Unbundled Maternity Billing Guide

Iowa Medicaid

IOWA Health and Human Services

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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.

Providers, please submit the Notice of Pregnancy form on the Initial in office visit.

The guidance for 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 resubmission 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 of the **Global reimbursement** claim process:

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

And the third clarifying statement:

Beginning October 1, 2025:

All member claims that meet the guidelines for Unbundled Maternity Services and do not have primary insurance other than Medicaid, **must be billed using** the Unbundled Maternity billing guidelines below.

For 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 Medicaid (MCOs and traditional 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	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	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

Antepartum

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.

When Maternal Fetal Medicine (MFM) Providers are brought in to consult, this process is followed for 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** and the proper Telehealth identifier on the claim for reimbursement.

The Telehealth list is updated and on Medicaid Website.
Provider Antepartum visit claim submission is per date of service:

Code	Modifier	Description
99203	**TH**	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, 30 minutes must be met or exceeded. **Must be In-person office appointment**
99213	**TH**	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, 20 minutes must be met or exceeded. **The initial appointment (new pregnancy) must be in-person.**

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" ***

Additional Obstetric Requirements

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 - NO PRIOR authorizations are required.

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

Hospital / Labor / Delivery

Hospital – Provider Claim Codes
If the member requires hospital admission prior to delivery, this code section is submitted for claims. 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" ***

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. 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.)

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

Provider Claim Codes

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

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

Primary Insurance – Medicaid as Third-Party Liability

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

If primary insurance is lost during pregnancy, the provider then will submit the retro TPL process that is currently in place.

More Information

When the Perinatal Center provider, or other maternal health provider, consults and conducts antepartum and postpartum appointments, the provider should follow the instructions to:

Code	Modifier	Description
99213	**TH**	Office or other outpatient visits 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. **The initial appointment (new pregnancy) must be in-person.** **If the 30 minutes is not met, submit claim anyway** (added 9/17/2025)
59430	**TH**	The provider visits the patient in the outpatient setting following the delivery.

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

Documentation should identify the activities of the visit. 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.

FAQ are Posted to Initiatives Website – please review regularly for updates.

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