2027 Maternity Coding Transition

A Practical Guide for Midwives, Practices & Billing Teams

From Global Maternity Billing to Phase-of-Care Reporting

MIDWIFERY
BUSINESS CONSULTATION

I. Purpose of This Guide

Beginning January 1, 2027, maternity CPT coding undergoes one of its most significant structural changes in decades. The traditional global maternity coding framework is being replaced by more granular reporting that separately recognizes antepartum care, labor management, delivery care, and postpartum care. The AMA states that 17 codes are deleted, 12 are added, and six are revised. For midwifery practices, this is more than a billing change.

It affects:

- Clinical documentation
- E/M coding
- Labor documentation
- Delivery documentation
- Postpartum documentation
- EHR workflows
- Charge capture
- Billing processes
- Payer contracts
- Patient financial estimates
- Cash flow
- Transfers between providers
- Team-based maternity care
- Quality and compliance auditing

Key Concepts

- 2026: Think primarily in terms of a maternity package.
- 2027: Think in terms of the individual phase of maternity care and the actual service provided.

II. The Four Phases of Maternity Care in 2027

The new framework separates maternity services into four major phases.

1. Antepartum Care
   - Prenatal evaluation and management occurring before the onset of labor.

- Beginning January 1, 2027, the existing antepartum package codes are deleted and antepartum encounters are generally reported using the appropriate E/M service for each encounter.

2. Labor Management
   - Labor becomes a separately identifiable phase of care.
   - Four new labor-management codes distinguish:

Initial vs. subsequent day and straightforward vs. complex labor management.

3. Delivery Care
   - Delivery becomes its own service rather than serving as the anchor for a global maternity package.
   - Separate codes distinguish vaginal delivery, VBAC, primary cesarean and repeat cesarean.
4. Postpartum Care
   - Postpartum care after the calendar date of delivery generally moves to the appropriate E/M reporting structure.
   - Routine postpartum care occurring on the same calendar date as delivery is included in the delivery service.

III. 2026 vs. 2027: The Fundamental Shift

2026 Approach	2027 Approach
Global maternity package	Phase-specific reporting
Antepartum packages available	Individual E/M encounters
Labor largely incorporated into delivery/global services	Separate labor-management codes
Delivery linked to global maternity structure	Delivery reported independently
Postpartum incorporated into global/postpartum codes	E/M reporting after delivery day
One practice commonly captures global care	Better accommodates multiple providers/teams
Limited visibility into individual encounters	Greater service-level visibility

The AMA explains that the restructuring is intended in part to better represent contemporary maternity care in which patients may receive services from multiple teams, transfer between facilities, use telehealth, or have individualized prenatal schedules.

IV. Codes Midwives Should Recognize

- Codes Deleted for 2027: following maternity codes are among those deleted effective January 1, 2027

59050	59426	59610
59400	59430	59612
59409	59510	59614
59410	59514	59618
59425	59515	59620
	59525	59622

- Do not simply replace each deleted code with one new code. The underlying reporting structure itself has changed.

V. New Labor Management Codes

- 59080: Initial day labor management — straightforward
- 59081: Initial day labor management — complex
- 59082: Subsequent day labor management — straightforward
- 59083: Subsequent day labor management — complex
    - Labor management includes services such as interim examinations, collection and interpretation of physiologic data, and induction or augmentation when applicable. It is generally reported once per calendar date.

VI. Straightforward vs. Complex Labor

- This will be an important education point for midwives.
- Straightforward labor is not synonymous with “normal vaginal birth.”
- The AMA's criteria for straightforward labor management require all applicable straightforward characteristics to be met, including singleton vertex presentation, routine maternal/fetal monitoring without findings requiring QHP intervention, normal progression or routine induction/augmentation, stable medical conditions not requiring additional labor management, and no previous cesarean. A deviation can move the labor-management service into the complex category.
- Examples that may affect labor complexity include:
    - Multiple gestation
    - Non-vertex presentation
    - Previous cesarean
    - Maternal deterioration
    - Fetal status requiring intervention
    - Medical conditions requiring active management during labor
    - Abnormal labor progression requiring additional management
    - Important
- Length of labor alone does not determine complexity.

- The record needs to show what made the labor clinically straightforward or complex.

VII. Labor Documentation Tips for Midwives

- Your labor note needs to communicate the clinical management of labor, not simply create a timeline.
- Document:
    - Maternal Status
    - Vital signs and relevant trends
    - Pain/coping status when clinically relevant
    - Relevant pregnancy complications
    - Medical conditions affecting labor
    - Maternal changes requiring intervention
    - Medications
    - Induction/augmentation
    - Response to interventions
    - Fetal Status
    - Presentation
    - Number of fetuses
    - Fetal heart rate assessment/monitoring
    - Clinically significant findings
    - Interventions performed because of fetal findings
    - Response to intervention
    - Labor Progress
    - Cervical examination findings
    - Station/presentation when applicable
    - Membrane status
    - Contraction pattern
    - Labor progression
    - Induction/augmentation
    - Changes in the management plan
    - Clinical Decision-Making
    - This becomes especially important
- Document: What happened → what you assessed → what you decided → why you decided it → what you did → how the patient/fetus responded

VIII. Delivery Coding Changes

- New delivery codes include:
    - 59431: Vaginal delivery, with or without episiotomy
    - 59432: Vaginal delivery after previous cesarean
    - 59502: Primary cesarean delivery: 59503

    - 59503: Repeat cesarean delivery
- The delivery codes represent the delivery service itself, rather than a global maternity package. Labor management may therefore be separately reportable when applicable.

IX. Perineal Laceration Documentation

- This is another important midwife-specific change.
- First- and second-degree laceration or episiotomy repairs performed by the delivering QHP/group are included in the vaginal delivery service.
- New codes separately identify: 59433
- Third-degree laceration/episiotomy repair: 59434
- Fourth-degree laceration/episiotomy repair
- These third- and fourth-degree repairs are separately reportable under the new framework.
- Documentation should identify:
    - Location
    - Degree
    - Structures involved
    - Repair performed
    - Technique when appropriate
    - Anesthesia
    - Suture/material
    - Blood loss when clinically relevant
    - Patient tolerance
    - Complications

X. Antepartum Care: The Major Documentation Change

- Beginning January 1, prenatal visits will generally be reported using the appropriate E/M service rather than an antepartum package.
- This means: Every encounter matters.
- A generic prenatal note should not be viewed merely as documentation that the patient "showed up for another prenatal."
- The record should demonstrate the actual professional service performed.

XI. E/M Documentation for Midwives

- For applicable office/outpatient E/M services, code selection may generally be supported through medical decision-making or total time, according to the rules applicable to that E/M category.
- The AMA specifically addressed the midwifery model in its 2027 maternity FAQ. It recognizes that low-risk midwifery visits may include substantial patient education and

shared decision-making and confirms that antepartum E/M selection can be based on MDM or total time on the date of the encounter, as applicable.

- Every midwife should understand:
  - E/M coding is no longer something only the biller needs to understand.
  - The clinician creates the documentation that ultimately supports the code.

XII. Consider Documenting Prenatal Encounters Around Five Questions

1. Why is the patient here?
   - Routine prenatal assessment?
   - New symptom?
   - Known complication?
   - Follow-up?
   - Additional concern?
2. What did I evaluate?
   - Maternal status
   - Fetal status
   - Laboratory results
   - Imaging
   - Symptoms
   - Pregnancy risk
   - Medical conditions
   - Medications
   - Psychosocial factors when relevant
3. What problems did I address?
   - Document conditions actually assessed or managed during the encounter.
4. What decisions did I make?
   - Testing
   - Treatment
   - Medication
   - Referral
   - Consultation
   - Surveillance
   - Follow-up
   - Change in care plan
5. What happens next?
   - Follow-up interval
   - Testing
   - Referral
   - Precautions
   - Care-plan changes
   - Escalation criteria

XIII. Don't Forget Time-Based Documentation

- Midwifery practices should determine whether time-based E/M selection may appropriately reflect certain encounters.
- This could be particularly relevant when a substantial portion of a visit involves medically necessary:
  - Counseling
  - Education
  - Shared decision-making
  - Care coordination
  - Reviewing records/results

- Ordering services
- Documenting the encounter
- Other qualifying work performed on the date of service.
- Avoid simply documenting:
  - "30-minute prenatal appointment."
  - Instead, when selecting an E/M service based on time, document the total qualifying time on the date of the encounter consistent with the applicable E/M guidelines.

XIV. Diagnosis Coding Still Matters

- CPT tells the payer what service occurred.
- ICD-10-CM tells the payer why the service occurred.
- The FY2027 ICD-10-CM files become effective October 1, 2026, rather than January 1, 2027.
- That means practices actually have two transition dates:
  - October 1, 2026
  - FY2027 ICD-10-CM
  - January 1, 2027
  - CPT 2027 maternity restructuring

XV. Pregnancy Diagnosis Documentation

- Continue emphasizing:
  - Trimester
  - Gestational age
  - Pregnancy supervision status
  - Maternal conditions affecting pregnancy
  - Pregnancy complications
  - Fetal conditions affecting management
  - Number of fetuses
  - Affected fetus when required
  - Specific complication being evaluated or treated

The FY2027 ICD-10-CM guidelines continue to distinguish supervision of high-risk pregnancy from complications occurring during labor/delivery and direct coders toward the applicable obstetric complication diagnosis when one exists.

XVI. Postpartum Care Changes

- The traditional postpartum/global structure changes significantly.
- Beginning January 1, 2027:
  - Same-calendar-day routine postpartum care → included in delivery care.
  - Subsequent inpatient postpartum management → applicable subsequent hospital E/M services.

- Post-discharge postpartum encounters → applicable E/M services based on the care provided and setting.

XVII. Postpartum Documentation Opportunity

- Practices should strengthen postpartum documentation now.
- Do not allow the postpartum note to become:
  - "Doing well. Breastfeeding. RTC one year."
  - Instead document the care actually provided
- Consider:
  - Maternal recovery
  - Bleeding
  - Pain
  - Perineal/incision healing
  - Blood pressure
  - Hypertensive disorders
  - Anemia
  - Infection concerns
  - Lactation
  - Breast concerns
  - Contraceptive counseling/management
  - Medications
  - Mood/mental health assessment
  - Sleep and recovery
  - Pelvic floor concerns
  - Chronic medical conditions
  - Pregnancy complications requiring follow-up
  - Referrals
  - Follow-up planning

XVIII. Transition Pregnancies: The Patients Who Cross January 1

- Example
  - Patient begins prenatal care: August 2026
  - EDD: February 2027
  - Delivery: February 2027
  - Postpartum: March–April 2027
  - This pregnancy crosses two CPT years.
  - The AMA's current CPT transition guidance states that for antepartum care spanning 2026 and 2027, the services occurring in 2026 remain subject to the 2026 framework, while encounters occurring in 2027 move to individual E/M reporting. For example, four to six qualifying antepartum visits occurring in 2026

may be reported with 59425, while 2027 encounters are reported individually with the appropriate E/M service. The AMA also advises checking individual payer policies.
    - Do NOT simply begin using 2027 rules early.

XIX. Create a Transition Patient List Now

- Practices should identify patients whose maternity care will cross January 1.
- Consider generating an EHR report based on:
    - EDD
    - Insurance
    - Provider
    - Practice location
    - Planned birth location
    - Risk status
    - Expected delivery provider
- Create a specific workflow flag: 2026–2027 TRANSITION MATERNITY PATIENT
- This allows billing and clinical staff to recognize these charts immediately.

XX. Biller Transition Plan

Your biller should not receive a memo on December 31.

- Schedule transition meetings now.
- Include:
    - Practice owner
    - Clinical lead
    - Biller/coder
    - Practice manager
    - EHR representative
    - Credentialing/contracting staff when applicable

XXI. Build a Payer Matrix

- This may become one of the most useful tools a practice creates.
- Use columns for:
    - Payer
    - Commercial/Medicaid/etc.
    - 2026 transition policy
    - 2027 antepartum requirements
    - Labor-management requirements
    - Delivery requirements
    - Postpartum requirements
- Required modifiers

- Diagnosis requirements
- Telehealth rules
- Place-of-service requirements
- Midwife reimbursement policy
- Authorization requirements
- Effective date
- Source of written guidance
- Last verified

XXII. Why Payer Verification Matters

- CPT coding rules and payer payment policies are not the same thing.
- CPT establishes the coding framework.
- Individual payers determine coverage, claim-processing requirements, contractual reimbursement and certain administrative requirements.
- There are already examples of state Medicaid programs issuing their own transition instructions. This means a rule used by one Medicaid program should not automatically be taught as a national requirement.
- For a national webinar:
    - Avoid saying: “Use modifier TH for prenatal care in 2027.”
    - Teach: “Some payers may require modifiers such as TH. Verify the written policy for each payer.”

XXIII. Biller Checklist

- Before January 1:
    - Confirm software contains 2027 CPT codes.
    - Deactivate deleted codes appropriately.
    - Update charge masters.
    - Update superbills.
    - Update favorites.
    - Update claim edits.
    - Review modifier rules.
    - Review payer policies.
    - Review fee schedules.
    - Test clearinghouse acceptance.
    - Update E/M workflows.
    - Build labor-management workflows.
    - Build postpartum E/M workflows.
    - Review place-of-service coding.
    - Review telehealth workflows.
    - Review home/residence E/M options when applicable.

- Develop transition-pregnancy procedures.
- Develop denial-management procedures.

XXIV. EHR Transition

- Review Every Maternity Template
- Prenatal - Does the template support E/M documentation?
- Labor - Does it demonstrate straightforward versus complex management?
- Delivery - Does it accurately describe delivery and repair?
- Postpartum - Does it document separately identifiable E/M work?
- Also review:
  - Smart phrases
  - Macros
  - Order sets
  - Diagnosis favorites
  - Charge capture
  - Superbills
  - Patient portal forms
  - Checkout workflows
  - Automatic charge generation
  - Billing interfaces

XXV. Practice Financial Transition

- The move away from traditional global maternity reporting may affect the **timing of revenue**, even when overall care remains similar.
- Practices should model:
    - 2026
    - Prenatal care
      ↓
      Delivery
      ↓
      Global maternity reimbursement
  - Versus
    - 2027
    - Antepartum E/M
      ↓
      Additional antepartum E/M
      ↓
      Labor management
      ↓
      Delivery

↓
Postpartum E/M
↓
Additional postpartum E/M

- Important: More individual codes do not automatically mean more reimbursement.
- Payment depends upon payer fee schedules, contracts, provider type, credentialing, modifiers, claim processing and other payer policies.

XXVI. Midwife Reimbursement Differential

- This deserves special attention in a midwifery webinar.
- Practices should specifically ask payers:
  - How will CNMs be reimbursed for the new maternity codes?
  - Will E/M reimbursement follow the existing contracted midwife fee schedule?
  - How will labor-management codes be valued for midwives?
  - How will postpartum E/M services be reimbursed?
  - Will the payer apply provider-type reductions or differentials?
  - Will existing maternity contract rates automatically transition?
  - Does our contract require amendment?
  - Do not assume that a payer's physician reimbursement methodology automatically answers the midwife reimbursement question.

XXVII. Patient Financial Transition

- Patients should understand that the billing structure is changing—not necessarily the clinical relationship or continuity of their maternity care.
- Practices should review:
  - Financial agreements
  - Good-faith estimates when applicable
  - Insurance estimates
  - Payment plans
  - Deposits
  - Refund policies
  - Transfer policies
  - Deductible explanations
  - Coinsurance explanations
  - Birth-center fees
  - Facility versus professional charges
  - Ancillary-service charges

XXVIII. A Simple Patient Explanation

- Practices can consider language such as: “Beginning in 2027, national maternity coding standards are changing how pregnancy, labor, delivery and postpartum services are reported to insurance. Your maternity care remains coordinated across your pregnancy, but individual phases and encounters may appear separately on insurance claims and Explanation of Benefits statements.”
- Then explain that: “An EOB is not necessarily a bill.”
- Patients should contact the practice before assuming that multiple claims represent duplicate billing.

XXIX. Patient Questions Practices Should Prepare For

- “Why am I receiving multiple EOBs?”
- “Why was my prenatal appointment billed separately?”
- “Why is there a labor charge and a delivery charge?”
- “Why did insurance apply this visit to my deductible?”
- “Why did my estimated maternity cost change?”
- “Why is postpartum being billed separately?”
- “Why did insurance deny this?”
- “Why does my birth-center bill look different from my midwife's bill?”

Develop scripts before January, not after the phones begin ringing.

XXX. Transfers of Care

- The restructuring may better represent maternity care provided by different teams, one of the reasons AMA cites for moving away from the legacy global structure.
- This is highly relevant to:
  - Home birth midwives
  - Birth centers
  - Hospital-based CNMs
  - Rural maternity units
  - MFM referrals
  - Hospital transfers
  - Collaborative practices
  - Locum midwives

XXXI. Documenting Transfers

- Clearly document:
  - Who provided care
  - What services were provided
  - When care began

    - When responsibility changed
    - Why transfer occurred
    - Where the patient transferred
    - Who accepted responsibility
    - Whether the midwife remained involved
    - What subsequent services the midwife provided
- Avoid vague statements such as:
    - "Transferred to hospital."
    - The documentation should establish the **clinical and professional handoff.**

XXXII. Group Practices Need Clear Internal Rules

- Ask:
    - Who owns the encounter?
    - Who enters the charge?
    - Who closes the encounter?
    - Who bills labor management?
    - Who bills delivery?
    - How are cross-coverage encounters handled?
    - How are locum services handled?
    - How are hospital and office encounters reconciled?
    - How do we prevent duplicate claims?
    - How do we capture missed charges?

The more granular the coding system becomes, the more important reliable charge capture becomes.

XXXIII. Home Birth Practice Considerations

Home birth practices should specifically review:

- Home/residence E/M coding
- Antepartum office versus home encounters
- Labor-management applicability and payer policies
- Delivery reporting
- Transfer workflows
- Post-transfer involvement
- Postpartum home visits
- Newborn services
- Separate maternal versus newborn claims
- Cash-pay agreements
- Insurance reimbursement arrangements
- Superbills

- Patient financial communication

XXXIV. Birth Center Considerations

Birth centers should distinguish:

- Professional services
- from
- Facility services.
- Do not assume changes to professional maternity CPT reporting automatically define how every birth-center facility claim will be handled.

Review:

- Professional claims
- Facility claims
- Payer contracts
- Authorization
- Credentialing
- Place of service
- Transfer situations
- Labor-only services
- Postpartum services
- Ancillary services

XXXV. Hospital-Based Midwifery Considerations

Hospital groups should clarify:

- Group billing
- Shared coverage
- Labor-management attribution
- Hospital E/M versus labor-management services
- Transfer between specialties/groups
- TOLAC/VBAC documentation
- Cesarean involvement
- Postpartum rounds
- Discharge services
- Teaching settings
- Residents
- APP/QHP billing policies
- Payer-specific rules

XXXVI. Audit Documentation Before January

Perform a mock 2027 audit using current charts.
Choose:

- 10 prenatal encounters
- 5 labor charts
- 5 deliveries
- 5 postpartum encounters

Ask:

- "If this encounter occurred January 2, 2027, would the documentation support the service we intend to bill?"
- That exercise will probably identify more problems than another staff PowerPoint.

XXXVII. First 90 Days of 2027

Create a maternity-specific monitoring process.
Track:

- Claims submitted
- Claims accepted
- Claims rejected
- Claims denied
- Clean-claim rate
- Days in A/R
- Payment amount
- Contractual adjustment
- Patient responsibility
- Modifier issues
- Diagnosis issues
- Medical-necessity edits
- Duplicate-service edits
- Labor-management denials
- E/M denials
- Postpartum denials
- Underpayments

XXXVIII. Don't Automatically Write Off Denials

A denial does not necessarily mean the service was coded incorrectly.

During a major coding transition, denials may reflect:

- Payer systems not updated

- Incorrect payer edits
- Missing modifiers
- Contract configuration problems
- Clearinghouse problems
- EHR mapping problems
- Incorrect diagnosis linkage
- Provider credentialing configuration
- True coding errors
- Identify the cause before changing the coding.

XXXIX. The Three-Way Audit

When a claim behaves unexpectedly, compare:

1. Documentation: What actually happened?

2. Coding: Does the claim accurately represent the documented service?

3. Payer Policy: How does the payer require that service to be submitted and reimbursed?

Do not change accurate documentation simply to make a claim pass an incorrect payer edit.

XL. Common Transition Mistakes to Avoid

- Mistake #1: Waiting until January to train clinicians.
- Mistake #2: Assuming the biller will handle everything.
- Mistake #3: Using 2027 CPT rules before January 1 without payer-specific transition direction.
- Mistake #4: Assuming every payer follows identical implementation rules.
- Mistake #5: Continuing generic prenatal documentation.
- Mistake #6: Assuming every long labor is complex.
- Mistake #7: Failing to document why labor became complex.
- Mistake #8: Forgetting postpartum E/M charge capture.
- Mistake #9: Failing to identify transition pregnancies.
- Mistake #10: Assuming reimbursement will remain identical.
- Mistake #11: Failing to update patient financial agreements.
- Mistake #12: Failing to monitor January denials.

XLI. Practice Transition Timeline

SEPTEMBER 2026 — EDUCATE

- Learn the CPT framework
- Identify transition patients

- Meet with billing
- Begin payer outreach
- Review contracts
- Audit current documentation

OCTOBER 2026 — BUILD

- Implement FY2027 ICD-10-CM on October 1
- Update templates
- Build payer matrix
- Build coding workflows
- Create documentation education

NOVEMBER 2026 — TEST

- Train clinicians
- Test EHR
- Test billing software
- Confirm payer policies
- Review fee schedules as they become available
- Run mock claims/workflows

DECEMBER 2026 — VERIFY

- Recheck payer guidance
- Finalize transition patient handling
- Update patient communications
- Verify software updates
- Confirm staff responsibilities

JANUARY 2027 — IMPLEMENT

- Use new CPT structure for services beginning January 1
- Monitor claims daily/weekly
- Escalate unexpected denials

FEBRUARY–MARCH 2027 — AUDIT

- Audit documentation
- Audit coding
- Review reimbursement
- Identify underpayments
- Correct workflow problems
- Retrain where necessary

XLII. The Five People Who Need to Be at the Table

- The Midwife: Did I document the care?
- The Coder/Biller: Does the claim accurately represent the documentation?
- The Practice Manager: Did the workflow capture the service?
- The Payer/Contracting Representative: How will the claim be processed and reimbursed?
- The Patient: Do I understand what I may owe and why?

A successful transition requires all five perspectives

XLIII. Ten Questions Every Midwifery Practice Should Answer Before January 1

1. Have all clinicians received E/M documentation education?
2. Have our prenatal templates been updated?
3. Can our labor documentation distinguish straightforward from complex management?
4. Does our EHR contain the new codes?
5. Have deleted codes been addressed?
6. Do we know how each major payer will handle transition pregnancies?
7. Have we reviewed our reimbursement contracts and fee schedules?
8. Have we identified every pregnancy crossing January 1?
9. Have we updated patient financial communication?
10. Who is responsible for monitoring 2027 denials and underpayments?

If the practice cannot answer these questions today, that becomes the transition worklist

XLIV. Key Takeaways for Midwives

1. This is not just a billing department change - Documentation and clinical workflow are directly affected.
2. Prenatal and postpartum encounters become increasingly important individually - The actual work performed must be captured.
3. Labor management becomes visible as its own service - Document clinical complexity and decision-making.
4. Delivery is no longer the center of a global package - Think across four distinct phases of maternity care.
5. CPT rules do not guarantee payer reimbursement - Verify individual payer requirements.
6. Transition pregnancies need proactive management - Identify them before January.
7. Patients need education too - Multiple claims or EOBs do not necessarily mean duplicate care.
8. Audit early - The first months of 2027 should involve active claim and documentation review.

XLV. Recommended Student Resources

- AMA — CPT 2027 Maternity Care Services Changes
- AMA — CPT 2027 Maternity Care FAQ
- AMA — 2027 Maternity Coding Primer Webinar
- CMS — FY2027 ICD-10-CM Resources

This material is provided for general educational purposes and reflects information available as of September 17, 2026. CPT, ICD-10-CM, payer policies, reimbursement methodologies, state Medicaid requirements, contracts, scope-of-practice requirements, and billing guidance may change. This material does not constitute legal, tax, financial, payer-specific, or individualized coding advice. Practices should consult the current CPT code set and official guidelines and verify requirements directly with applicable payers, regulatory agencies, coding professionals, compliance professionals, and other qualified advisors.