AmeriHealth Caritas Ohio

Obstetrics

Reimbursement Policy ID: RPC.0068.7700

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes the reimbursement guidelines for submitting claims for obstetrical services, including antepartum, delivery, anesthesia, doula and postpartum services. The policy also addresses the maternity authorization waiver.

Exceptions

N/A

Reimbursement Guidelines

Pregnancy related services are reimbursable when claims are submitted accordingly. Services include education, care coordination, counseling, high risk monitoring, nurse midwife services, preconception care,

prenatal care, ultrasounds (see RPC.0038.7700), prenatal risk assessment, delivery, and transportation. This policy describes the reimbursement guidelines for submitting claims for obstetrical services, including antepartum, delivery, anesthesia and postpartum services.

A Primary Care Provider (PCP) can serve as the member's personal practitioner and is responsible for coordinating and managing the medical needs of the health plan members. Advanced nurse practitioners, nurse midwives, and licensed physicians in the following specialties may serve as Plan PCPs:

- General Practice
- Pediatrics
- Internal Medicine
- Geriatrics
- Obstetrics/gynecology (OB/GYN)
- Family Practice

OB/GYN practitioner as PCP

Participating Obstetricians are responsible for medical services during the course of the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care may include:

- Treatment of minor colds, sore throat, or asthma
- Treatment of minor injuries
- Preventative health screenings and maintenance
- Routine gynecological care

Initial prenatal visit

For purposes of billing and reimbursement, each new pregnancy (270 days) is considered a new patient whether or not the patient has been seen previously by the provider/practice.

Prenatal visits

The health plan requires the provider to submit the appropriate level evaluation and management (E/M) CPT code from the range of procedure codes used for an established patient for the subsequent prenatal visit(s). The reimbursement for these services shall include, but is not limited to:

- The obstetrical (OB) examination
- Routine fetal monitoring (excluding fetal non-stress testing)
- Diagnosis and treatment of conditions both related and unrelated to the pregnancy
- Routine dipstick urinalysis

Delivery

The health plan requires childbirth delivery procedures to be reported with weeks of gestation diagnosis (Z3A-Z3A.49). If these codes are billed without a week of gestation diagnosis the claim will be denied.

Institutional claims must reflect the appropriate ICD-10 procedure code for delivery:

ICD-10 Procedure Code	Description
10D00Z0	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Classical
10D00Z1	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Low Cervical
10D00Z2	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Extraperitoneal

10D07Z3	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Low Forceps
10D07Z4	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Mid Forceps
10D07Z5	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, High Forceps
10D07Z6	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Vacuum
10D07Z7	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Internal Version
10D07Z8	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Other
10E0XZZ	Obstetrics, Pregnancy, Delivery, Assisting the passage of products of conception from the genital canal, Products of Conception, External, No Device, No Qualifier

Professional claims must reflect the appropriate CPT code for delivery.

CPT Code	Description
59400-59410	Vaginal delivery, Antepartum and Postpartum care
59510-59515	Cesarean delivery
59610-59622	Delivery after previous Cesarean delivery

Authorization may be waived for obstetrical admissions with newborn deliveries exceeding 3 days (72 hours) after vaginal delivery and 5 days (120 hours) after cesarean section.

Postpartum
Providers should submit CPT code 59430 for postpartum visit(s).

Anesthesia
Administration of obstetrical anesthesia using these CPT codes is reimbursable for

- Neuraxial analgesia for vaginal delivery (includes repeated subarachnoid needle placement, drug injection, and necessary epidural catheter replacement during labor); or
- Anesthesia for cesarean delivery.

CPT Code	Description
01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
+01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia

For neuraxial labor analgesia, the time unit begins when the analgesic is inserted and ends at delivery. Total duration is limited to two hundred forty minutes (four hours).

Doula Services
Reimbursement for doula services is contingent upon the submission of a valid claim that includes an appropriate diagnosis code supporting the services rendered. Those diagnosis codes are

ICD-10 Code	Description
Z32.2	Encounter for Childbirth Instruction for all prenatal visits/delivery
Z32.3	Encounter for Childcare Instruction for all postpartum visits

Claims submitted without one of the required diagnosis codes could result in a claim denial.

CPT codes and modifiers applicable to maternity management services:

CPT Code & Modifier	Visit Type & Code Description	Allowed Visits
T1032	Prenatal doula visit – in person	24 Units 4 Units = 1 Visit 15 Minutes = 1 Unit
T1032 GT	Prenatal doula visit – virtual (Telehealth)	
T1032	Postpartum doula visit – in person	24 Units 4 Units = 1 Visit 15 Minutes = 1 Unit
T1032 GT	Postpartum doula visit – virtual (Telehealth	
T1033	Doula labor and birth support – in person	1 Delivery
T1023	Report of Pregnancy Form Completion	1 Form

Definitions

Antepartum
The period of time between conception and the onset of labor.

Doula
Trained professionals providing non-medical, continuous physical, emotional, and informational support to pregnant individuals before, during, and after childbirth.

Lactation Consultant
A health professional who specializes in helping women to breastfeed their babies.

Neuraxial Anesthesia
Neuraxial anesthesia and analgesia techniques include spinal, epidural, and combined spinal-epidural.

Postpartum
The period of time after the delivery of the baby.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI)
V. American Congress of Obstetricians and Gynecologists (ACOG)
VI. https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/newborns-mothers-health-protection-act.pdf

VII. https://codes.ohio.gov/ohio-administrative-code/rule-5160-4-21
VIII. https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-10
IX. https://codes.ohio.gov/ohio-administrative-code/rule-5160-8-43
X. Ohio Department of Medicaid: Office of Policy:Hospital Billing Guidelines. Revised July 26, 2021
XI. Ohio Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0038.7700 Obstetric Ultrasound

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
06/2026	Added: • CPT codes • Lactation Consultant definition
05/2026	Reimbursement Policy Committee Approval
04/2026	Added Doula Services language and Doula definition
01/2026	Reimbursement Policy Committee Approval
01/2026	Annual review • No major changes
09/2025	Updated reimbursement guidelines for Institutional and Professional claims Updated Edit Sources
06/2025	Minor updates to formatting and syntax
04/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
03/2025	Annual review • No major changes
03/2025	Updated to include • Maternity authorization waiver • Additional delivery coding requirements
11/2024	Reimbursement Policy Committee Approval
11/2024	Annual review • No major changes
10/2024	Updated to include delivery procedures and gestational age
09/2024	Reimbursement Policy Committee Approval