healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Obstetric Billing Guidelines		
Policy Number:	PO-RE-132v2		
Effective Date:	10/01/2025	**Last Approval Date:**	11/21/2025

I. Policy Description

This policy describes the reimbursement of global obstetrical (OB) codes and the itemization of maternity care services. Maternity care encompasses prenatal, delivery, antepartum, and postpartum care. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services. Please refer to your provider contract with Healthfirst for additional details.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)

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 claim form or its electronic equivalent. Providers are responsible for verifying the individual member's specific plan benefits and to obtain prior authorization/ reauthorization before an item, procedure or service is rendered, if required.

Reimbursement Guidelines

1. Prenatal, Antepartum and Postpartum Care Only
   - Healthfirst will reimburse global obstetric (maternity care) package code(s) when the same provider/provider group renders the prenatal, antepartum care, delivery and postpartum care.

- Healthfirst considers the postpartum/postnatal period to be 12 weeks (84 days) following the date of the cesarean or vaginal delivery. After the initial postpartum period, subsequent care should not be covered by the global maternity codes but should be billed using the appropriate Evaluation and Management (E/M) or procedure codes, when applicable.

- When rendering global maternity care, providers should bill under the appropriate global maternity care code rather than unbundling services (i.e., reporting antepartum, delivery and postpartum services separately), when applicable. *See applicable code list under section II.*
    - To appropriately capture HEDIS data measurements, Healthfirst requires providers to report the following Category II CPT codes on a separate claim form:

CPT Code	Code Description
0500F	Initial Prenatal Visit
0502F	Subsequent Prenatal Visit
0503F	Postpartum Visit

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

- Billing Submission Guidelines:
    - Submit CPT 0500F, 0502F, and 0503F codes for each individual prenatal or postpartum visit as it occurs on a separate claim form.
    - Submit these claims in real-time (at the time of service).
    - These codes are informational only and must be submitted even when global billing codes such as 59400 or 59510 are used.
    - Do not bundle Category II codes with the global maternity claim; submit them as separate no-charge claims.

- Applicable Codes Requiring Reporting
  Global Codes must be accompanied by informational Category II CPT code claims:
    - 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622

- Antepartum-Only Codes also require separate Category II CPT code claims:
    - 59425 (4-6 visits)
    - 59426 (7+ visits)

- Billing Example:
  For a member with 8 prenatal visits, 1 post-partum visit, and a routine vaginal delivery, the reporting for each visit should include the applicable date or date range. The details for reporting are as follows:
    - 1 initial prenatal visit
    - 6 subsequent prenatal visits
    - 1 postpartum visit
    - 1 Routine vaginal delivery

- Required claim submission:

CPT Code	Units	Description
59400	1	Global OB Package (billed as standard)
0500F	1	Initial Prenatal Visit (billed separately at time of service)
0502F	6	Subsequent Prenatal Visits (separate claims per visit)
0503F	1	Postpartum Visit (billed separately)

2. Other Billing Scenarios
   - The following are instances where it is appropriate to submit a claim separately for prenatal, delivery and/or postpartum services:
     - When the member's coverage started after the pregnancy started.
     - When the member's coverage terminates before the delivery.
     - When the pregnancy does not result in a delivery.
     - When the member care is transitioned to another provider in a different location before completion of the global services.
     - When, during the member's pregnancy, there is a change in the member's benefits.
     - If a provider in a different practice provides the prenatal and/or postpartum care but does not handle the delivery, the delivering provider can file a claim using the antepartum/postpartum care only codes according to how many times the provider sees the patient.

3. Antepartum Care Only

   If the patient is treated for antepartum services only, the physician and/or other health care professional should use the following CPT codes:
   - 59425 if 4-6 visits are provided.
   - 59426 if 7 or more visits are provided.
   - For cases involving 1-3 visits, please refer to the relevant Evaluation and Management (E&M) codes, i.e. 99202-99205, 99212-99215, see the applicable code section for the appropriate CPT code.

   As described by American Congress Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA), the antepartum care only codes 59425 and 59426 should be reported as described below:
   - A single claim submission of CPT code 59425 or 59426 for the antepartum care only, excluding the confirmatory visit that may be reported and separately reimbursed when the antepartum record has not been initiated.
   - The units reported should be one.
   - The dates reported should be the range of time covered. For example, if the patient had a total of 4-6 antepartum visits, then the physician and/or other health care professional should report CPT code 59425 with the "from and to" dates for which the services occurred.

   If all the antepartum care was provided, but only a portion of the antepartum care was covered under Healthfirst, then adjust the number of visits reported and the "from and to" dates to reflect when the patient became eligible under Healthfirst.

4. 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

5. 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 may be denied or subject to audit, even if the global codes are correct.

4. Category II CPT codes (0500F, 0502F, 0503F) are considered informational-only and will not be reimbursed. However, their submission is mandatory and must accompany global claims for Healthfirst members.

5. Global obstetric codes (e.g., 59400, 59510) will continue to be reimbursed when a provider or provider group delivers all components of maternity care (i.e., prenatal, delivery, and postpartum services).

6. 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.

7. 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 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.

II. Applicable Codes

Code	Description	Comment
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	
59409	Vaginal delivery only (with or without episiotomy and/or forceps	
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	
59425	Antepartum care only; 4-6 visits	
59426	Antepartum care only; 7 or more visits	
59430	Postpartum care after vaginal delivery, including postpartum examination, with or without pelvic or perineal repair	
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	
59514	Cesarean delivery only	
59515	Cesarean delivery only; including postpartum care	
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	
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.	
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.	
0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)	
0502F	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]	
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

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

New York State Medicaid Update June 2024 Volume 40 # 6

VI. Revision History

Revision Date	Summary of Changes
11/21/2025	Healthfirst, as a Medicaid Managed Care (MMC) plan, is implementing enhanced billing requirements for obstetric care in compliance with New York State Medicaid directives: • **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.

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 amounts that Healthfirst or the member owes the provider.