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A Coding Primer: Previewing the CPT® 2027 Restructure for Maternity Care Services Codes

June 2, 2026

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Our Presenters

Zach Hochstetler, MBA, MPP
Vice President, CPT® Coding & Payment
American Medical Association

Leslie Prellwitz, MBA, CCS, CCS-P, CPMA
Director, CPT Content Management & Development
American Medical Association

Tammy Love, RHIA, CCS, CDIP
Director, Coding, Classification & Policy
American Hospital Association

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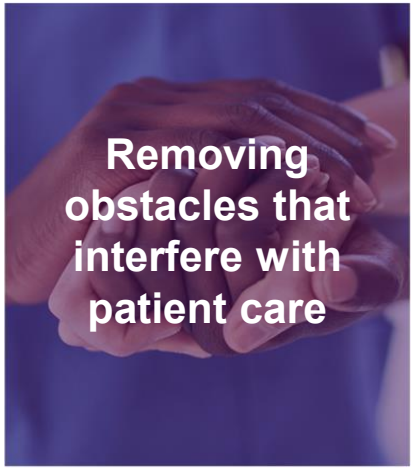

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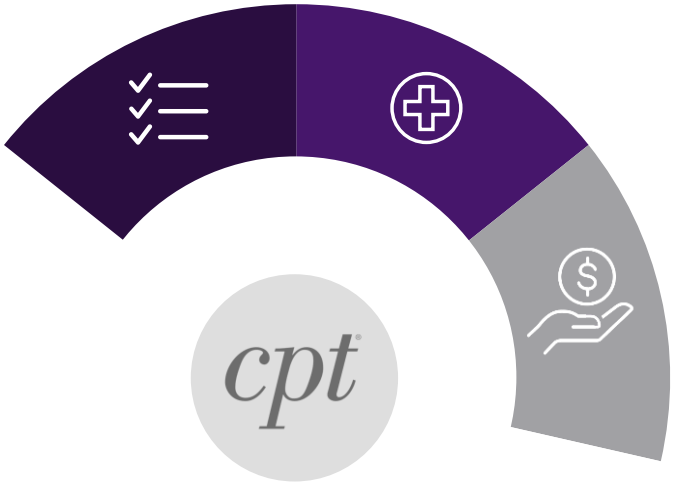
CPT®: Perception



- **Medical Code Set Terminology Standard**
- **Claims-Based Reporting**
- **Fee-for-Service Payment**

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CPT®: Perception vs. Reality

- **Medical Code Set Terminology Standard**
- **Claims-Based Reporting**
- **Fee-for-Service Payment**
- **Quality Management**
- **Alternative Payment Models**
- **Interoperability**
- **Research**

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Agenda

- Historical Context
- Summary of Changes
- Changes by Phase
  - Antepartum Care
  - Labor Management
  - Delivery Care
  - Postpartum Care
- ICD-10-CM and DRG Reporting
- Considerations and Readiness
- Additional Resources
- Q&A

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Historical Context

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Why change?

- Current CPT® code structure 30+ years old
- Changes in patterns of maternity care provided created increasing patient complexity
  - Escalation of care from rural hospitals to tertiary centers;
  - Increasing length and complexity of labor, and increasing use of labor induction to safely reduce cesarean delivery rates;
  - Increasing focus on hemorrhage, cardiovascular disease, and maternal mental health to decrease key maternal morbidity and mortality;
  - Changes in patients and providers/practices;
  - Data and information to better track care provided; and
  - Addition of telehealth / e-services
- → ***Care variations not reflected in current coding***

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Maternity Care Services Workgroup Charge

The Workgroup will assess the current practice of Maternity Care including antepartum care, labor management, delivery, and postpartum services to bring forth a Code Change Application with suggested changes to existing codes as well as proposed new codes which reflect the current practice of medicine while aligning to the rules, guidelines, and conventions of the current CPT® code set, while meeting the needs of all stakeholders.

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Maternity Care Services – Benefits of CPT® Coding Restructure

Reflects Modern, Team-Based Obstetric Care

Physicians can accurately report the care they deliver patients experience fewer gaps during transitions, and payers gain visibility into real-world care delivery.

Improves Transparency, Data Quality and Measurement

Creates reliable tracking for quality improvement, risk adjustment and population-level analysis, particularly for maternal morbidity and mortality.

Supports Evidence-Based Labor and Postpartum Care

Aligns CPT coding with evidence-based practice, improves outcome measurement, and supports appropriate postpartum follow-up and intervention.

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Summary of Changes

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Level-Setting: Terms

- Use of the term “**physician**” is for brevity. Term also includes other qualified health care professionals (e.g., Certified Nurse Midwife) as defined by the CPT® code set
- “Unrelated physician” = a physician or other QHP who is not in the same group practice, or in the same group practice but of a separate specialty designation

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CPT® Structural Shift for Maternity Care Services

- **This is a structural shift, more than a routine coding update**
- Replaces global maternity package with **service-based framework**
- Impacts:
  - Claims volume and patterns
  - Provider attribution
  - Quality and analytics

- Global model assumes **single physician, continuous care**
- Current reality:
  - Team-based (OBs, midwives, hospitalists)
  - Shift-based, facility-centric
  - Increasing labor and postpartum complexity

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Maternity Care – CPT® Coding Prior to Jan. 1, 2027

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Maternity Care – Effective Jan. 1, 2027

Code Restructure Summary:

- Global codes deleted
- Antepartum, Labor Management, Delivery and Postpartum care now reported with separate codes
- New subsections and revised guidelines
- Some existing codes relocated

Code Change Counts:		
Deleted	Added	Revised
17	**12**	**6**

Download the full list of CPT® codes with guidelines for maternity care services:
ama-assn.org/cpt-maternity-care

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CPT® Code Hierarchy: Structural Change

Prior to Jan. 1, 2027

Maternity Care and Delivery

- Antepartum and Fetal Invasive Services
- Excision
- Introduction
- Repair
- Vaginal Delivery, Antepartum and Postpartum Care
- Cesarean Delivery
- Delivery after Previous Cesarean Delivery
- Abortion
- Other Procedures

Effective Jan. 1, 2027

Maternity Care Services

- Antepartum Care
  - Antepartum Procedures and Fetal Invasive Services
- Labor Management
  - Labor Procedures
- Delivery Care
  - Vaginal Delivery
  - Cesarean Delivery
- Maternal Postpartum Care
  - Postpartum Procedures
- Excision
- Introduction
- Abortion
- Other Procedures

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Key CPT® Changes

Antepartum
- Report using E/M
- *MDM: Pregnancy?*
- *Transition Reporting*

Postpartum
- Report using E/M

Labor Management
- Biggest change
- New section/separately reportable
- Report per day
- Complexity, defined

Delivery
- Streamlined reporting

New codes:
- 3rd and 4th degree episiotomy laceration repair
- Hysterectomy following cesarean

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Maternity Care Services: Key Overall Guidelines

- Maternity care includes outpatient/inpatient antepartum care, labor management, delivery care, and inpatient and outpatient postpartum care

- Many overall guidelines are similar to current
  - ✓ Pregnancy confirmation during any encounter may be reported with the appropriate E/M code for that setting
  - ✓ Surgical complications of pregnancy? See Surgery Section

- New:
  - ✓ Care provided by a nonphysician qualified health care professional who may not report E/M? Refer to specific service (eg, genetic counseling [96041], medical nutrition therapy [97802, 97803, 97804])
  - ✓ Newborn care – see inpatient newborn care services

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Reporting:
Antepartum Care

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Antepartum Care – Codes Included

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

A Key Change: What is Not Here…

Relocated from "Repair" and "Other Procedures"

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Antepartum – Routine Reporting

- Antepartum Care includes the management of pregnancy prior to the onset of labor
- Reported *per encounter* with the appropriate evaluation and management (E/M) service based on location of patient

  ►Antepartum care includes the management of pregnancy prior to the onset of labor. Antepartum care is reported with the appropriate evaluation and management (E/M) codes (eg, office or other outpatient services [99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215], telemedicine services [98000-98015], virtual check-in [98016], home or residence services [99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350], initial or subsequent hospital inpatient or observation services [99221, 99222, 99223, 99231, 99232, 99233], hospital inpatient or observation care services [including admission and discharge services] [99234, 99235, 99236], or critical care services [99291, 99292]).◄

- *E/M code selection options apply – Time or Medical Decision Making (MDM)*

Guideline current as of April 12, 2026; review CPT® 2027 Professional Edition *when available for final verbiage.*

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Antepartum Standard Care – Medical Decision Making

- For MDM: E/M code reported will be determined based on services provided during that encounter
- Code selection based on 3 elements:
  - Problem(s) Addressed
  - Amount and/or complexity of Data to be reviewed and analyzed
  - Risk of complications and/or morbidity or mortality of patient management
- *Pregnancy as a condition will be evaluated under "Problem(s) Addressed"*

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Preparation: MDM Reporting – Documentation is Key

- Each encounter reported separately → potential for E/M level variation
- Documentation to support E/M code selection is key, particularly on Risk
- → Ensure documentation reflects patient severity

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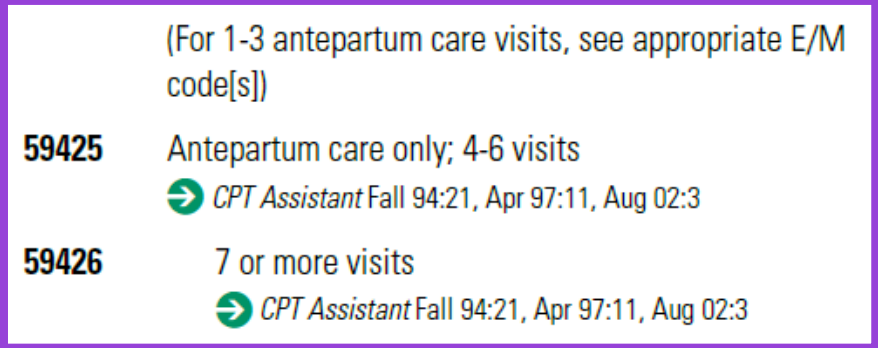
Preparation: Transition Reporting

The Coding Conundrum

Q: *For patients with antepartum care in both the 2026 and 2027 calendar years, the global delivery codes will expire before their care is completed. How should antepartum care be reported across y*

A: From a CPT® reporting perspectiv
services in both 2026 and 2027:

Antepartum visit services provided in
59426 or E/M codes, depending on th
provided in 2027 should be reported v


(For 1-3 antepartum care visits, see appropriate E/M code[s])

59425 Antepartum care only; 4-6 visits
CPT Assistant Fall 94:21, Apr 97:11, Aug 02:3

59426 7 or more visits
CPT Assistant Fall 94:21, Apr 97:11, Aug 02:3

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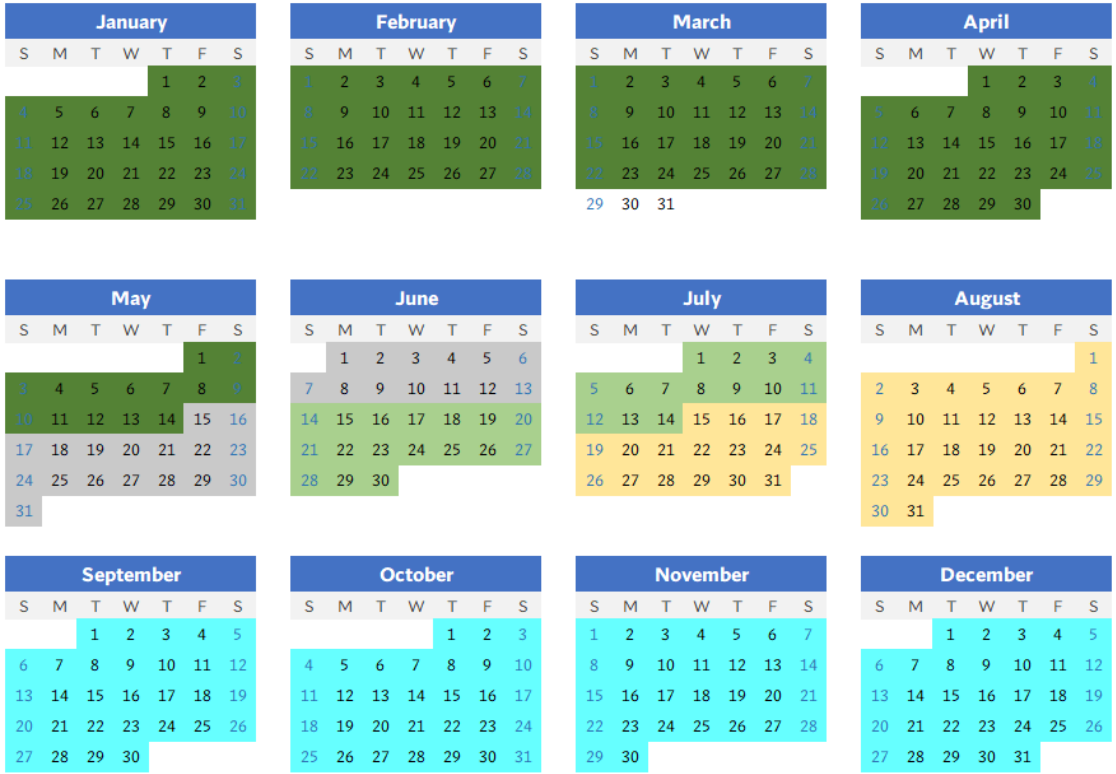
Preparation: Transition Reporting – Consider Due Dates



DATE OF FIRST 10 WEEK PRENATAL VISIT

- Due dates in 2026
- Due dates Dec/Jan
- Due dates Jan/Feb: 7 or more visits (CPT® 59426)
- Due dates Feb/April: 4-6 visits (CPT® 59425)
- Due dates April on: likely less than 4 visits (E/M codes)

Illustrative Guide for Planning Purposes

- Pregnancies with first 10-week visits January through May will likely utilize current OB global codes (including antepartum-only codes)
- Pregnancies with first 10-week visit September 1 and after will likely have 3 or less prenatal visits and need to use E/M codes per current CPT® guidelines for antepartum visits less than 4

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Preparation: Use of ICD-10-CM to Identify a "Pregnancy-Related" E/M Service

- Use *ICD-10-CM* Codes Specific to Pregnancy:
  - Encounter for supervision of normal pregnancy (e.g., Z34.XX)
  - Conditions affecting the management of pregnancy, childbirth and purperium (categories O00-O9A)
    - Used to describe the entire obstetric experience (conception to end of 6 weeks after delivery)

- Consider: Use a Modifier
  - **TH** – Obstetrical treatment/services, antepartum or postpartum

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Antepartum and Fetal Invasive Procedures

- Antepartum and Fetal Invasive Services codes remain—some services were relocated from ‘Other Procedures’ and ‘Repair’ subsections
- May be separately reported from Antepartum E/M
- Diagnostic imaging services may be separately reported in addition to antepartum E/M visits

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Antepartum – Revised/Deleted Codes

Deleted Jan. 1, 2027:

59050, *Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation*

Effective Jan. 1, 2027:

For interpretation and report of fetal heart tracing:

▲**59051** *Fetal monitoring during labor by consulting physician (i.e., non-attending physician) or other qualified health care professional, with interpretation and report*

Consultation requested for parturient or fetal well-being other than fetal heart monitoring? See appropriate E/M procedure code.

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Reporting:
Labor Management

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Labor Management – Codes Included

Report based on complexity and length

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
Labor Procedures	
59030	Fetal scalp blood sampling
▲59051	Fetal monitoring during labor by consulting physician (i.e., non-attending physician) or other qualified health care professional, with interpretation and report

Relocated from "Antepartum and Fetal Invasive Services" subsection

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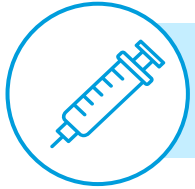
Labor Management: What's Included

Interim physical examinations

Collection and interpretation of physiologic data (e.g., partograms, tocometric data, vital signs, pulse oximetry)



Induction/augmentation of labor (e.g., mechanical cervical dilation/ripening methods, prostaglandins, oxytocin, amniotomy)

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Labor Management Guidelines: Daily Reporting Guidelines

- Facility reporting: “Initial Day” is reported once per facility admission unless there is a unique provider
- Reporting similar to *guidelines* for Hospital Care E/M:
  - Face-to-face encounter required
  - Reported once per calendar date
  - Multiple visits by same physician/QHP on a single calendar date, same setting—report as a single management service
  - A continuous visit (i.e., requiring continuous personal physician or other QHP attendance at bedside or elsewhere on the floor or unit focused on a single parturient) that spans the transition of two calendar dates is reported as a single service on one of the two calendar dates
  - Coverage: If Dr. B is on call / covering for Dr. A, encounter is classified as it would have been by Dr. A
- **May not** typically be reported on the same day as Hospital Care codes by same physician

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Labor Management Guidelines

- Reporting rules for consultations during labor were added
- A planned or scheduled cesarean would not have a labor management code associated with the service
- Once labor management begins, all other E/M services stop (e.g., hospital care)
    - *Exception:* Office or other outpatient E/M services are allowed to be reported on the same day if the patient is seen in the office and subsequently admitted to the facility for labor onset on the same day

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Initial Day vs. Subsequent Day

Initial Day

- The first calendar date induction begins or the parturient requires labor management services. The physician or other QHP or same group practice has not previously performed labor management services during the same facility admission and stay.
- The parturient is transferred to a new facility after receiving labor management services at a previous facility.
- A physician or other QHP of a different specialty/subspecialty assumes care for reasons other than covering for another physician/ QHP (e.g., escalation of care for medical necessity.

Subsequent Day

- If none of the criteria is met for “initial,” a subsequent day code is reported.
- Is reported “per” subsequent day of labor management.

A delivery code may be reported on the same day as Initial or Subsequent Labor Management code.

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Labor Management: Straightforward vs. Complex

A table was added to help identify the level of labor management.

Straightforward: Must meet *all* criteria

- Singleton vertex presentation
- Routine maternal/fetal monitoring
- Fetal monitoring (e.g., heart rate) not requiring physician or other QHP intervention
- Normal progression of labor or routine labor induction or augmentation
- Stable medical conditions (e.g., well-controlled hypertension, diet-controlled diabetes) not requiring additional management during labor
- No previous cesarean delivery

Complex:

- Any encounter that does not meet *all* of the Straightforward criteria
- Illustrative examples provided; not exhaustive

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Straightforward vs. Complex

- An increase in complexity throughout the calendar date will result in an increase in the labor management reported.

Parturient escalates from Straightforward to Complex on same date of service → <u>Complex</u> code is reported

- One labor management code is reported per physician per parturient per day.
- *Exception*: An increase in complexity of labor requires a care transfer from one group to another.
    - <u>Example</u>: A CNM who is part of a small group is managing a parturient. Throughout the day the parturient's condition deteriorates and the CNM transfers the parturient's care to a physician in a separate group practice.

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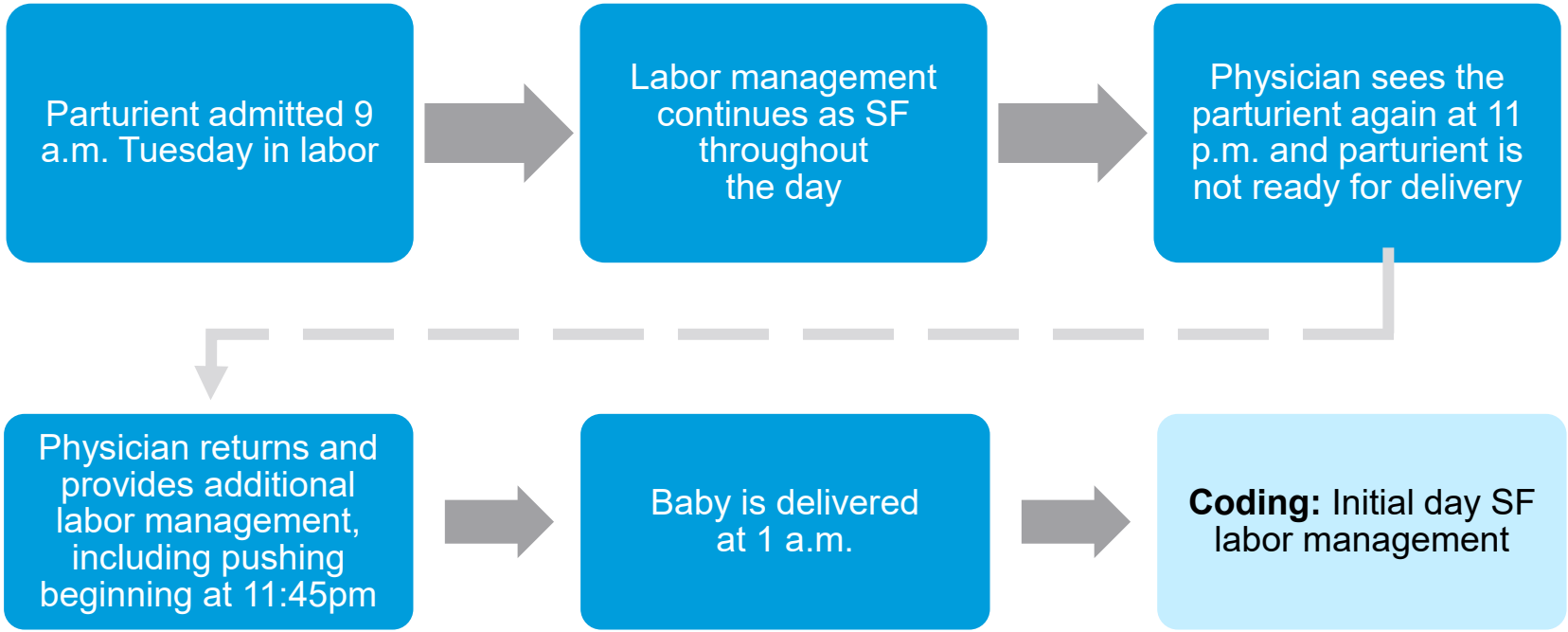
Labor Management (Only) Examples



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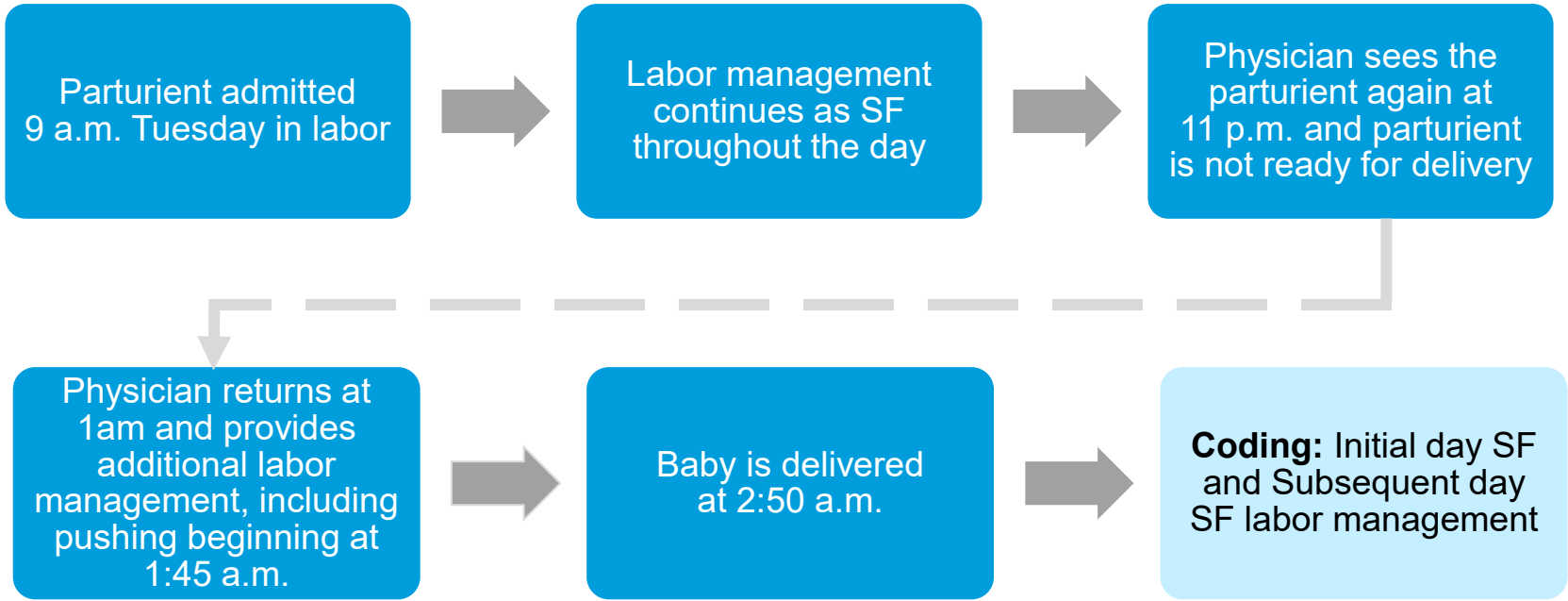
Labor Management (Only) Examples



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Reporting: Delivery Care

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Delivery Care – Codes Included

- No longer part of global care
- No longer dependent on who performs postpartum

Vaginal Delivery

Code	Descriptor
●59431	Vaginal delivery, with or without episiotomy;
●59432	after previous cesarean delivery
▲59414	Delivery of placenta only (separate procedure)
▲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)
●59433	Repair of episiotomy or laceration; third-degree laceration
●59434	fourth-degree laceration

Cesarean Delivery

Code	Descriptor
●59502	Cesarean delivery; primary
●59503	repeat
●59504	Subtotal or total hysterectomy after cesarean delivery

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Delivery Care, Defined

- Delivery care begins when labor is:
  - *Complete* (presenting part of the fetus is visible and firmly rimmed by the vaginal introitus)

or

  - *Interrupted* (eg, arrest of labor is diagnosed and a subsequent decision for cesarean delivery is made)
- Complexity of labor/decision for delivery is only reported under labor management
- Can be reported on the same day as initial or subsequent labor management even when same physician provides **both**
- Includes same day *routine* postpartum care

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Vaginal Delivery

Includes:

- Management of the delivery (both parturient and fetus/baby)

And if performed by delivering physician/group:

- Episiotomy
- Repair of 1st or 2nd degree episiotomy/laceration
- Placenta delivery

Does not include:
Attempted vaginal delivery when a cesarean was ultimately required

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Vaginal Delivery: Revised Codes

For reporting by Unrelated physician

- 59414 Delivery of placenta only (separate procedure)
- 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)

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New Codes: Episiotomies/Lacerations

Any physician may separately report

- 59433 Repair of episiotomy or laceration; third-degree laceration
- 59434 fourth-degree laceration

- Previously Unlisted
- 1st and 2nd degree repair included in delivery code

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Coding Example: Labor and Vaginal Delivery

Scenario: Parturient presents in labor and requires SF labor management. Delivery occurs the same day, and the parturient sustains a 3rd degree laceration.

• Labor Management, Initial Day, Straightforward	59080
• Vaginal Delivery (no previous cesareans)	59431
• Placenta delivery	No code
• Repaired 3rd degree laceration	59433

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Cesarean Delivery

Includes:

- Incision of abdominal wall and uterus
- Delivery of the fetus(es) and placenta(s) through the incised abdominal wall and uterus
- Closure of the uterine and abdominal incisions

- Only reported **once** regardless of the number of delivered fetuses

Multiple gestations with vaginal and cesarean deliveries for the same parturient?

Vaginal delivery code (59431, 59432) – **once per fetus** delivered vaginally

Cesarean delivery code (59502, 59503) – **once regardless** of number of fetuses delivered

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Cesarean Delivery: Primary

- **59502** Cesarean delivery; **primary**

- Reported when the parturient has never had a previous cesarean
- Typically, the patient will labor before a primary cesarean → labor management may be reported separately
- If primary cesarean is planned or scheduled and NO labor management is performed → an E/M service (e.g., initial or subsequent hospital inpatient or observation care) may be separately reported on the same calendar date when performed

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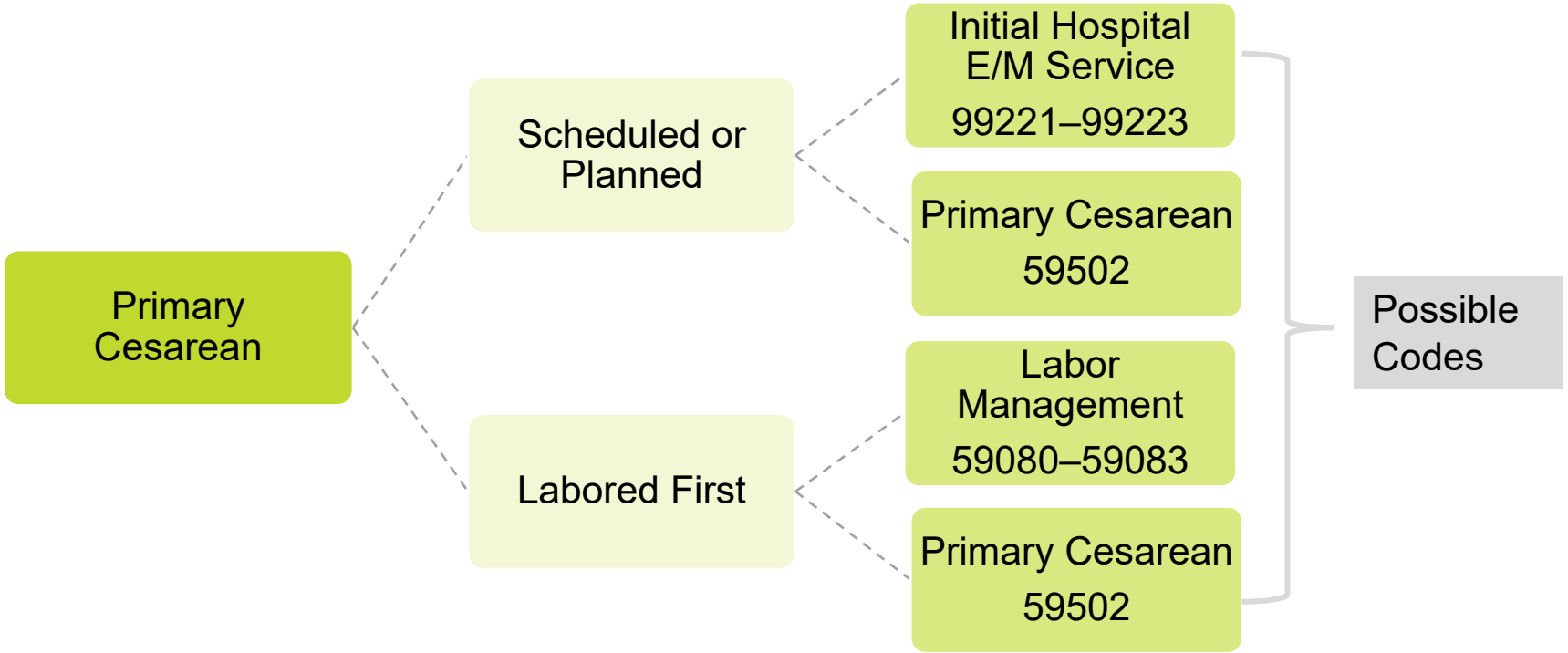
Primary Cesarean Delivery



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Cesarean Delivery: Repeat

- **59503** Cesarean delivery; **repeat**

- Reported when the parturient **has** had a previous cesarean
- Typically, this will be scheduled or planned
- If labor management is performed (i.e., TOLAC, Trial of Labor After Cesarean) in anticipation of a VBAC, a labor management code may be reported

- Admission or intake work is included in valuation—"initial or subsequent hospital inpatient or observation care services (99221, 99222, 99223, 99231, 99232, 99233) are included and may not be separately reported on the same calendar date as a repeat cesarean delivery."

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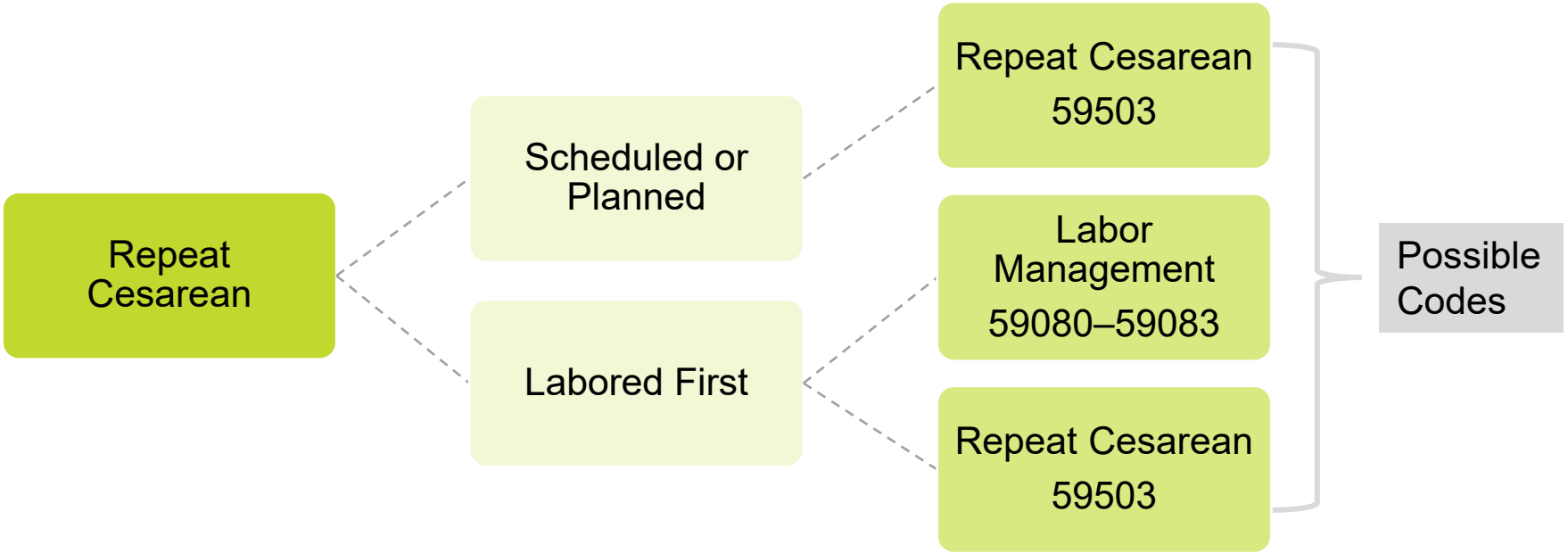
Repeat Cesarean Delivery



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Cesarean Delivery Procedures

Deleted Code:

+59525 *Subtotal or total hysterectomy after cesarean delivery [List separately in addition to code for primary procedure.]*

New Code:

- 59504 Subtotal or total hysterectomy after cesarean delivery

Add-on structure removed → Code may be reported by the same or different physician who reports the cesarean

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Multiple Births

Labor Management

- 1 code regardless of number of fetuses
- Complex by default

Vaginal Delivery

1 code “per” fetus(es) delivered vaginally

Cesarean Delivery

1 code regardless of number of fetus(es) delivered

Mixed Vaginal and Cesarean Delivery

- 1 code “per” fetus(es) delivered vaginally
- 1 code regardless of number of fetus(es) delivered by cesarean

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Reporting: Postpartum Care

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Summary of Changes

- All current postpartum care codes deleted effective Jan. 1, 2027
- Routine postpartum care on the same calendar day as delivery → not separately reported; included in delivery care code
- For a facility birth, postpartum care will be reported as follows:
  - Appropriate E/M subsequent hospital care codes (each management day until discharge day) and/or discharge day management codes (report only on day of discharge)
  - Outpatient E/M services (99212–99215) for services provided subsequent to discharge
- E/M rules apply

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New: Postpartum Procedures

Uterine Tamponade

May not be reported for pharmacological management only

●59623 Uterine tamponade (eg, balloon, catheter, vacuum, packing material)

(Do not report 59623 for pharmacologic management of hemorrhage)

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Postpartum Procedures

Code	Descriptor
● 59623	Uterine tamponade (e.g., balloon, catheter, vacuum, packing material)
59160	Curettage, postpartum
59350	Hysterorrhaphy of ruptured uterus

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ICD-10-CM and MS-DRG Reporting

ICD-10-CM – Chapter 15 Highlights

- Conditions that affect the management of pregnancy, childbirth, and the puerperium are classified to categories O00 through O9A in chapter 15 of ICD-10-CM.
  - ➢ take precedence over codes from other chapters.
  - ➢ O09 through O9A are used to describe the entire obstetric experience, beginning at conception and ends six weeks (42 days) after delivery.
  - ➢ "Completed" weeks of gestation is important in several ICD-10-CM codes and refers to full weeks.
    - For example, if the provider documents gestation at 39 weeks and 6 days, the code for 39 weeks of gestation should be assigned, as the patient has not yet reached 40 completed weeks (Z3A.39)
- Should the provider document that the pregnancy is incidental to the encounter, code **Z33.1, Pregnant state, incidental**, is assigned in place of any chapter 15 codes.

****It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.**

For full guidelines, see ICD-10-CM Official Guidelines for Coding and Reporting: FY 2026 - October 1, 2025 - September 30, 2026. https://stacks.cdc.gov/view/cdc/250974. Last accessed May 18, 2026.

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ICD-10-CM – Chapter 15 Highlights

- Assignment of the final character for trimester is based on the provider's documentation of the trimester for the current admission/encounter.
- The date of the admission should be used to determine weeks of gestation (category Z3A) for inpatient admissions that encompass more than one gestational week.
- Codes from category Z37 assigned for outcome of the delivery for inpatient stays.
- Routine/Normal deliveries assign code O80 (encounter for full-term uncomplicated delivery) for the principal diagnosis.
- When deliveries are not deemed "normal", the principal diagnosis should reflect the main circumstance or complication of the delivery.

For full guidelines, see ICD-10-CM Official Guidelines for Coding and Reporting: FY 2026 - October 1, 2025 - September 30, 2026. https://stacks.cdc.gov/view/cdc/250974. Last accessed May 18, 2026.

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ICD-10-CM – Chapter 15 Highlights

- When assigning codes from chapter 15, it is important to assess whether a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.
- Postpartum complications are any complications that occur throughout the six weeks following the delivery.
- There is a sequela code to use for complications that occur after the postpartum period (O94). This code follows the codes for the condition.

For full guidelines, see ICD-10-CM Official Guidelines for Coding and Reporting: FY 2026 - October 1, 2025 - September 30, 2026. https://stacks.cdc.gov/view/cdc/250974. Last accessed May 18, 2026.

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MS-DRGs in MDC 14 Pregnancy, Childbirth and the Puerperium

No changes to Medicare Severity Diagnosis Related Groups (MS-DRG)

MS-DRG	MDC	TYPE	MS-DRG Title - Table 5 - IPPS FY 2026
768	14	SURG	VAGINAL DELIVERY WITH O.R. PROCEDURES EXCEPT STERILIZATION AND/OR D&C
783	14	SURG	CESAREAN SECTION WITH STERILIZATION WITH MCC
784	14	SURG	CESAREAN SECTION WITH STERILIZATION WITH CC
785	14	SURG	CESAREAN SECTION WITH STERILIZATION WITHOUT CC/MCC
786	14	SURG	CESAREAN SECTION WITHOUT STERILIZATION WITH MCC
787	14	SURG	CESAREAN SECTION WITHOUT STERILIZATION WITH CC
788	14	SURG	CESAREAN SECTION WITHOUT STERILIZATION WITHOUT CC/MCC
796	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH MCC
797	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH CC
798	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITHOUT CC/MCC
805	14	MED	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH MCC
806	14	MED	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC
807	14	MED	VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC

Centers for Medicare & Medicaid Services. Table 5: MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay. www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page#Tables . Last accessed May 31, 2026.

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Considerations & Readiness

Hospital and Non-Hospital Clinical and Non-Clinical Teams

Leadership

- Revenue cycle complexity changes: more line items, more same-day rules, more edits
- Reimbursement timing may shift: from one “global” claim to multiple claims across time
- Denial risk may increase initially: new payer edits and policy interpretation
- Better data visibility: supports maternal health ROI, staffing, and service line strategy
- Align Compensation models (work Relative Value Units (RVUs))
- Prepare IT systems and billing logic
- Assess organizational impact (clinical, financial, operational)
- Identify OB service model (employed vs contracted vs mixed)
- Establish cross-functional readiness team

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Payer & Contracting

- 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

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Physician and Qualified Health Providers (QHPs)

- Documentation and CPT® Code Application:
  - **Labor complexity drivers** (clear vs complex)
    - Day-by-day labor progression
    - Care transitions (handoffs)
  - Align documentation with:
    - E/M leveling (antepartum/postpartum)
    - Delivery components vs separately reportable services
  - Education
    - E/M application to maternity
    - Labor management logic
    - Delivery inclusions/exclusions

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Provider/QHP 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

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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

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Large/Tertiary vs. Rural – Differences

- **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

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Governance & Alignment

- 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

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HIM/Coding/Clinical Documentation Specialists

- 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

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Revenue Cycle

- Update charge capture pathways for new CPT® code families.
- Configure claim edits/scrubbers for same-day restrictions and code pair rules.
- Establish a cross-midnight validator process for labor management 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.

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Additional AMA Resources

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Authoritative AMA Resources

CPT® Assistant articles:

- June 2026 – Overview and Antepartum
- July 2026 – Labor Management and Delivery
- August 2026 – Postpartum and Other Procedures

CPT® Advanced Coding Pack

- Q&As
- Extended articles
- Case studies – June through September focus

Learn more on the AMA website:

ama-assn.org/cpt-maternity-care

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Q&A

What we covered:

- Practical guidance on coding for the four phases: antepartum care, labor management, delivery and postpartum care
- Where to apply evaluation and management (E/M) coding requirements
- Clinical scenario walk-throughs
- Practice management strategies and facility/hospital reporting considerations

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WORKSHOP

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Click **Keep Learning** at the top of your webinar screen to sign up to receive an email when registration opens in July!

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Appendix

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Maternity Care Codes Deleted Effective Jan. 1, 2027

Section	CPT® Code and Descriptor
Antepartum and Fetal Invasive Services	59050 - Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation
Vaginal Delivery, Antepartum and Postpartum Care	59400 - 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 59425 - Antepartum care only; 4-6 visits 59426 - Antepartum care only; 7 or more visits 59430 - Postpartum care only (separate procedure)

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Maternity Care Codes Deleted Eff. Jan. 1, 2027 *(cont.)*

Section	CPT® Code and Descriptor
Cesarean Delivery	59510 – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
	59514 – Cesarean delivery only;
	59515 – Cesarean delivery only; including postpartum care
	+59525 – Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)

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Maternity Care Codes Deleted Eff. Jan. 1, 2027 *(cont.)*

Section	CPT® Code and Descriptor
Delivery After Previous Cesarean Delivery	59610 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

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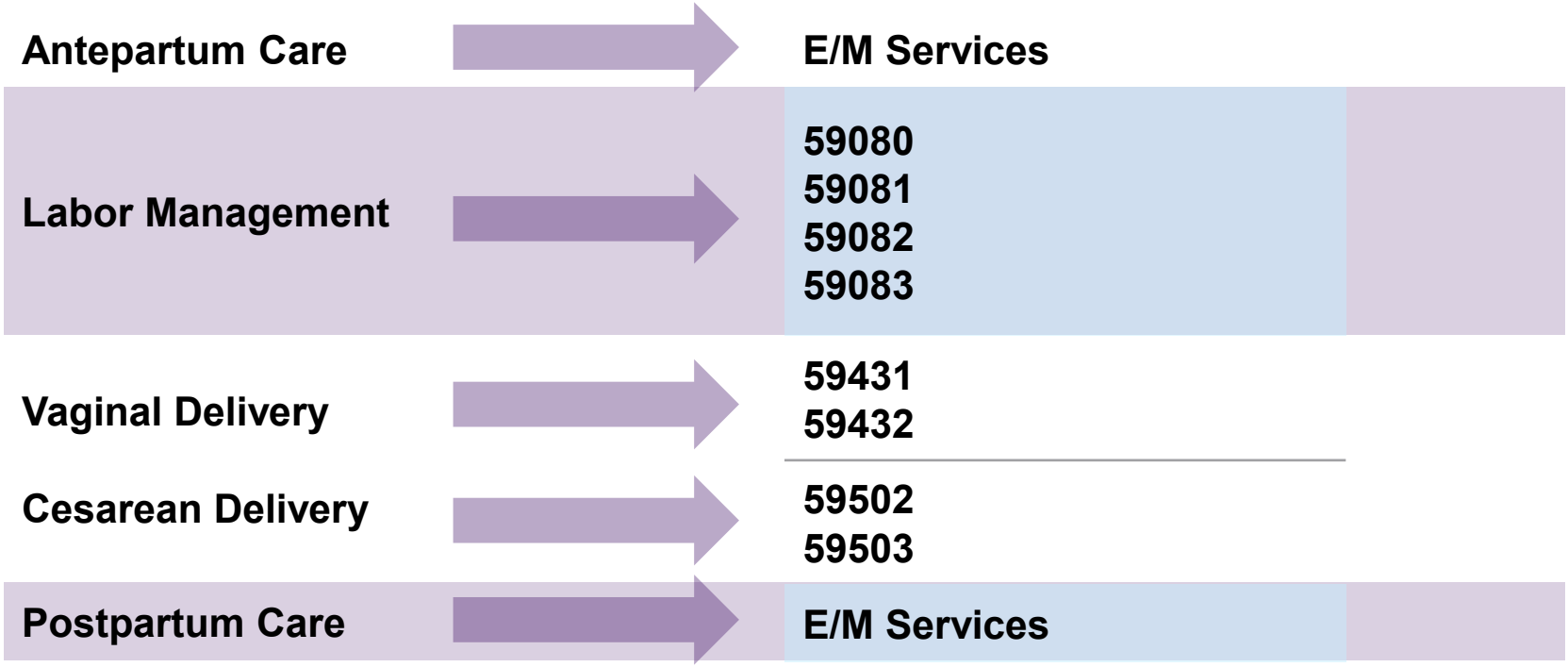
Coding Recap – Profee



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