum care CPT code is reimbursed per pregnancy. Antepartum services are not prorated. Units billed must be one (1), and the date of service must be the date of the last antepartum visit rather than a date range.

For dates of service on or after January 1, 2027, CPT 59425 and 59426 are no longer available. Routine prenatal visits must be billed separately using the appropriate E/M codes with **modifier TH**. **Modifier TH is required on all separately billed routine prenatal visits on and after January 1, 2027.**

Antepartum Care Billing Examples:

Example 1: Antepartum care only, fewer than four visits in 2026

A member is seen for three antepartum visits in 2026, and care is transferred before delivery. Report the appropriate E/M code(s) based on documentation and visit level. Do not bill CPT 59425 or 59426.

Example 2: Antepartum care only, four or more visits completed in 2026

A member receives six antepartum visits from one provider in 2026, transfers before delivery, and all antepartum services occur before January 1, 2027. The provider may bill CPT 59425 with one unit and the date of the last antepartum visit, provided the pregnancy is not subject to the June 1, 2026, transition rule.

Example 3: Antepartum care only for a pregnancy subject to the transition rule

A member begins prenatal care on or after June 1, 2026, or has an estimated due date on or after January 1, 2027. Routine prenatal visits should be billed with the appropriate E/M code and modifier TH rather than CPT 59425 or 59426.

Obstetrical Deliveries Only

Whether prior to, at, or after 39 weeks' gestation, require the use of a modifier (U7, U8 or U9). Failure to include a U7, U8, or U9 modifier, as appropriate, on a claim will result in denial of the claim.

- U7 – Delivery less than 39 weeks for medical necessity Full payment
- U8 – Delivery less than 39 weeks electively Reduced payment
- U9 – Delivery 39 weeks or greater Full payment

Delivery and Global Billing Scenarios by Estimated Due Date (EDD)

The following examples illustrate how claims should be submitted based on the estimated due date and the applicable billing period.

Pregnancies with EDD in 2026:

Example 1: EDD in Q3 2026

- EDD August 18, 2026; first prenatal visit January 14, 2026; same provider group renders routine prenatal care, vaginal delivery, and postpartum care. Because antepartum care began before June 1, 2026, and care concludes in 2026, the existing 2026 global billing approach may apply if all global package requirements are met.

Example 2: EDD in Q4 2026, prenatal care started before June 1, 2026

- EDD November 30, 2026; first prenatal visit April 10, 2026; same provider group manages the full maternity episode. Because prenatal care was initiated before June 1, 2026, and delivery occurs in 2026, the legacy global approach may still be used if the provider or provider group delivered all components of care.

Example 3: EDD in Q4 2026, prenatal care started on or after June 1, 2026

- EDD December 20, 2026; first prenatal visit June 15, 2026. Routine prenatal visits must be billed with the appropriate E/M code and modifier TH, with pregnancy-related O or Z ICD-10 diagnosis codes. Delivery services should be billed based on the actual services rendered and the date of service in 2026.

Pregnancies with EDD in 2027:

Example 4: EDD in Q1 2027

- EDD February 5, 2027; first prenatal visit July 3, 2026. Because the pregnancy will complete in 2027, routine prenatal visits should be billed using E/M codes with modifier TH. Do not rely on bundled antepartum or global codes that will not be available for applicable 2027 dates of service.

Example 5: EDD in Q2 2027

- EDD May 12, 2027; first prenatal visit September 1, 2026. Bill prenatal visits per encounter using the appropriate E/M code with modifier TH and pregnancy-related diagnosis coding. Do not bill deleted antepartum or global codes for dates of service on or after January 1, 2027.

Example 6: EDD in Q3 2027

- EDD August 25, 2027; first prenatal visit December 10, 2026. Bill routine prenatal services using the appropriate E/M code with modifier TH. Follow applicable coding guidance in effect for 2027 dates of service for delivery and postpartum services.

For MMC and HARP, continue reporting the applicable Category II CPT code (0500F or 0503F). With encounter-based E/M billing, the applicable Category II CPT code may be reported on the same claim as the E/M visit representing that service; a separate no-charge informational claim is not required.

Labor Management and Delivery Services

Labor management codes are separated from the delivery services and may be reported separately using the applicable labor management CPT codes (59080, 59081, 59082, 59083).

Initial day labor management (59080, 59081) may only be reported **once** per setting using the highest level (i.e., straightforward or complex) of labor management provided on that calendar date.

Subsequent day labor management (59802, 59083) may be provided on multiple calendar dates.

When a patient presents for scheduled cesarean delivery and is not in labor, a labor management code is not reported.

Labor management services require face-to-face encounters and are reported by calendar date. Prolonged labor management may span across multiple dates of service.

If labor resolves or if labor is determined to be false labor, and the patient is discharged home, appropriate labor management services may be used when medically necessary and documented. Documentation of billed labor management services must reflect active physician or qualified health care professional (QHP) management of labor.

Examples may include:

- Ongoing assessment of labor progression
- Cervical change assessment
- Management of contractions
- Medical management to continue or halt labor progression.

Routine triage, observation, or brief evaluation without active labor management is not separately reportable as labor management.

Delivery Care

Delivery care begins when labor is complete or interrupted (eg, arrest of labor and subsequent decision for cesarean delivery is made).

Immediate (same calendar date) postpartum care is considered part of delivery care services and is not separately reported.

Documentation Requirements

The following information **must be** documented in the medical record by the treating/requesting provider:

- Patient's pregnancy by week of gestation
- Patient's first or subsequent pregnancy
- Gestational week(s) and day(s) (e.g., 30 weeks, 3 days) complications developed.
- Reason pregnancy is high-risk (e.g., elderly gravida, poor prenatal history)
- Underlying or pre-existing conditions (e.g., hypertension, diabetes, anemia)
- Control of gestational diabetes (e.g., diet, insulin)
- Fetal condition affecting management of pregnancy.
- and trimester

Adjudication and Appeal Process

1. Reimbursement for services will be based on the provider's contract with Healthfirst, Medicare RBRVS Fee Schedule, Medicaid Fee Schedule or at the Healthfirst Standard Fee Schedule rate.
2. Healthfirst will no longer accept claims that include modifier "P". Please ensure compliance with the correct coding and billing guidelines as you submit claims moving forward.
3. Claims submitted without the required informational Category II codes for applicable MMC and HARP services may be denied or subject to audit. Claims that do not follow the coding and billing requirements in this policy, including prenatal E/M billing and TH modifier requirements, may be denied or rejected.
4. Category II CPT codes (0500F, 0503F) are informational-only and are not separately reimbursed. For applicable MMC and HARP services, the appropriate Category II CPT code must be reported for the initial prenatal and postpartum visit, as applicable. When the corresponding service is billed using an individual E/M code, the Category II CPT code may be submitted on the same claim as that E/M service; a separate no-charge informational claim is not required.
5. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.
6. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.

II. Applicable Codes

Codes that will be **deleted** and **unavailable** when service dates include dates on or after January 1, 2027:

Code	Description	Comment
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	Monitoring, deleted as of January 1, 2027
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Bundled/Global, deleted as of January 1, 2027
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	Delivery, deleted as of January 1, 2027

59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	Partial Bundle, deleted as of January 1, 2027
59425	Antepartum care only; 4-6 visits	Partial Bundle, deleted as of January 1, 2027
59426	Antepartum care only; 7 or more visits	Partial Bundle, deleted as of January 1, 2027
59430	Postpartum care only (separate procedure)	Postpartum, deleted as of January 1, 2027
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	Bundled/Global, deleted as of January 1, 2027
59514	Cesarean delivery only;	Delivery, deleted as of January 1, 2027
59515	Cesarean delivery only; including postpartum care	Partial Bundle, deleted as of January 1, 2027
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	Surgical, deleted as of January 1, 2027
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	Bundled/Global, deleted as of January 1, 2027
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	Delivery, deleted as of January 1, 2027
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Partial Bundle, deleted as of January 1, 2027
59618	Routine obstetric care includes antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	Bundled/Global, deleted as of January 1, 2027
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	Delivery, deleted as of January 1, 2027
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	Partial Bundle, deleted as of January 1, 2027

Codes that have been added or will continue to be used for 2027:

Code	Description	Comment
59051	Fetal monitoring during labor by consulting physician	New Code for 2027- Refined to clarify use by non-attending providers
59080	Initial day labor management; straightforward, per day (Do not report 59080 in conjunction with 59081, for the same calendar date)	Labor Management Codes
59081	Initial day labor management; complex, per day (Do not report 59080, 59081 in conjunction with 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236)	Labor Management Codes
59082	Subsequent day labor management; straightforward, per day (Do not report 59082 in conjunction with 59083, for the same calendar date)	Labor Management Codes
59083	Subsequent day labor management; complex, per day (Do not report 59082, 59083 in conjunction with 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236)	Labor Management Codes
59300	Episiotomy or vaginal repair, by other than attending physician	New Code for 2027- Clarified as a standalone repair
59412	External cephalic version	New Code for 2027- Removed "with or without tocolysis"
59414	Delivery of placenta (separate procedure)	New Code for 2027- Standardized for use without global bundles
59431	Vaginal delivery, with or without episiotomy	Delivery-Only Codes
59432	after a previous cesarean	Delivery-Only Codes
59433	Repair of third-degree vaginal/perineal laceration or episiotomy	Specialized Surgical & Repair Codes
59434	Repair of fourth-degree vaginal/perineal laceration or episiotomy	Specialized Surgical & Repair Codes
59502	Cesarean delivery; primary	Delivery-Only Codes
59503	For patients with a history of previous cesarean delivery (Repeat	Delivery-Only Codes

59504	Subtotal or total Hysterectomy following cesarean delivery	Specialized Surgical & Repair Codes
59623	Uterine tamponade (eg, balloon, catheter, vacuum, or packing material)	Specialized Surgical & Repair Codes
59898	Unlisted laparoscopy procedure, maternity care and delivery	New Code 2027
59899	Unlisted procedure, maternity care and delivery	New Code 2027
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	

99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.	
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	

99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	
0503F	Postpartum care visit (Prenatal)	

III. Definitions

Term	Meaning
CPT II Codes	CPT Category II codes are supplemental tracking codes that can be used for performance measurement. The use of the tracking codes for performance measurement will decrease the need for record abstraction and chart review and thereby minimize administrative burdens on physicians and other health care professionals.

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

AMA CPT® 2027 Maternity Care Services Code Changes
New York State Medicaid Update - May 2025 Volume 41 - Number 5
American College of Obstetricians and Gynecologists Statement, Payment for Obstetric Services
American Medical Association Webinar and Slides
American Medical Association RUC recommendations, minutes and voting
American Medical Association RUC Recommendations for CPT 2027

VI. Revision History

Revision Date	Summary of Changes
10/19/2026	<ul style="list-style-type: none"> Clarified that, with the transition to individual E/M billing, applicable Category II CPT codes (0500F and 0503F) may be reported on the same claim as the corresponding E/M visit and are no longer required to be submitted on separate no-charge informational claims. Clarified that modifier TH is required on all separately billed routine prenatal visits, including applicable services on and after January 1, 2027. Updated Category II reporting, prenatal E/M billing, billing examples, and adjudication language throughout the policy for consistency with NYS Medicaid guidance.
05/18/2026	<p>Key changes include:</p> <ul style="list-style-type: none"> Added billing guidance requiring the use of appropriate E/M codes with

	<p>modifier TH for routine prenatal visits initiated on or after June 1, 2026, and for pregnancies with an estimated due date on or after January 1, 2027.</p> <ul style="list-style-type: none"> Added directions to report pregnancy-related O or Z ICD-10 diagnosis codes in the appropriate claim positions for affected prenatal services. Clarified that specified bundled and global obstetric CPT codes are not available for service dates on or after January 1, 2027. Retained existing informational Category II reporting requirements for MMC and HARP prenatal and postpartum visits. Added billing examples for antepartum-only services and for pregnancies with estimated due dates in 2026 and 2027.
3/16/2026	<ul style="list-style-type: none"> Category II CPT billing are only applicable to the MMC and HARP LOB Antepartum Care Only Billing <ul style="list-style-type: none"> Antepartum services are no longer prorated. Providers must bill based on the total number of antepartum visits rendered during the pregnancy. Only one antepartum care CPT code (59425 or 59426) will be reimbursed per pregnancy. Claims must be billed using the date of the last antepartum visit as the date of service, rather than a date range. Units billed must be one (1) for CPT codes 59425 and 59426. CPT code selection is based on total visit count: <ul style="list-style-type: none"> CPT 59425 for up to six (6) antepartum visits CPT 59426 for seven (7) or more antepartum visits Confirmatory visits may be billed separately when the antepartum record has not been initiated. For one (1) to three (3) visits, providers must continue to report the appropriate Evaluation and Management (E&M) CPT codes.
11/21/2025	<p>Healthfirst, as a Medicaid Managed Care (MMC) plan, is implementing enhanced billing requirements for obstetric care in compliance with New York State Medicaid directives:</p> <ul style="list-style-type: none"> All participating providers must submit separate informational claims for each prenatal and postpartum service using CPT Category II codes—even when using global or bundled billing codes. These changes apply only to services rendered on or after July 1, 2024, for NYS Medicaid members enrolled in Healthfirst MMC plans.

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Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amount that Healthfirst or the member owes the provider.