Postpartum Provider Payment Policy

Postpartum care includes hospital and office visits for routine, uncomplicated care following a vaginal or Cesarean section delivery.

The following codes should be billed for delivery and postpartum services provided to patients for which:

- A vaginal or cesarean delivery after a previous Cesarean delivery (VBAC) was not attempted:

CPT Codes	Services
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59414	Delivery of placenta (separate procedure)
59515	Cesarean delivery only; including postpartum care

- For delivery and postpartum services provided to patients for which a VBAC was attempted:

CPT Codes	Services
59612 / 59614	Vaginal delivery only, after previous Cesarean delivery (with or without episiotomy and/or forceps)
59620 / 59622	Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery

Separate payment may be made for multiple-birth delivery for the following CPT procedure codes: 59409, 59410, 59514, 59515, 59612, 59614, 59620, and 59622. Multiple-birth deliveries must be reported using any of the above-mentioned CPT procedure codes on multiple lines of the claim detail, with modifier 59 appended to indicate twins, triplets, quadruplets, etc.

Reimbursement would be as follows:

- For a single delivery or the first delivery of a multiple birth, one hundred percent (100%).
- For the second delivery of a multiple birth, fifty percent (50%).
- For the third delivery of a multiple birth, twenty-five percent (25%).
- For each additional delivery of a multiple birth, zero percent (0%).

In accordance with OAC 5160-1-10 Limitations on elective obstetric deliveries:

(A) Payment for any cesarean section, labor induction, or any delivery following labor induction is subject to the following criteria:
  (1) Gestational age of the fetus must be determined to be at least 39 weeks; or
  (2) If a delivery occurs prior to 39 weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery.

(B) Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks gestation that are not considered medically necessary are not eligible for payment.

Postpartum care, when performed as a separate procedure:

For the reimbursement of codes 59410, 59430, 59515, 59614, or 59622, the provider must, at a minimum, render an evaluation and management service four to six weeks after delivery.

Postpartum care rendered prior to discharge from the inpatient hospital, outpatient hospital, or birthing center (i.e., the delivering institution) is considered incidental to the delivery services and/or postpartum service. This should not be a factor when selecting the delivery-only codes or the delivery codes bundled with the postpartum care services.

Delivery Services Only

Postpartum Provider Payment Policy

For reimbursement of delivery-only codes, the provider or provider group must render, at a minimum, the delivery service.

Delivery and Postpartum Care

For reimbursement of the delivery and postpartum care codes, the provider or provider group practice must render, at a minimum, both the delivery and at least one evaluation and management service four to six weeks after delivery.

Postpartum Care Only

For the reimbursement of the postpartum care-only code, the provider or provider group practice must render, at a minimum, at least one evaluation and management service four to six weeks post-surgery.

Date		Action
Effective Date	December 2017	Original
Revision Date	January 2023	Added link to OAC 5160-1-10