

TITLE:	OBSTETRICAL/MATERNITY SERVICES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	01/01/2027
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

- 3.1. **Antepartum Services** Prenatal obstetrical care furnished before delivery and reported with the appropriate evaluation and management code based on the setting, service level, and documentation for each encounter.
- 3.2. **Labor Management** Physician or other qualified health care professional management of labor reported with the applicable CPT labor management code when performed and supported by documentation.
- 3.3. **Postpartum Services** Obstetrical care furnished after delivery. Routine postpartum care on the delivery date is included in delivery reporting. Postpartum services furnished on later dates are reported with the appropriate evaluation and management code under the 2027 CPT structure.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical

record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

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Reimbursement Guidelines

Coding and Reimbursement Structure

Effective for dates of service on and after January 1, 2027, Curative will apply the 2027 CPT obstetrical and maternity reporting structure. Deleted global maternity codes and bundled antepartum or postpartum package reporting should not be used for dates of service on or after January 1, 2027. Professional obstetrical services should be reported using the appropriate antepartum evaluation and management services, labor management codes when applicable, delivery codes, and postpartum evaluation and management services as supported by the medical record.

Antepartum Services

For patients receiving antepartum care in 2026 who will deliver in 2027, report the completed routine antepartum encounters furnished in calendar year 2026 as follows:

- for 1-3 visits, report the appropriate individual E/M codes;
- for 4-6 visits or 7 or more visits, use the applicable antepartum-only code below.
- Antepartum-only claims should identify the last included 2026 encounter as the date of service; billing need not be held until delivery.

59425 (Antepartum care only; 4-6 visits)

59426 (Antepartum care only; 7 or more visits)

For all antepartum encounters furnished on or after January 1, 2027, use visit/service-based reporting regardless of the date of the first prenatal visit or confirmation of pregnancy:

Report the appropriate evaluation and management (E/M) code for the encounter and setting, such as office or other outpatient services (99202-99215), hospital inpatient or observation services, home or residence services, or telemedicine services, when applicable and covered. For qualified health care professionals who may not report E/M services, report the appropriate service-specific code.

Curative requires HCPCS modifier TH for prenatal and postpartum office or other outpatient E/M visits to identify maternity-related services. Modifier TH alone does not determine preventive status, coverage, or member cost-sharing; processing also depends on the service, diagnosis, member benefit plan, and applicable requirements.

Claims must include the appropriate first-listed ICD-10-CM diagnosis and additional diagnosis codes supported by the encounter. For routine prenatal care without complications, use the appropriate Z34 code; do not report Z34 with a Chapter 15 obstetric code. Report the applicable obstetric diagnosis for complications or high-risk supervision when documented. Add a Z3A weeks-of-gestation code when applicable under ICD-10-CM guidelines; do not assign Z3A for postpartum conditions, pregnancies with abortive outcomes, or elective termination of pregnancy.

Documentation must support medical decision-making or time consistent with current CPT guidelines.

The E/M level reported should reflect the service provided during the encounter, considering the presenting problem, the amount and/or complexity of data reviewed, and the risk of complications and/or morbidity or mortality associated with patient management. Appending the "TH" modifier to the E/M code differentiates the visit as related to prenatal care. Providers are responsible for ensuring that documentation accurately reflects the patient's severity and the services rendered.

Prenatal Visit Utilization and Medical Necessity: Prenatal visit frequency and modality should reflect the documented clinical needs of the patient. Routine prenatal E/M visits do not require prior authorization under this policy. Each encounter must be supported by medical record documentation and accurately coded. Curative may review utilization and request documentation supporting medical necessity; exceeding an expected visit frequency does not by itself establish that a service is not medically necessary or require a high-risk diagnosis. High-risk or complication diagnoses must be reported only when supported by the medical record.

Labor Management

Report initial day labor management as 59080 (straightforward) or 59081 (complex), and subsequent day labor management as 59082 (straightforward) or 59083 (complex), when performed and documented. These services include interim examinations, physiologic data assessment, and induction or augmentation of labor; those components are not separately reported. A face-to-face encounter is required. Multiple visits by the same physician, QHP, or same group practice in the same setting on a calendar date are reported as one service at the highest applicable complexity. A continuous encounter requiring continuous personal attendance at bedside or on the unit focused on one patient and spanning two calendar dates is reported as one service on one of those dates.

Initial labor management includes admission E/M work and may be reported only when a CPT criterion is met: the first day labor management is required or induction begins; the physician, QHP, or same group has not previously provided labor management during the admission; transfer to a new facility; or assumption of care by a different specialty or subspecialty for a

reason other than coverage. A covering clinician follows the encounter classification that would apply to the unavailable clinician. Advanced practice nurses and physician assistants working with physicians are treated as the same specialty and subspecialty. Otherwise, report subsequent labor management.

Report only the highest applicable labor complexity for the calendar date; do not report both straightforward and complex services for that date. Do not report subsequent labor management on the date initial labor management begins. Apply the CPT complexity criteria: labor duration alone does not establish complexity unless prolonged labor is diagnosed. Multiple gestations do not increase the number of labor management services reported. Do not separately report hospital inpatient or observation care codes 99221-99223 or 99231-99236 on the same date as labor management when the same physician, QHP, or same group manages both services. A significant, separately identifiable E/M service in another initial setting may be reported with modifier 25 when CPT criteria are met. Labor management may be reported with delivery care on the same date when both are performed; do not report labor management for a planned cesarean without labor. A consultant who does not assume labor management may report the appropriate E/M service; fetal monitoring by a non-attending consulting physician or QHP may be reported with 59051 when applicable.

Delivery Services

Select the 2027 delivery code matching the method and services performed: 59431 for vaginal delivery, 59432 for vaginal delivery after a previous cesarean, 59502 for primary cesarean delivery, and 59503 for repeat cesarean delivery. Report 59504 for subtotal or total hysterectomy performed after cesarean delivery during the same operative session; append modifier 51 to 59504 when the same physician performs both procedures. Do not use former global or delivery-with-postpartum descriptors.

For multiple gestations, report the appropriate vaginal delivery code for each fetus delivered vaginally, but only one cesarean delivery code regardless of the number delivered by cesarean.

For mixed delivery methods, report the applicable vaginal code per vaginally delivered fetus and one applicable cesarean code. For an unsuccessful vaginal delivery attempt followed by cesarean delivery of that fetus, report only the applicable cesarean delivery code. Labor management remains limited to the applicable daily service, regardless of the number of fetuses.

First- and second-degree episiotomy or laceration repair is included in vaginal delivery care. Third- or fourth-degree repair may be reported separately with 59433 or 59434. Apply CPT restrictions for separate reporting of placenta delivery (59414) or first-/second-degree repair (59300), including the same-group, same-specialty and subspecialty restrictions.

For planned primary cesarean delivery without labor, an appropriate hospital inpatient or observation E/M service may be separately reported on the same date when performed. For repeat cesarean delivery, the specified initial or subsequent hospital inpatient or observation E/M services are included on the delivery date. Labor management may be separately reported when labor occurs and CPT criteria are met. The former multiple-birth payment grid must not be used as a 2027 coding crosswalk. Payment remains subject to applicable benefits, contracts, and payment policies.

Postpartum Services

Routine postpartum care on the delivery date is included in delivery care. Do not separately report same-day postpartum hospital care codes 99231-99236 or discharge management codes 99238-99239. On subsequent calendar dates, report the appropriate E/M service for the setting and care provided, including subsequent hospital care, discharge management, office or other outpatient care, home or residence care, telemedicine, or critical care when applicable. Deleted postpartum package code 59430 must not be reported for dates of service on or after January 1, 2027.

Postpartum complications should be reported with the appropriate E/M or procedure code and diagnosis reflecting the services performed and the complication. Separately reportable postpartum procedures include uterine tamponade (59623), postpartum curettage (59160), and repair of a ruptured uterus (59350), when performed and supported by CPT rules. Do not report 59623 for pharmacologic management of hemorrhage alone. Non-obstetric services during the postpartum period follow the applicable CPT and diagnosis coding rules.

Transition for deliveries occurring in 2026: Any postpartum services rendered on or after January 1, 2027, that are related to a delivery occurring in 2026 are considered included in the Global OB payment for that delivery and are not separately reimbursable. This applies to routine postpartum care, management of postpartum complications, and related postpartum procedures. The transition to the 2027 CPT reporting structure does not create separate reimbursement for these services.

5. REFERENCE DOCUMENTS AND MATERIALS

- 5.1. American Medical Association, CPT 2027 Professional Edition and associated publications; Maternity Care Services codes and guidelines (early-release reference, effective January 1, 2027).
- 5.2. Centers for Medicare and Medicaid Services CY 2027 Physician Fee Schedule proposed rule

6. COLLABORATING DEPARTMENTS

- 6.1. Claims
- 6.2. Compliance
- 6.3. Medical Management
- 6.4. Network
- 6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	Author	Version	Comments
10/01/2026	CJ Wisecarver	001	Initial Version