



Advancing Health in America

CPT® 2027 Maternity Care Services - Coding Restructure

May 28, 2026

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Introduction

Speaker

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Speaker disclosures

- No disclosures

What's Changing

- Fundamental redesign of maternity care CPT® (Current Procedural Terminology) coding, replacing the legacy global maternity package with a service-based reporting framework.
- Changes modernize professional CPT reporting to reflect team-based, fragmented, and higher-complexity obstetric care.
- Resulted from a Maternity Care Services workgroup and multi-stakeholders

CPT[®] Code Changes - High Level

- **Current state:** Maternity care is reported under one global code, simplifying billing but obscuring care variation and complexity.
- **Beginning Jan. 1, 2027:** CPT updates will introduce more granular, phase-based reporting: **antepartum, labor management, delivery, and postpartum.**

CPT Code Deletions	CPT Code Additions	CPT Code Revisions
17	12	6

Antepartum Care: Shift to E/M-Based Reporting

- **Key Change (2027):**
 - **All antepartum visit codes deleted.**
 - Report each encounter using Evaluation and Management (E/M) codes - prior to onset of labor.
- **Implications:**
 - Apply standard E/M rules (leveling, documentation).
 - Reporting aligns with care location – (Office, Hospital, Telemedicine).
- **Operational Impact:**
 - Increased need for accurate encounter-level documentation.
 - Greater transparency of visit complexity and frequency.

Labor Management: New Daily Reporting Model

- **Daily Reporting Structure:**
 - Report once per calendar date
 - New codes for: Initial Day and Subsequent Days
- **Two Levels of Care: Straightforward and Complex**
- **Facility Reporting Rules:**
 - “Initial Day” reported once per admission
 - Exception: different provider
- **Alignment:**
 - Mirrors inpatient hospital care reporting conventions
- **Operational Considerations:**
 - Clear documentation of day-to-day complexity
 - Coordination across providers during admission

Delivery: Streamlined & Component - Based Coding

- **Simplified Delivery Codes:**

- Vaginal delivery: With / without episiotomy (Vaginal Birth After Cesarean - **VBAC included**)
- Cesarean delivery: Primary vs. repeat

- **Key Structural Change:**

- Codes represent delivery only
- Labor management reported separately

- **New Distinct Procedure Codes:**

- 3rd-degree and 4th-degree laceration/episiotomy repair
- Post-cesarean hysterectomy (stand-alone)

- **Impact:**

- Improved clinical specificity
- More accurate representation of resource intensity

Postpartum Care: Transition to E/M + Procedural Specificity

- **Key Change (2027):**
 - All postpartum codes deleted
 - Report per encounter using E/M codes
- **Same-Day Care:**
 - Routine postpartum care included in delivery code
- **Facility-Based Reporting:**
 - Use subsequent hospital care codes per direct encounter
 - Report each day after delivery until discharge
- **Operational Impact:**
 - Increased focus on daily documentation
 - Better capture of ongoing postpartum complexity

Care Model Considerations

- **Employed or aligned groups (single governance model)**
 - Easier standardization of documentation and charge capture across phases
 - Clearer accountability for labor management “day” reporting and postpartum E/M workflows
- **Independent/contracted/privileged clinicians**
 - Higher variation in handoffs, coverage models, and documentation patterns
 - Greater need to clarify: who reports labor management days, postpartum visits, and transition documentation

Large/Tertiary vs. Rural

- **Large/tertiary hospitals**

- More multi-day labor management and complex case mix → higher operational complexity
- More transfers within the facility (e.g., escalation of care) → more documentation dependency

- **Rural hospitals**

- Higher likelihood of transfer to tertiary centers
- Opportunity to reflect services provided **prior to transfer**, but requires explicit transfer documentation and timing

Large/Tertiary vs. Rural

Care Dimension	Large / Tertiary Hospital	Rural Hospital
Provider model	Subspecialty OB teams	Family medicine, CNM, mixed coverage
Labor staffing	24/7 in-house OB	On-call, often cross-coverage
Transfers	Infrequent	Common & expected
Labor duration	Managed on-site	Often prolonged or interrupted by transport
Postpartum care	Dedicated OB follow-up	Often primary care or telehealth

Payer & Contracting Considerations

- Anticipate potential payer implementation differences: edits, bundling logic, prior auth policies
- Review payer contracts and internal assumptions for:
 - maternity episode arrangements
 - professional/facility billing coordination
 - denial management pathways for new rules

Provider Documentation - “Minimums”

- **Labor management daily note should support**
 - Date and status (labor onset or induction start)
 - Initial vs subsequent day logic
 - Straightforward vs complex rationale (brief but explicit)
 - Key interventions and monitoring
- **Delivery documentation should support**
 - Mode determination point and delivery performed
 - Any separately reportable procedures (e.g., severe laceration repair, uterine tamponade)
- **Postpartum documentation should support**
 - Inpatient postpartum management days and discharge day work
 - Outpatient postpartum visits after discharge

Financial Forecasting

- Model expected shift in claim timing (antepartum/postpartum E/M + labor per-day)
- Identify high-variance scenarios (multi-day labor, transfers, mixed provider models)
- Build payer-specific sensitivity estimates (commercial vs. Medicaid, etc.)
- Financial impact will vary based on:
 - **Provider type** Obstetrician (OB), Certified Nurse-Midwife (CNM), family medicine, Nurse Practitioner (NP)
 - **Employment vs. contracted models**
 - **Care delivery patterns** (transfers, prolonged labor, team-based care)

Nursing, Provider, Health Care Professionals

Shared Clinical and Documentation Readiness

- Clearly document start of care phases
 - Antepartum (pre-labor), labor onset/induction, delivery, postpartum
- Support calendar-day reporting logic (especially labor management)
- Reflect clinical complexity (straightforward vs. complex care)
- Ensure timing, transitions, and handoffs are explicit

Care Transitions (Critical Across All Settings)

Shared Clinical and Documentation Readiness

- Explicit documentation of: Transfers (to/from hospital or higher level of care)
 - Provider handoffs
 - Responsibility for ongoing care
- Align on **“who is managing/reporting each phase”**

Nursing, Provider, Health Care Professionals

Hospital Based

- Daily documentation supports labor management day reporting
- Clear initial vs. subsequent day distinctions
- Capture care escalation, monitoring, interventions
- Coordinate across shifts, covering providers, and teams

Nursing, Provider, Health Care Professionals

Non-Hospital Based (Office, Clinic, Telehealth)

- Use E/M documentation standards for antepartum & postpartum visits
- Accurately reflect visit frequency and medical decision-making
- Ensure continuity with hospital care documentation
- Clearly document referrals, transfers, and follow-up plans

Governance and Alignment

Readiness Considerations

- Establish internal “who bills what” principles for labor management days and postpartum E/M.
- Confirm documentation and charge capture accountability across employed and independent clinicians.
- Align with OB leadership and HIM on standard workflows and escalation documentation.

Coding and Clinical Documentation

Readiness Considerations

- Create phase-based coding tip sheets (antepartum / labor / delivery / postpartum).
- Train coders and billers on calendar-date rules and prohibited combinations.
- Develop and promote provider-facing “documentation requirements”.
- Create a transfer/handoff documentation standard (internal + facility transfer scenarios).
- Build denial playbook: top edits, documentation fixes, appeal language.
- Conduct “shadow coding” audits on 2026 cases under 2027 logic.
- Track error themes and refresh education quarterly.

Revenue Cycle

- **Readiness Considerations**

- Update charge capture pathways for new code families.
- Configure claim edits/scrubbers for same-day restrictions and code pair rules.
- Establish a cross-midnight validator process for labor days.
- Define reconciliation workflow to prevent duplicate billing across clinicians/groups.
- Prepare for new edits and denials: update work queues and appeal templates.
- Implement pre-go-live “shadow billing” analysis using 2026 cases.
- Track KPIs: denial rate, days in A/R, edit rate, rebills/overlaps.

Key Points - What Matters Most

- **This is more than coding - it is a care delivery and documentation transformation.**
- Shift from global to encounter-based reporting increases visibility of the health care team's work.
- **Documentation drives everything -**
 - Accurate, timely, and daily documentation is essential across all phases of care.

Key Points - What Matters Most

- **Interdisciplinary coordination is critical**
 - Nursing, physicians, Health Information Management (HIM), and revenue cycle - operate as one system.
- **Anticipate potential early disruption - but long-term opportunity**
 - Improved data to support staffing, maternal health outcomes, and program investment.
- **Leadership focus for 2026–2027 - Standardize workflows**
 - Clarify roles and accountability.
 - Support education and change management.

References

- CPT® 2027 Maternity Care Services code changes
- CPT webinar “A coding primer: Previewing the CPT 2027 restructure for maternity care services” (June 2, 2026).