

Frequently asked questions: 2027 perinatal billing changes

Fee-for-service Medical Assistance (MA) – Minnesota Health Care Programs (MHCP)

Resources Links:

- [Reproductive Health/OB-GYN - Obstetric Services](#) in the MHCP Provider Manual MHCP
- [Payment for Obstetric Services American College of Obstetricians and Gynecologists \(ACOG\)](#) webpage
- [American Medical Association \(AMA\) Maternity Care Services Codes Guidelines \(PDF\)](#)
- [New Obstetric Billing Codes: Virtual Town Hall Series \(ACOG\)](#)

Section 1: Prenatal and postpartum billing

1. What codes should providers start using as of June 1, 2026?

The Minnesota Department of Human Services recommends using the appropriate Evaluation and Management (E/M) codes for prenatal billing starting June 1, 2026, for newly pregnant people; those codes include 99202 through 99499 and are now available. Providers should bill with the TH modifier to indicate a prenatal visit. The new labor and delivery codes will be available starting Jan. 1, 2027.

Providers who are unable to bill per encounter by June 1, 2026, may use the following billing protocol for patients with 2027 due dates:

- **Care initiated between May 15 through July 14, 2026:** 59246 and TH modifier
- **Care initiated between July 15 through Aug. 31, 2026:** 59425 and TH modifier
- **Care initiated between Sept.1 through Dec. 31, 2026:** Bill prenatal care per encounter with the appropriate E/M code and TH modifier

2. Will there be a cap on the number of times specific codes can be billed during the pregnancy and postpartum period?

We do not anticipate capping the number of prenatal or postpartum E/M visits at this time. We may conduct post-payment review of claims for program integrity purposes. Some perinatal care codes, such as example labor management and delivery codes, will have caps on billing. Labor management codes will mainly only be available to bill once per calendar day, unless there is a transfer of care.

Ancillary care with preexisting caps, such as physical therapy, will remain unchanged.

3. When should the TH modifier be used?

The TH modifier will be used from 2026 onwards and should only be used on E/M codes related to outpatient prenatal or postpartum care. Do not bill the TH modifier if the outpatient visit is directly unrelated to prenatal or postpartum health. Do not use the TH modifier for labor management, delivery codes, or any antepartum or postpartum inpatient days.

4. Should the TH modifier be used with facility fee codes?

No, only with E/M codes.

5. How should providers bill for group prenatal care?

Bill for each patient as their own visit with the appropriate E/M with the TH modifier. Document appropriately to support the level of service that you select ensuring that the time billed reflects the time you spend with the individual patient, not the entire group.

6. Can prenatal visits be billed “incident to” when performed by an APP if the doctor has already established care and meets other requirements?

In Minnesota, the eligible billing provider should be listed on the claim and not bill “incident to” the physician. Advanced practice providers (APPs), such as nurse practitioners and certified nurse midwives, are recognized billing providers and can bill E/M codes independently. There is no pay differential in the MHCP fee schedule for APPs.

Section 2: Labor management and delivery billing

1. What happens if we have a newly pregnant person in June 2026 who delivers early before the coding changes are deleted?

Providers have the following three billing options:

- Providers can use the existing option to bill per encounter for care provided. Providers would use the appropriate E/M code + TH modifier for prenatal care and would use the appropriate labor and delivery code for a preterm delivery.
- Providers can use the appropriate CPT code for multiple prenatal visits (59426 plus 59425) + TH modifier. Providers would use the appropriate labor and delivery code for a preterm delivery.
- Lastly, because DHS’ timely filing requirement allows providers up to 12 months for services to be billed,
- Providers may opt to delay billing for services provided in 2026 until 2027 because the timely filing requirement allows providers up to 12 months for services to be billed. This allows providers to use bundled codes for care provided in 2026. The obstetric bundled codes will be discontinued for dates of service past Dec. 31, 2026, allowing providers to retroactively bill for a date of service within the approved date span and the claim will pay.

We recommend billing when prenatal care and delivery are complete.

2. Free-standing birth centers have traditionally billed 59400 for the facility fee on the UB04 facility form. Will that still be accepted or will there be a new code to use?

The new code is 59431. Bill facility charges using the MN–ITS 837I Outpatient Services, as follows:

- Type of bill is 0840 through 0848
- Revenue code is 0724
- Use code 59431 for delivery in the birth center, S4005 for transfers to a hospital

3. How should transfer of care during labor management be documented in claims? Should providers use a modifier?

When labor management begins at your facility prior to a transfer, you are able to bill the labor code that is most appropriate (first versus subsequent day; straightforward versus complex). The receiving provider is also able to bill for initial day of labor code.

We do not anticipate requiring a modifier for transfer of care during labor management. Transfer of care is currently captured through post payment review of claims. We will notify providers if this changes.

4. Will labor management and delivery codes be allowable for POS 12 (home) and POS 25 (birth center) too?

Yes, we will continue to cover labor management and delivery across all current POS, including home birth and birth centers.

5. We usually bill delivery and postpartum globally. Should we begin unbundling this as of June 1, 2026?

We recommend unbundling codes as soon as possible, ideally before June 1, 2026.

6. How should groups with a hospitalist model bill for labor and postpartum inpatient codes when multiple providers see the patient throughout a single date of service?

The codes are intended to be used only once on each calendar date of service (DOS). The covered group within the hospitalist model can only bill one code for each day of service. The code reflecting the highest level of service should be billed. If there was a formal transfer of care to a different group, then each group can use a labor management code.

7. How do you code for a delivery for twins or other multiple gestations?

Use one labor management code for multiple gestations. For vaginal delivery of Twin A and Twin B, use a vaginal delivery code for each delivery. For a Cesarean delivery of Twin A and Twin B, use only one Cesarean delivery code. The Cesarean delivery is considered one surgery, therefore, only use one delivery code.

8. Would you use 22 modifier for a multiples c-section?

The -22 modifier indicates that substantially more work has been done, including increased complexity, time or technical difficulty. If the Cesarean birth includes multiple births that meets one or more of those conditions, a -22 modifier may be added to the claim and appropriate documentation in the medical record should be completed.

9. If a patient presents for cervical balloon and then discharged home to return the next day would you code 59200 and then labor management code the next day?

According to CPT instructions, labor management does not begin until the patient is admitted for labor with the goal of achieving delivery. If the patient is admitted with those goals or when an induction is planned during a current hospitalization, report initial day labor management (59080 and 59081) for the calendar date labor or induction begins.

ACOG will provide additional clarification as more information is available from the AMA CPT Editorial Panel. Please consider attending one of their town halls.

June 2: [Townhall: E/M for Antepartum Care | ACOG Online Learning](#)

June 16: [Townhall: Labor Management & Delivery | ACOG Online Learning](#)

June 30: [Townhall: Procedures & Postpartum | ACOG Online Learning](#)

10. What constituents a calendar day when a patient is in labor?

When a physician or provider is bedside or working with the patient at 11:55 p.m. and continues working with the patient until 12:15 a.m., that is considered a continuous visit over midnight and not two separate visits. When the provider steps away at 12:15 a.m. and comes back at 2:00 a.m., the 2:00 a.m. visit is a new visit and that starts a new calendar day.

11. How should free-standing birth center bill for a postpartum day?

The calendar day of the delivery includes all postpartum care and discharge if they discharge that day. The next day they would bill an appropriate E/M code and any other services such as discharge.

12. How should providers bill when a provider performs a cesarean birth and another performs a hysterectomy on the same patient?

Billing for a hysterectomy is now an individual code that can be billed by a different provider. If the same provider performs the cesarean birth and hysterectomy, that provider can bill both codes.

Section 3: Additional questions

1. Are other health insurers impacted by this coding change?

Yes, the obstetric coding changes are happening at a national level; all health insurers and health care providers will be impacted by this change. Fee-for-service MHCP billing is following AMA and ACOG recommendations to begin unbundling starting as soon as June 1, 2026, for newly pregnant people. Other insurers may have other recommendations. We recommend providers reach out to other insurers for additional guidance.

2. Can we still bill bundled codes in 2027 for dates of service in 2026?

Yes, for patients who delivered in 2026, providers can still use bundled codes for billing. Providers are unable to use a bundled code for patients who had prenatal care in 2026 but delivered in 2027.

3. When does the Minnesota Department of Human Services anticipate the fee schedule will be available? What will the impact on obstetric care rates be?

We set rates for new codes using guidance from the Centers for Medicare and Medicaid Services (CMS). CMS rates will not be released until November or December 2026. We update our fee schedule monthly and publishes the entire schedule mid-month.