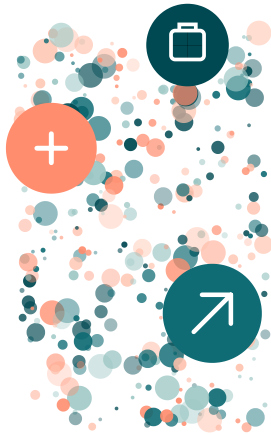


RCM

CODING

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2027 maternity billing changes

The global package is going away. Here's what changes.

Effective Jan. 1, 2027, the CPT® code book will see a monumental restructure of the Maternity Care Services section. For decades, obstetric medical coding relied on “global maternity packages” — single omnibus codes that bundled antepartum care, delivery, and routine postpartum care into a single billing entity.

“

Say goodbye to bundled procedures and hello to individual service codes.

Effective January 1, 2027

CPT® Maternity Care Services restructure

In 2027, the global maternity packages will be deleted, along with their delivery-only and postpartum-only counterparts.

In their place, the AMA has mandated a **component-based reporting model**. Providers must now document and explicitly report each stage of maternity care as individual, independent functional services. This shift guarantees modern team-based obstetric care, improves transparency, enhances data quality and measurement, and supports evidence-based labor and postpartum care.

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INSIDE THIS EDITION

- Why the change — and the full list of deleted codes
- How to report antepartum care, labor management, delivery, and postpartum care in 2027
- Straightforward vs. complex labor management, side by side
- A one-page “at a glance” summary for your front desk

Understand the reason for the change

The current CPT® code structure has remained largely unchanged for over 30 years, yet maternity care has evolved dramatically during that time.

Today's clinical environment reflects greater patient complexity and new patterns of care that the existing codes fail to capture.

WHAT THIS MEANS FOR YOUR REVENUE

With the global package gone, every antepartum visit, every day of labor management, and every postpartum visit is billed on its own. A visit that isn't documented, a labor day without a face-to-face note, or a postpartum encounter that never reaches the claim is no longer absorbed into a global fee — it is revenue that simply doesn't get billed.

KEY DRIVERS

- Escalation of care from rural hospitals to tertiary centers
- Longer and more complex labor patterns, with greater use of induction to safely reduce cesarean (C-section) delivery rates
- Heightened focus on hemorrhage, cardiovascular disease, and maternal mental health to reduce morbidity and mortality
- Shifts in patient demographics and provider practice models
- Expanded use of data and information systems to better track care provided
- Integration of telehealth and e-services

Codes deleted from the CPT® code book in 2027

The table below (continued on the next page) shows which codes will be deleted, the functional domain each belonged to, and the new mechanism that replaces it.

CODES	DESCRIPTOR	FUNCTIONAL DOMAIN	NEW MECHANISM
59050	Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation	—	Replaced by new code 59051 (Fetal monitoring during labor by consulting physician [ie, non-attending physician] or other QHP, with interpretation and report)
59400 59409 59410	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care 59409 — Vaginal delivery only (with or without episiotomy and/or forceps) 59410 — ... including postpartum care	Legacy vaginal delivery global packages and delivery-only codes	Services will be mapped to specific components
59425 59426	Antepartum care only; 4–6 visits 59426 — ... 7 or more visits	Legacy antepartum care codes	Use outpatient E/M codes or telehealth/home equivalents
59430	Postpartum care only (separate procedure)	Legacy postpartum care stand-alone code	Use E/M codes based on location (outpatient vs. inpatient)

Codes deleted from the CPT® code book in 2027 (continued)

CODES	DESCRIPTOR	FUNCTIONAL DOMAIN	NEW MECHANISM
59510 59514 59515 +59525	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care 59514 — Cesarean delivery only 59515 — ... including postpartum care +59525 — Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)	Legacy cesarean global packages, stand-alone codes, and add-on hysterectomy	Use new primary/repeat C-section codes, hysterectomy, and E/M care blocks
59610 59612 59614 59618 59620 59622	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery 59612 — Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) 59614 — ... including postpartum care 59618 — Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery 59620 — Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery 59622 — ... including postpartum care	Legacy VBAC and trial of labor after cesarean (TOLAC) global and delivery packages	Use new VBAC delivery or repeat C-section following failed TOLAC

Here's how to report antepartum care in 2027

Antepartum care encompasses the comprehensive medical management of a pregnancy prior to the physiological onset of labor or permanent surgical interruption. Under the 2027 framework, you'll document all prenatal visits, whether routine or high risk, utilizing evaluation and management (E/M) codes, examples of which include:

NEW PATIENT

99202–99205 (Office or other outpatient visit for the evaluation and management of a new patient, ...)

ESTABLISHED PATIENT

99211–99215 (Office or other outpatient visit for the evaluation and management of an established patient ...)

Telemedicine E/M services (**98000–98015**) may also be used for antepartum visits where appropriate.

PREGNANCY CONFIRMATION

When a patient presents for an initial encounter to confirm pregnancy, the clinician must code the service using the appropriate E/M code for that specific setting.

ANTEPARTUM CARE, CONTINUED

AUXILIARY PROFESSIONALS (NON-E/M)

For specialized care provided by auxiliary qualified healthcare professionals (QHPs) who are legally restricted from reporting standard medical E/M codes, code directly to dedicated functional lines, such as:

- **Genetic counseling: 96041** (Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter)
- **Medical nutrition therapy: 97802–97804** (Medical nutrition therapy ...)

ANTEPARTUM PROCEDURES & FETAL INVASIVE SERVICES

You may separately report antepartum and fetal invasive procedures from prenatal E/M visits, and you can also separately report any diagnostic imaging services (for example, obstetrical ultrasound evaluation of the fetus[es] including maternal pelvis and placenta) in addition to antepartum E/M visits.

INITIAL SITE OF SERVICE SEPARATION

If a pregnant patient is admitted to a facility for acute antepartum monitoring or complications (excluding active labor management) straight from an initial site of service, such as the clinic or the emergency department (ED), the services at the initial site are separately reportable. According to the 2027 CPT® Maternity Care Services guidelines, you'll append **modifier 25** (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the initial site's E/M code to denote a significant, separately identifiable E/M service by the same professional/group on the same date.

Antepartum procedure and fetal invasive service codes

CODE	DESCRIPTOR	CODE	DESCRIPTOR
59000	Amniocentesis; diagnostic	59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59001	... therapeutic amniotic fluid reduction (includes ultrasound guidance)	59076	Fetal shunt placement, including ultrasound guidance
59012	Cordocentesis (intrauterine), any method	59320	Cerclage of cervix, during pregnancy; vaginal
59015	Chorionic villus sampling, any method	59325	... abdominal
59020	Fetal contraction stress test	59412	External cephalic version
59025	Fetal non-stress test	59866	Multifetal pregnancy reduction(s) (MPR)
59070	Transabdominal amnioinfusion, including ultrasound guidance	59871	Removal of cerclage suture under anesthesia (other than local)
59072	Fetal umbilical cord occlusion, including ultrasound guidance		

Relocated in 2027: CPT® will move codes **59320**, **59325**, **59412**, **59866**, and **59871** from other subsections to the antepartum procedures and fetal invasive services subsection.

Learn how to report labor management

Labor management represents integrated clinical decision-making to continually assess, support, and balance the physiological well-being of the parturient and the fetus(es). This encompasses managing active labor progression and any concurrent maternal/fetal medical conditions or emerging complications, such as gestational diabetes, preeclampsia, abnormal fetal heart rate tracings, or labor dystocia.

EFFECTIVE JANUARY 1 — LABOR MANAGEMENT CODES

CODE	DESCRIPTOR
59080	Initial day labor management; straightforward, per day
59081	... complex, per day
59082	Subsequent day labor management; straightforward, per day
59083	... complex, per day

INCLUSIONS

Labor management codes include routine interim physical examinations, collection and interpretation of continuous/intermittent physiologic data (for example, partograms, maternal vital signs, and pulse oximetry), and standard methods for the induction or augmentation of labor — which means you **cannot separately report** the services.

CROSS-COVERAGE

If a provider is on call or cross-covering, the encounter is classified exactly as it would have been by the primary attending. Advanced practice registered nurses (for example, certified nurse midwives) and physician assistants (PAs) working in tandem with physicians are considered as practicing within the exact same specialty configuration.

Labor management code guidelines are similar to E/M services, in that the code restrictions include:

FACE-TO-FACE VISIT

All labor management codes strictly require a documented face-to-face encounter with the parturient by the reporting provider.

DAILY CALENDAR CAP

These codes are restricted to a maximum of once per calendar date. You must aggregate and report multiple separate encounters over a single calendar date by the same provider or within the same group practice/exact specialty as a single labor management service using the highest level of complexity reached on that date.

CONTINUOUS VISITS

A continuous bedside visit that spans the midnight transition of two dates is considered a single, unbroken service. You must report it as a single unit on either the initial or subsequent date, but never on both.

MULTI-GESTATION RULE

For multiple gestations (for example, twins, triplets), report labor management exactly once per calendar date, regardless of the number of fetuses being monitored.

CONSULTING PHYSICIANS

A consulting physician or QHP who does not assume care of the patient reports E/M codes rather than labor management. Related labor procedures are reported separately: **59030** (Fetal scalp blood sampling) and **59051** (Fetal monitoring during labor by consulting physician, with interpretation and report).

LABOR MANAGEMENT, CONTINUED

INITIAL VS. SUBSEQUENT DAY

Initial day codes include the E/M workload of facility admission. If labor crosses multiple days, report subsequent day codes for additional dates up until the delivery date. You cannot assign subsequent day codes on the date that the initial labor management service begins. Initial day labor management can only be reported once per stay, unless the patient is transferred to a completely new facility or a specialist of a completely different subspecialty assumes care due to extreme medical necessity.

E/M AND LABOR MANAGEMENT ON SAME DAY

Providers are strictly prohibited from reporting standard facility inpatient/observation E/M codes on the same date as labor management codes when the same provider or group practice is managing both the general hospital care and active labor.

LABOR MANAGEMENT FACTORS

The selection between straightforward (59080, 59082) and complex (59081, 59083) tracking is driven by the medical decision making (MDM) and maternal/fetal clinical pathology. The labor duration doesn't dictate complexity, unless the provider documents a clinical diagnosis of prolonged labor. If a patient starts as straightforward but escalates into complex labor on the same date, report only the complex code.

The levels of labor management are defined by the following factors

STRAIGHTFORWARD LABOR MANAGEMENT Note: all of the following factors must be met	COMPLEX LABOR MANAGEMENT Examples of complex labor management include
Singleton vertex presentation	More than one fetus
Routine maternal/fetal monitoring	Fetal monitoring abnormalities that require physician/QHP intervention
Fetal monitoring does not require physician/QHP intervention	Prolonged first or second stage of labor
Normal progression of labor or routine induction/augmentation	Labor complications such as intraamniotic infection/inflammation, preeclampsia
Stable medical conditions do not require additional management during labor	One or more severe maternal morbidity indicators like acute renal failure, eclampsia
No previous cesarean delivery	Maternal medical conditions (for example, hypertension, diabetes, morbid obesity) that require additional management
	Previous cesarean delivery

VBAC/TOLAC complexity: Always code complex labor management (**59081** or **59083**) if the patient has a history of a previous C-section and is attempting a trial of labor after cesarean (TOLAC) for a vaginal birth after cesarean (VBAC), even if the labor progresses normally and has no complications.

↑ Determine how to code delivery care

Delivery care officially commences when active labor is clinically complete. This is defined as when the presenting part of the fetus is visible and firmly rimmed by the vaginal introitus, or when labor is permanently interrupted (for example, the provider diagnoses an arrest of labor and makes an immediate clinical decision to transition to an emergency cesarean delivery). Delivery care codes encompass the active management of both the parturient and the fetus(es) during extraction.

VAGINAL DELIVERY

CODE AND DESCRIPTOR	BUNDLING / EXCLUSIONARY RULES
59431 — Vaginal delivery, with or without episiotomy	This code includes delivery of fetus/placenta and first- or second-degree episiotomy/spontaneous laceration repair performed by the provider performing the vaginal delivery.
59432 — ... after previous cesarean delivery	Assign this code to report a successful VBAC delivery. Labor management is reported separately — and is always complex (59081/59083) for a TOLAC.
59414 — Delivery of placenta only (separate procedure)	Do not report if the service is performed by a provider of the exact same specialty/group practice who codes the delivery. Do not report with 59431–59432.

EPISIOTOMY OR LACERATION REPAIR

If the patient experiences an episiotomy or laceration during delivery, you'll assign one of the following new codes to report the repair:

CODE AND DESCRIPTOR	BUNDLING / EXCLUSIONARY RULES
59300 — Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)	Report 59300 when a provider who did not perform the vaginal delivery performs the repair.
59433 — Repair of episiotomy or laceration; third-degree laceration 59434 — ... fourth-degree laceration	These codes are explicitly excluded from standard vaginal delivery codes. Use these codes to separately report the repair.

BREECH VAGINAL DELIVERY

A breech vaginal delivery may be reported with a vaginal delivery code (**59431, 59432**) with **modifier 22** (Increased procedural services).

MULTIPLE GESTATIONS

For vaginal delivery of multiple gestations, report **one delivery code per fetus**. When one or more fetuses deliver vaginally and one or more via cesarean for the same parturient, report the vaginal delivery code (59431, 59432) per fetus delivered vaginally and the cesarean delivery code (59502, 59503) **once**, regardless of the number of fetuses delivered via cesarean.

↑ New cesarean delivery codes for 2027

Use the following new codes to report cesarean deliveries in 2027. Coding C-section deliveries requires careful attention to important guidelines.

CODE AND DESCRIPTOR	BUNDLING / EXCLUSIONARY RULES
59502 — Cesarean delivery; primary	Use this code when the patient has no prior history of C-section. If the cesarean follows a trial of labor, report labor management separately; if it is scheduled without labor, an E/M service may be reported separately (see guidelines below). Report the cesarean code once regardless of the number of fetuses.
59503 — ... repeat	Use this code when the patient has a prior history of C-section, including failed TOLAC attempts resulting in surgery.
59504 — Subtotal or total hysterectomy after cesarean delivery	This code replaces the legacy add-on code +59525. Use it for a subtotal or total hysterectomy performed during the same operative session; when the same physician performs both the cesarean and the hysterectomy, report 59504 with modifier 51 .

Cesarean delivery guidelines

If a vaginal delivery is actively attempted but clinical failure occurs resulting in an immediate transition to a cesarean delivery, you'll report **only the appropriate C-section delivery code**.

If the provider decides to perform an unscheduled or unplanned C-section delivery for a laboring parturient, the delivery begins when the decision is made. You may report the C-section delivery (primary or repeat) code in conjunction with **complex labor management (59081, 59083)**. However, "When a patient presents for a scheduled or planned cesarean delivery and is not in labor, a labor management code is not reported," according to the 2027 CPT® guidelines.

This means you can separately report an E/M service, such as an initial or subsequent hospital inpatient or observation care service, on the same date as a planned or scheduled primary C-section delivery that occurs without labor. Conversely, the initial or subsequent hospital inpatient or observation care services are included in repeat C-section delivery because the delivery is usually a planned event without labor, so you cannot report the E/M services separately on the same date as the delivery.

IMMEDIATE POSTPARTUM CARE BUNDLING

Postpartum clinical management performed on the same date as the delivery is bundled into the delivery care service line and is not separately reportable. Same-day facility discharge codes (**99238–99239** [Hospital inpatient or observation discharge day management ...]) are strictly prohibited if executed on the same date as delivery.



Familiarize yourself with new maternal postpartum care guidelines

Maternal postpartum care under the CPT® 2027 framework encompasses ongoing physical, psychological, and systemic assessments tailored to the recovering patient. Similar to antepartum care, post-delivery recovery services have been completely unbundled from global delivery packages and are tracked exclusively through E/M codes based on the timing and location of the service. Here's a look at some of the new regulations:

INPATIENT POSTPARTUM RULES

Inpatient maternal postpartum evaluations performed on a date other than the date of delivery are reported with an E/M code, such as the following:

- **99231–99233** (Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination ...)
- **99291** and **+99292** (Critical care, evaluation and management of the critically ill or critically injured patient ...)
- **99238–99239**

SAME-DAY CODING BAN

You cannot report standard E/M codes, combined admission/discharge codes, or dedicated discharge codes for maternal postpartum care if the service takes place on the same date as the delivery, as same-day recovery care is fully bundled into the delivery service line.

OUTPATIENT POSTPARTUM RULES

For routine or complicated outpatient postpartum encounters occurring subsequent to delivery care, providers must report the corresponding outpatient E/M service code — office (**99202–99215**), telemedicine (**98000–98015, 98016**), or home/residence (**99341–99350**).

UTERINE TAMPONADE — NEW CODE 59623

In 2027, you'll report **59623** (Uterine tamponade (eg, balloon, catheter, vacuum, packing material)) if a provider encounters severe postpartum hemorrhage and places an intra-uterine tamponade (for example, a Bakri balloon, catheter, vacuum, or uterine packing material). Code 59623 is strictly restricted to mechanical or physical tamponade insertion. You cannot report 59623 for pharmacological management of postpartum hemorrhage, as pharmacological stabilization is considered part of standard delivery/recovery care.

IMPORTANT

Remember that you must bill all services provided to the **newborn baby** completely independently from the maternal chart.

Stay tuned to BillingFreedom as we continue to examine the upcoming 2027 CPT® Maternity Care Services code and guideline changes.

2027 maternity billing changes at a glance

A one-page summary of the new component-based model. Keep it near the front desk and the coding team.



Antepartum

Global and antepartum-only codes retire. Bill each prenatal visit with E/M codes.

- **99202–99205** new patient · **99211–99215** established
- Genetic counseling **96041**; nutrition therapy **97802–97804**
- Append **modifier 25** to the initial-site E/M when the patient is admitted for antepartum monitoring
- Antepartum procedures and imaging are separately reportable



Labor management

Bill daily; once per calendar date; face-to-face required.

- **59080** initial day, straightforward · **59081** initial day, complex
- **59082** subsequent day, straightforward · **59083** subsequent day, complex
- TOLAC/VBAC is always complex
- No inpatient E/M on the same date by the same group



Delivery

Delivery is a standalone event. Same-day postpartum care and discharge are bundled.

- **59431** vaginal delivery · **59432** VBAC · **59414** placenta only
- **59300** 1st/2nd-degree repair by a different provider · **59433** 3rd-degree · **59434** 4th-degree
- **59502** primary C-section · **59503** repeat · **59504** hysterectomy after cesarean (modifier 51 if same surgeon)
- Failed TOLAC → report only the C-section code (with 59081/59083); planned C-section without labor → no labor management code



Postpartum

Postpartum-only code retires. Bill by timing and location with E/M codes.

- Inpatient (not delivery date): **99231–99233**, **99291/+99292**, **99238–99239**
- Outpatient: corresponding outpatient E/M
- Uterine tamponade: **59623** (mechanical only)
- Newborn services are billed independently from the maternal chart

BillingFreedom is ready for 2027. Are you?

Talk to an OB/GYN billing specialist about getting your practice ready for the maternity billing and coding changes — payer contracts, documentation templates, and staff training on visit-to-visit codes.



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