MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

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Director, Bureau of Policy and Strategic Engagement
Health Services Administration

Project Number:	2623-Practitioner	**Comments Due:**	October 1, 2026	**Proposed Effective Date:**	As Indicated

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Policy Subject: Updates to Coverage of Maternity Care Services

Affected Programs: Medicaid, Healthy Michigan Plan, MI Coordinated Health, Maternity Outpatient Medical Services, MIChild

Distribution: All Providers

Policy Summary: This bulletin updates Medicaid program coverage and billing requirements for routine maternity care services in alignment with coding changes adopted by the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel.

Purpose: To align with the AMA's CPT coding guidelines for maternity care services.

Proposed Policy Draft

Michigan Department of Health and Human Services
Health Services

Distribution: All Providers

Issued: September 1, 2026 (proposed)

Subject: Updates to Coverage of Maternity Care Services

Effective: As Indicated (proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MI Coordinated Health, Maternity Outpatient Medical Services, MIChild

This bulletin updates Medicaid program coverage and billing requirements for routine maternity care services in alignment with coding changes adopted by the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel.

Effective January 1, 2027, the AMA CPT Editorial Panel is deleting the current global maternity care CPT codes representative of antepartum, labor and delivery, and postpartum care services (e.g., 59400, 59510, 59620) and transitioning to the reporting of separate CPT codes for services rendered. Under this revised coding structure, routine maternity-related services must be reported per encounter using the appropriate evaluation and management (E/M) or other applicable CPT code(s) that most accurately describes the services rendered based on the location of the patient.

The Michigan Department of Health and Human Services (MDHHS) will continue to require providers to utilize the appropriate maternity care CPT codes through December 31, 2026. Refer to the MDHHS Medicaid Provider Manual for additional information.

Claim Requirements Beginning January 1, 2027

Claims submitted with the global maternity care CPT codes on and after January 1, 2027, will be eligible for payment only if all dates of services occurred on or before December 31, 2026.

Claims for maternity care services submitted to MDHHS must include the appropriate E/M and/or other applicable obstetric services CPT code(s) in accordance with current AMA guidelines. To be eligible for the enhanced reimbursement rate as outlined within bulletin MSA 14-32 and the Obstetrical Services subsection of the Practitioner Reimbursement Appendix within the MDHHS Medicaid Provider Manual, providers must append modifier TH and the appropriate obstetric International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code(s) to the routine antepartum and postpartum E/M CPT code. Routine labor management and delivery care services must be billed with the

applicable CPT and ICD-10-CM diagnosis codes to be eligible for the enhanced reimbursement rate. Documentation must support medical decision making or time consistent with current CPT guidelines.

Antepartum	Labor Management	Delivery	Postpartum
Report the appropriate obstetric ICD-10-CM diagnosis code(s) per published coding guidelines and include modifier TH to indicate routine antepartum care. A code from category Z3A may be reported to identify the weeks of gestation, as applicable.	Report the appropriate obstetric ICD-10-CM diagnosis code(s) per published coding guidelines to indicate routine labor management care. A code from category Z3A may be reported to identify the weeks of gestation, as applicable.	Report the appropriate obstetric ICD-10-CM diagnosis code(s) per published coding guidelines to indicate routine delivery care. A code from category Z3A may be reported to identify the weeks of gestation, as applicable.	Report the appropriate postpartum care ICD-10-CM diagnosis code(s) per published coding guidelines and include modifier TH to indicate routine postpartum care.
Includes all E/M care of the patient and/or fetus(es) prior to onset of labor. Up to 13 antepartum E/M visits per pregnancy are covered under the enhanced reimbursement methodology. Additional visits provided during the antepartum period will be reimbursed utilizing the payment rate methodology for physician services. Separate and distinct procedures performed on the same date of service (e.g., diagnostic tests) may be covered when billed in accordance with correct coding guidelines.	May be reported once per calendar date. May not typically be reported on the same day as Hospital Care codes by the same provider.	Delivery care begins when labor management is complete and is inclusive of same day routine postpartum care. May be reported on the same day as initial or subsequent labor management, even when the same provider performs both services. Multiple gestation – cesarean deliveries are covered once regardless of the number of fetuses delivered. MDHHS covers the cesarean delivery in addition to a vaginal delivery when subsequent fetus(es) are delivered via cesarean.	Up to two postpartum E/M visits are covered under the enhanced reimbursement methodology per pregnancy when rendered within 12 weeks postpartum. Additional visits provided during the postpartum period will be reimbursed utilizing the payment rate methodology for physician services. Routine postpartum care is not separately reimbursed when reported on the same calendar day as delivery care.

Refer to the Telemedicine fee schedules published at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Telemedicine for a list of telemedicine-eligible services.

Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, and Tribal Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Tribal Health Centers (THC), and Tribal FQHCs furnishing eligible routine antepartum and postpartum maternity care services in the clinic setting will be reimbursed according to the Prospective Payment System (PPS) or All-Inclusive-Rate (AIR) methodology for qualifying visits. Services should be billed on the institutional claim form using an Organization/Group – Type 2 clinic specialty-enrolled National Provider Identifier (NPI). The Attending Provider field must include an eligible Individual – Type 1 NPI.

Effective January 1, 2027, the AMA CPT Editorial Panel is deleting the current global maternity care CPT codes representative of antepartum and postpartum care services (e.g., 59425, 59426, 59430) furnished in the clinic setting and transitioning to the reporting of separate CPT codes for services rendered. Under this revised coding structure, routine antepartum and postpartum care services provided in the clinic setting on and after January 1, 2027, must be reported with the appropriate E/M CPT and clinic qualifying visit payment codes, obstetric ICD-10-CM diagnosis code(s), and the TH modifier.

Billing Requirements for Services Provided Outside the Clinic Setting

FQHCs, RHCs, THCs, and Tribal FQHCs may bill for eligible labor management and delivery care services furnished in the hospital setting. These non-clinic services must be billed separately on a professional claim form (CMS 1500/837P) using an Organization/Group – Type 2 non-clinic specialty-enrolled NPI as the Billing Provider and an eligible Individual – Type 1 NPI as the Rendering Provider. Services performed outside of the clinic will be reimbursed under the Fee-for-Service (FFS) methodology. (Refer to additional billing requirements for clinic-specific provider types within the MDHHS Medicaid Provider Manual.)

Medicaid Health Plans and Highly Integrated Dual Eligible Special Needs Plans

Medicaid Health Plans (MHP) and Highly Integrated Dual Eligible Special Needs Plans (HIDE SNP) provide, at a minimum, the full range of covered services described in this policy. MHPs and HIDE SNPs may choose to provide additional services over and above those specified. MHPs and HIDE SNPs are allowed to develop prior authorization and documentation requirements that differ from FFS Medicaid requirements in accordance with their contract, applicable state law, and federal regulations. For beneficiaries enrolled in an MHP or HIDE SNP, the provider must check with the health plan for coverage requirements.