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Client Alert: A New Era for Maternity Billing: The Current Procedural Terminology Code Overhaul Reshaping Obstetric Reimbursement in 2027

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Starting January 1, 2027, providers will no longer bill obstetric services through a single global Current Procedural Terminology (CPT) code spanning approximately 9-10 months of care. Instead, the new code structure will involve separate reporting for each phase of the pregnancy continuum. These changes are a result of a multi-year collaboration between the CPT Editorial Panel, the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and the American Academy of Family Physicians (AAFP). The code set retires 17 legacy codes, replacing them with 12 new and six revised codes organized as follows:

- **Antepartum:** All current antepartum codes will be deleted. Each prenatal encounter will be reported individually through standard evaluation and management (E/M) codes based on the location of the patient (office, hospital, telehealth) at the time of service.
- **Labor Management:** New labor management codes will be reported daily. These codes are divided into "Initial Day" and "Subsequent Day" categories and with two complexity levels: straightforward and complex.
- **Delivery:** Introduces new codes for vaginal (with/without) episiotomy, vaginal birth after cesarian (VBAC), and cesarean (primary vs. repeat) deliveries, as well as codes for third- and fourth-degree laceration repair and hysterectomy following a cesarean delivery.

- **Postpartum:** Routine postpartum care provided on the same day of delivery will be bundled into the delivery code and will not be separately reported. For inpatient postpartum care furnished after the day of delivery, providers will use subsequent hospital E/M codes for each inpatient day until discharge, followed by a discharge day management code.

The collaborators involved in the maternity billing overhaul recognized that the global code, introduced in the 1990s, does not reflect modern obstetric practice. For example, today's maternity patients are frequently managed by multiple unaffiliated clinicians and may be transferred between facilities. Prenatal care has also shifted toward tailored, individualized visits incorporating telehealth and home monitoring. Additionally, the U.S. continues to suffer markedly worse maternal mortality outcomes than peer nations.

The new codes are meant to allow payers and providers to "reliably assess quality, risk, and birthing outcomes" and "improve the ability of all parties to analyze care patterns, understand drivers of maternal morbidity and mortality, and design payment models that reward high-quality care."

Despite this major shift, patients should not see much of a change to their health plan benefits or cost-sharing responsibilities. However, it is inevitable that this new code set will impact the day-to-day operations of obstetric providers. In anticipation of the CPT code overhaul set to take effect next year, providers should develop targeted staff training and update their billing and clinical workflows accordingly. Providers should work with their electronic health record (EHR) and practice management vendors to confirm systems can support the new phase-specific and daily billing structures. Additionally, providers should review existing payer contracts referencing the global obstetric code and assess amendment and/or renegotiation needs.

ACOG recommends obstetric providers consider the following questions:

1. Documentation: Do our notes clearly support the phases of care and service reported?
2. Workflow: Do our physicians, coders, and billers share the same understanding of the new structure?
3. Systems: Do our EHR templates and charge capture processes reflect the 2027 model?

ACOG is hosting a live webinar on August 3, 2026, to discuss the new code structure, identify common maternity reporting scenarios, address documentation concerns, and set forth guidance for how to operationalize the upcoming changes.

What Does This Mean for Hospitals?

For hospitals with labor and delivery units, the 2027 CPT overhaul will require operational adjustments beyond those facing physician practices. From a facility billing and charge capture perspective, hospitals will need to align their processes with the new discrete coding structure, particularly for postpartum inpatient care. The unbundled attribution model may also affect financial dynamics with community obstetricians who deliver at the facility but provide prenatal and postpartum care elsewhere, warranting proactive engagement. Finally, the granular data produced by the new coding framework will enable hospitals to better analyze care patterns and support quality improvement initiatives related to maternal outcomes. Hospitals should work with revenue cycle teams, clinical departments, and community physicians to prepare for these changes.

If you have questions about how the changes to maternity billing will impact your practice, please contact Mara Rendina, Kate Crawford, or a member of Shumaker's Health Law team.

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