

## MATERNITY CARE

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### I. CPT<sup>1</sup> PROCEDURE CODES

59000 - 59899, 82105, 82106, 82731, 84702

### II. DESCRIPTION

Maternity care is the medical services related to conception, delivery and abortion, including prenatal and postpartum care (generally through the sixth post-delivery week), and treatment of complications of pregnancy.

### III. POLICY

A. Services and supplies associated with antepartum care (including well-being of the fetus), childbirth, postpartum care, and complications of pregnancy may be cost-shared.

B. The mother and child hospital length-of-stay benefit may not be restricted to less than 48 hours following a normal vaginal delivery and 96 hours following a cesarean section. The decision to discharge prior to those minimum length-of-stays must be made by the attending physician in consultation with the mother.

C. Maternity care for pregnancy resulting from noncoital reproductive procedures may be cost-shared.

D. Services and supplies associated with antepartum care, childbirth, postpartum care and complications of pregnancy may be cost-shared where the surrogate mother is a TRICARE beneficiary.

E. Progesterone therapy for the prevention of preterm birth is covered only when the following criteria are met:

1. Weekly injections of 17 alpha-hydroxyprogesterone caproate between 16 and 36 weeks of gestation for pregnant women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

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2. Oral progesterone therapy or injections of 17 alpha-hydroxyprogesterone caproate are **NOT** covered for other high risk factors for preterm birth, including, but not limited to multiple gestations, short cervical length, or positive fetal tests for cervicovaginal fetal fibronectin.

IV. EXCLUSIONS

A. Services and supplies related to noncoital reproductive procedures.

B. Home Uterine Activity Monitoring (HUAM), telephonic transmission of HUAM data, or HUAM-related telephonic nurse or physician consultation for the purpose of monitoring suspected or confirmed pre-term labor is unproven.

C. Off-label use of FDA-approved drugs to induce or maintain tocolysis.

D. Lymphocyte or paternal leukocyte immunotherapy in the treatment of recurrent spontaneous fetal loss is unproven.

E. Salivary estriol test for preterm labor is unproven (CPT<sup>2</sup> procedure code 82677).

F. Home infusion for tocolytic therapy.

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