

Unbundled Maternity Billing Guide

Iowa Medicaid

IOWA Health and Human Services

(Updated 6/2026)

IOWA Health and Human Services

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Unbundled Maternity Billing Guide

The obstetrical claims period begins on the date of the initial visit in which **pregnancy was confirmed** and extends through the end of the postpartum period, 12 months after the date of the infant delivery.

Beginning **October 1, 2025**, the Unbundled Global Package Reimbursement method will be used for the obstetrical claims period. This method provides for individual elements to be reimbursed separately for point of care services.

The Notice of Pregnancy (NOP) form is strongly recommended to be submitted to the members identified MCO, with the Initial office visit. This form is located on each of the MCOs websites. The NOP form is considered by the MCO's as the most accurate identification of pregnancy and is the foundation to ensure the new reimbursement structure functions as intended. The NOP is intended to align clinical care, member benefits, and claims processing from the onset of pregnancy. This form initializes the MCOs claims systems immediately to apply pregnancy-related claim edits and member benefits.

While the pregnancy may later be identified through submitted claims, the reliance on claims alone can introduce timing delays or inaccuracies due to coding variations or billing errors. The early notification of pregnancy, by using this form, clarifies the pregnancy for proper claims configuration from the beginning of the members care.

Fee For Service does not utilize a Notice of Pregnancy form. No form is needed to be submitted for FFS members.

The guidance for Obstetrical Billing as of October 1, 2025, includes the directive of:

- If Iowa Medicaid, including MCOs, received a claim request to reimburse for a pregnancy test prior to October 1, 2025, BUT the woman has not attended her **first in-person** Antepartum appointment until October 1 or after, this woman's billing qualifies for the ***__required unbundled__*** process.
- Any provider office visits prior to September 2025 including and up to September 30, 2025, are not unbundled but remain in the Global Bundled Package reimbursement.

Any error in the claim reimbursement request will result in a denial of the claim and require submission of a corrected claim.

Restating the above:

Use the **Unbundled reimbursement** claim process:

- first antepartum **on or after** 10/1/25
- Member has Medicaid as primary (does NOT have any other medical coverage)

Use the **Global reimbursement** claim process:

- first antepartum or any antepartum visits **prior** to 10/1/25
- Member has primary, commercial or Medicare, insurance with Medicaid secondary

And the third clarifying statement:

Beginning October 1, 2025:

- All Iowa Medicaid members claims meeting the guidelines for Unbundled Maternity Services and do not have primary insurance, **must be billed using** the Unbundled Maternity billing guidelines below.
- For Iowa Medicaid members that meet ***the guidelines for Unbundled Maternity Services **and** have primary insurance other than Medicaid, the **bundled maternity codes** must be billed and submitted to the member's primary insurance prior to submission to Iowa Medicaid (MCOs and traditional FFS Iowa Medicaid) as indicated in the Primary Insurance section of this guide. (The members pregnancy qualified for the unbundle – but because of the Primary Insurance – it must stay Bundled.) The Bundled Process still needs to be billed for both MCO's and traditional Medicaid. Bill by the primary insurance process and then submit the same Bundled Process to MCOs and Traditional Medicaid.

A chart summary of changes:

DATE OF SERVICE	MEMBER'S PRIMARY INSURER	BILLING GUIDANCE
PRIOR TO 10/1/2025	Iowa Medicaid	• Use bundled methodology for OB services.
10/1/2025 AND BEYOND	Commercial or Medicare	• Follow primary carrier's guidelines for OB/maternal services.
10/1/2025 AND BEYOND	Iowa Medicaid	• **If the member is pregnant and has attended the first antepartum visit (or more):** Use global/bundled maternity billing. • ***If the member is pregnant but has NOT attended the first antepartum visit:** Use the new unbundled maternal health billing guidance.

Overarching Statement Regarding Bill Type

Billing unbundled maternity codes outlined in this manual should be submitted on the appropriate claim form type based on how the provider is enrolled with HHS and MCOs. Most claims will continue to be submitted on HCFA 1500 with a few exceptions for provider types that are allowed to submit on a CMS 1450.

Claim submission requires an ICD-10 pregnancy applicable code, in any position, attached to this guide.

The **Initial Antepartum** visit must be an **in-person office** visit. After the Initial Antepartum visit, the antepartum visits may be an in-person office visit or **Video** Telehealth, determined by the providers initial and continued assessments.

The Initial Antepartum visit must be in-person.
Include Category II Code 0500F on the initial antepartum visit.
The Category II Code 0500F indicates the unbundling program begins.

When Maternal Fetal Medicine (MFM) Providers are brought in to consult, this process is followed by the MFM provider. There are **no PA's required**, so no counting of visits is needed.
The codes identified below must be **submitted with the TH Modifier** for claims submitted by the MFM providers and the proper Telehealth identifier on the claim (when the visit is completed by telehealth) for reimbursement.

The Telehealth List is updated and on Medicaid Website. (Medicaid Fee Schedules)

Definition of an Established Patient: an individual who has received professional services from the same physician or healthcare provider within the past three year.

Provider Antepartum visit claim submission is per date of service:

Code	Modifier	Description
99202	**TH and Category II Code 0500F**	Office visit for the evaluation and management of a **new** patient, which requires: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. 20 minutes face-to-face with the patient and/or family must be met or exceeded **Must be In-person office appointment**
99203	**TH and Category II Code 0500F**	Office visit for the evaluation and management of a **new** patient, which requires: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. 30 minutes face-to-face with the patient and/or family must be met or exceeded **Must be In-person office appointment**
99204	**TH and Category II Code 0500F**	Office visit for the evaluation and management of a **new** patient, which requires: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The presenting problem(s) is/are of moderate to high severity. 45 minutes face-to-face with the patient and/or family must be met or exceeded. **Must be In-person office appointment**

Code	Modifier	Description
99205	**TH and Category II Code 0500F**	Office visit for the evaluation and management of a **new** patient, which requires: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The presenting problem(s) is/are of moderate to high severity.

Code	Modifier	Description
		60 minutes face-to-face with the patient and/or family must be met or exceeded. **The initial appointment (new pregnancy) must be in-person.**
99211	**TH**	Office visit for the evaluation and management of an **established** patient, and straightforward medical decision making. 5 minutes must be met or exceeded. **The initial appointment (new pregnancy) must be in-person,** then antepartum may be office or outpatient by video telehealth. An RN visit may be submitted for this with the RN visit notes identifying the provider was informed of the RN Assessment. **Submit the Category II Code 0500F if this is the established patient's Initial OB visit.**
99212	**TH**	Office visit for the evaluation and management of an **established** patient, which requires a problem focused history, a problem focused examination and straightforward medical decision making 15 minutes must be met or exceeded. **The initial appointment (new pregnancy) must be in-person,** then antepartum may be office or outpatient by video telehealth**. Submit the Category II Code 0500F if this is the established patient's Initial OB visit**
99213	**TH**	Office visit for the evaluation and management of an **established** patient, which requires an **expanded** problem focused history; an expanded problem focused examination and a medical decision making of low complexity 15 minutes must be met or exceeded. **The initial appointment (new pregnancy) must be in-person,** then antepartum may be office or outpatient by video telehealth. **Submit the Category II Code 0500F if this is the established patient's Initial OB visit**

Code	Modifier	Description
99214	**TH**	Office visit for the evaluation and management of an **established** patient, which requires moderate to high severity of presenting problem(s) A **detailed** history, a detailed examination, and medical decision making of moderate complexity 30 minutes must be met or exceeded. **The initial appointment (new pregnancy) must be in-person**, then antepartum may be office or outpatient by video telehealth. **Submit the Category II Code 0500F if this is the established patient's Initial OB visit**

Code	Modifier	Description
99215	**TH**	Office visit for the evaluation and management of an **established** patient, which requires a comprehensive history, a comprehensive examination and medical decision making of high complexity 40 minutes must be met or exceeded. **The initial appointment (new pregnancy) must be in-person,** then antepartum may be office or outpatient by video telehealth. **Submit the Category II Code 0500F if this is the established patient's Initial OB visit**

NO Prior Authorizations are required for any number of antepartum visits
(Documentation should identify the activities of the antepartum visit. Usual post-pay audits may occur.)
***Remember to use Modifier "TH" ***

Maternity Diagnosis Codes

Please include diagnosis codes on your claim. The attached Spreadsheet has the suggested codes. If a new diagnosis is identified during a member visit update the claim with the additional code.

Additional Obstetric Requirements ***Remember to use Modifier "TH" ***

Code	Modifier	Description
80081	TH	OB panel lab tests, including HIV - allowed once per pregnancy
81003	TH	Routine Urinalysis (added 9/17/2025)
85004	TH	Blood Count L W. diff
85027	TH	Complete blood count: automated diff
86592	TH	Syphilis test
86762	TH	Rubella antibody
86900	TH	Blood type ABO
86901	TH	Blood type RH
J2790	TH	RHOGAM injection – as needed
59025	TH	Fetal non-stress test
76805	TH	Maternal/fetal trans-abdominal ultrasound
76801	TH	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester, transabdominal; single or first gestation
76802	TH	Each additional gestation, in addition to 76801
76805	TH	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥14 weeks 0 days); complete
76810	TH	Each additional gestation, in addition to 76805
76811	TH	Detailed fetal anatomic ultrasound (pregnant uterus, fetal and maternal evaluation plus detailed fetal anatomy) for known/suspected anomaly or increased risk
76812	TH	Each additional gestation in conjunction with 76811
76813	TH	Nuchal translucency measurement, single or first gestation, typically 10–14 weeks
76814	TH	Nuchal translucency, each additional gestation
76815	TH	Limited OB ultrasound (eg, fetal heartbeat, placental location, fetal position, qualitative amniotic fluid) one or more fetuses
76816	TH	Follow-up OB ultrasound (subsequent study for growth, or re-exam of known/suspected abnormality

Code	Modifier	Description
76817	TH	Transvaginal obstetric ultrasound (eg, cervical length, early pregnancy, placental location as indicated)
76818	TH	Fetal biophysical profile with non-stress testing
76819	TH	Fetal biophysical profile without non-stress testing

Hospital / Labor / Delivery

Hospital – Provider Claim Codes
If the member requires hospital admission prior to delivery, this code section is submitted for claims with the TH modifier. The provider may submit claims for assessment on date of delivery for prior care when the per day minimum time is met.

If the member is requiring hospitalization, post-delivery care with provider attending in person, the subsequent hospital code is submitted with the TH modifier. The date of discharge management is as specified in the description below.

(claim submission is per date of service)

Code	Modifier	Description
99222	TH	Initial hospital inpatient or observation care, **per day** 55+ min
99232	TH	Subsequent hospital inpatient or observation **per day** 35 min
99238	TH	Hospital discharge day mgmt. 30 min or less

Limited Medicaid eligibility such as Emergency/Delivery only or Presumptive Eligibility should have TH Modifier added to the claim. (added 09/17/2025)

*****Remember to use Modifier "TH" *****

Provider Delivery Claim Submission:
(claim submission is per date of service)

Code	Modifier	Description
59409	TH	Vaginal Delivery
59514	TH	Cesarian Section (C/S)
59612	TH	Vaginal birth after C/S (VBAC)
59620	TH	C/S after VBAC attempt
59514/80	TH	C/S assist (added 09/17/2025)
59514/AS	TH	C/S assist (added 09/17/2025)

*****Remember to use Modifier "TH" *****

Postpartum

Claim submission is per date of service, each provider visit is billable. The 3 provider visits, each independently billable, is only for the Ob/Gyn provider. There is no time frame expected. Each provider will determine the member postpartum follow up needs.

(Documentation should identify the activities of the postpartum visit. Usual post-pay audits may occur.)

Use Category II Code 0503F to indicate each postpartum

Provider Claim Codes

Code	Modifier	Description
59430	TH	The provider visits the patient in the outpatient setting following the delivery. Encourage 3 provider visits.

If referrals are made to other providers [Internal Medicine, Endocrinology, General Practitioner, etc.] their visits are open to bill as part of the full Iowa.

Medicaid postpartum coverage. They will not use the TH Modifier.

Primary Insurance – Medicaid as Third-Party Liability

***Primary insurance -** Commercial (private) and Medicare, continue the current bundled process. ***

If primary insurance is lost during pregnancy, and the member has not delivered the infant, the provider will submit claims for the unbundled process.

More Information (Added 09/17/2025)

When the perinatal center provider, or other maternal health provider, consults and conducts antepartum and postpartum appointments, the provider should follow the instructions to follow same process as in Antepartum section of this guide.

As always, all visit documentation may be reviewed, however documentation is not required to submit with the claim.

Documentation should identify the activities of the visit. The usual post-pay audits may occur.

Rural Health Clinics (RHC), Federally Qualified Health Clinics (FQHC), and Indian Health Services (HIS)

If the RHC, FQHC, or IHS provides Maternal Health Care, this process will apply. When the encounter is related to antepartum or postpartum care, the TH Modifier is required on the T1015 code on the claim.

FAQs and other resources are posted to the HHS website – please review regularly for updates.

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