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AMA
AMERICAN MEDICAL ASSOCIATION

A Health Plan Primer: Previewing the CPT® 2027 Restructure for Maternity Care Services

March 2, 2026

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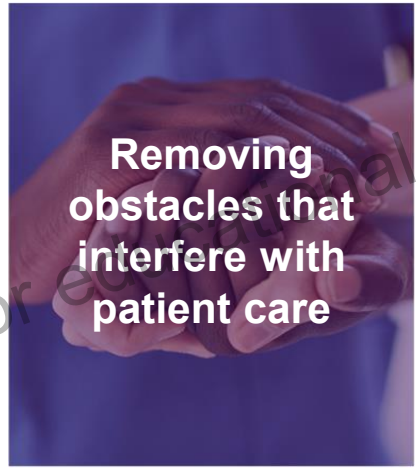
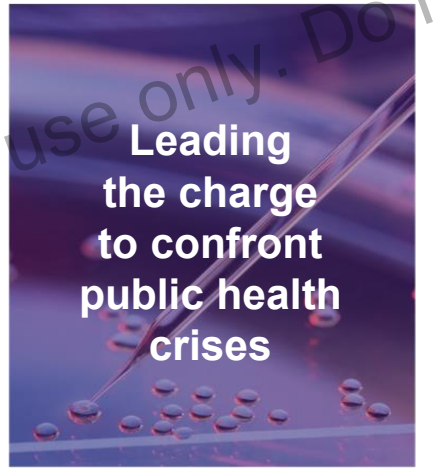
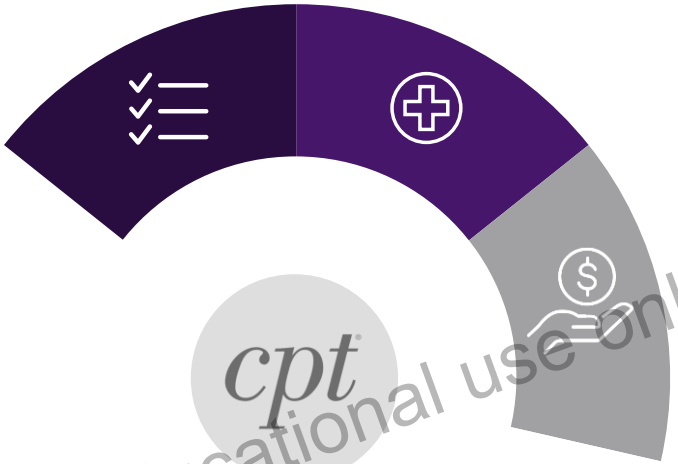
AMA: The Physicians' Powerful Ally in Patient Care



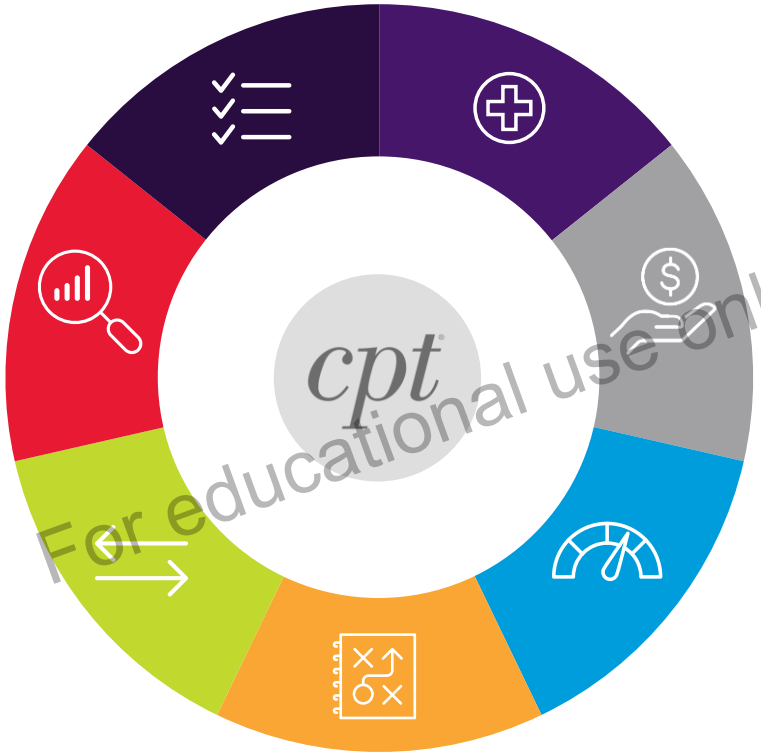


CPT®: Perception



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

CPT®: Perception vs. Reality



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

Agenda

Today we will cover:

- Historical Context of CPT® Code Changes
- Overview of High-Level Changes
- Four Phases of Maternity Care
  - Antepartum Care
  - Labor Management
  - Delivery Care
  - Postpartum Care
- Single Payer Perspective
- Q&A
- Educational Opportunities on the Horizon

Level-Set for Presentation

- We will be using generic placeholder codes (e.g., 59XX1) as final code numbers will be available in September (i.e., these are not a new code structure).
- If we use the term "**physician**" it is only for brevity. This term will also include other qualified health care professionals (e.g., Certified Nurse Midwife) as defined by the CPT® code set.
- When we refer to an "unrelated physician" we are referring to 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.

● Indicates a new code ▲ Indicates a revised code

Historical Context

February 2024 CPT Editorial Panel Meeting

- A code change application was presented to the CPT Editorial Panel ("the Panel") to overhaul CPT® coding for maternity care services.
- While this proposal was rejected by the Panel, the Chair of the Panel made the decision to create a workgroup due to the complexity of the changes and understanding the need for "change."
- **Workgroup Goal:** To bring back a code change application that can address the concerns of all parties involved.

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.

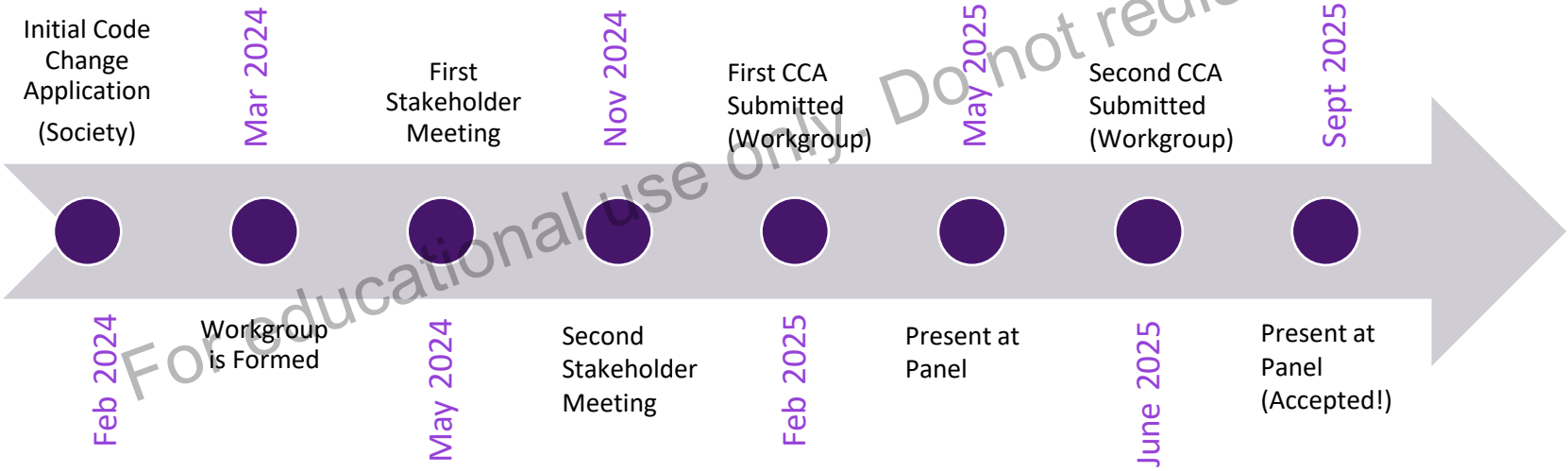
Why change?

- Current CPT® code structure 30+ years old
- Changes in patterns of maternity care provided since codes 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

Workgroup Composition

- Clinical expertise gathered for this workgroup included:
  - Obstetrics and Gynecology
    - Academic and rural
  - Family Practice
  - Nurse Midwives

Timeline



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.

Valuation of New Maternity Care CPT® Codes

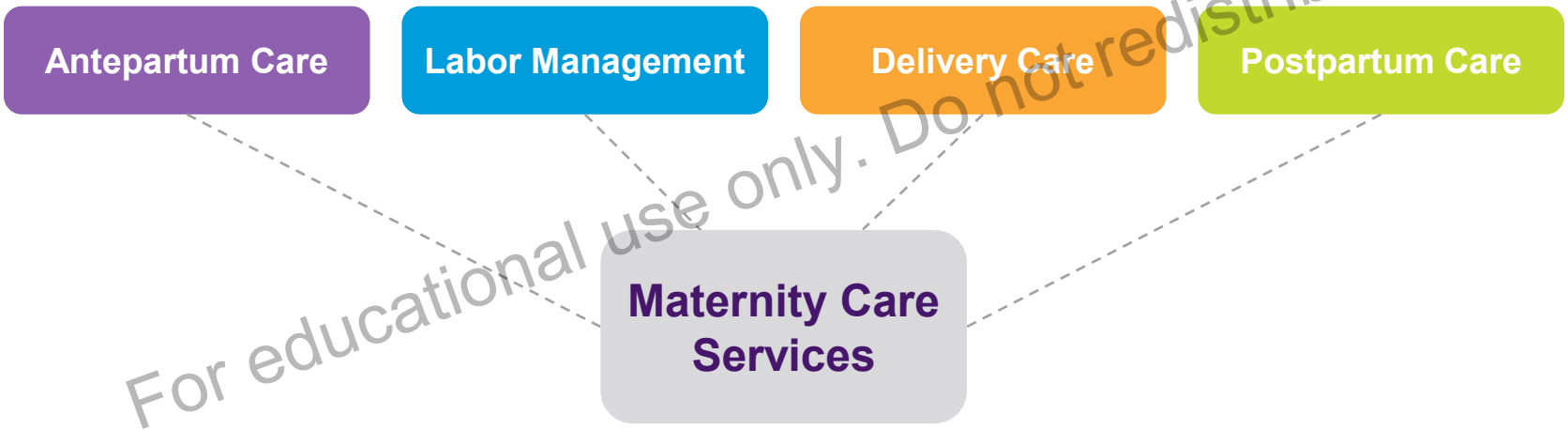
- Immediately upon the adoption of the new maternity care coding structure in September 2025, a robust survey of over 650 obstetricians, family medicine physicians and nurse midwives was conducted to measure the time and intensity of these services.
- The data from these surveys were presented to the AMA/Specialty Society RVS Update Committee (RUC) in January 2026. The RUC developed recommendations based on these data and intense deliberations prior to and during the RUC meeting.
- Work relative value recommendations were submitted the Centers for Medicare & Medicaid Services (CMS) in February 2026. There are no direct practice costs associated with these services as those costs are incurred by the facility.

RUC Recommendations – Maternity Care

- The RUC recommendations for maternity care services are publicly available on the AMA website at: www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting
- CMS will review these recommendations, and other data, and propose relative values for these services in July 2026. After a 60-day comment period, final values will be published in November 2026 to be implemented on Jan. 1, 2027.
- Using CDC information and payer data, the RUC analyzed its work RVU recommendations and affirmed that, if adopted by CMS, the RVUs for the coding changes are anticipated to be **budget neutral**.

Summary of Changes

Maternity Care Services Phases Identified



Summary of CPT® Code Changes

Deleted	Added	Revised
17	12	6

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

CPT® Code Hierarchy: Current vs. Future

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

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)

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)

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

Section Overviews: **Antepartum Care**

Antepartum Care – Codes Included

A Key Change: What is Not Here…

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)

Overarching Antepartum Guidelines

- No longer included in any global codes (as those were deleted)
- Antepartum Care will be reported *per encounter* with the appropriate evaluation and management (E/M) service based on location of patient
  - Examples:
    - Office or Other Outpatient E/M Services
    - Hospital Care Services
    - Telemedicine Services
- Includes all E/M care of the patient and/or fetus(es) prior to the onset of labor
- For care provided by a nonphysician qualified health care professional who may not report E/M services, refer to the specific service
  - Examples: genetic counseling or medical nutrition therapy
- Antepartum and Fetal Invasive Services codes remain, but some services were relocated there

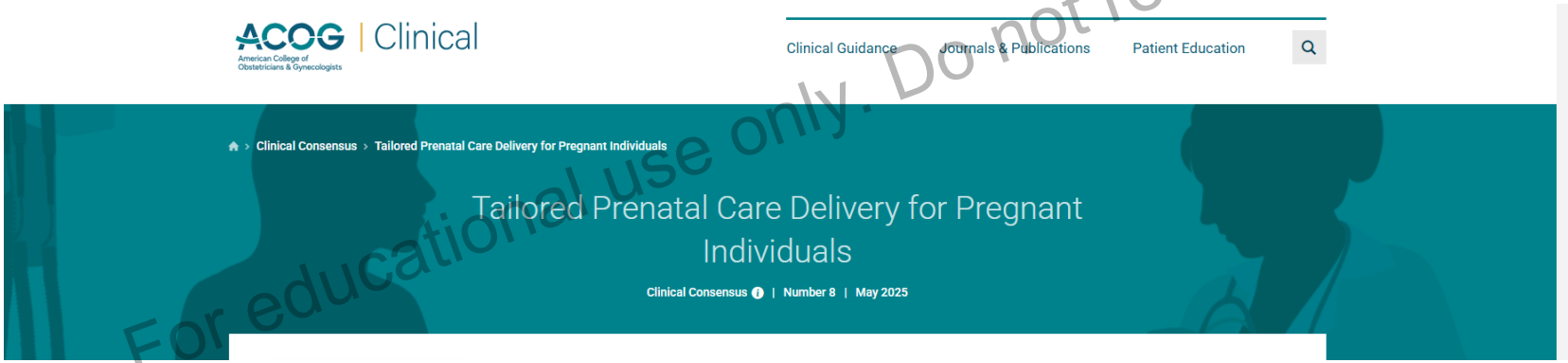
Antepartum Standard Care – E/M Rules: Evaluating Pregnancy

- E/M rules will apply for Antepartum care visits and levels will vary
- Time or Medical Decision Making (MDM) would be available to report the service
- For MDM: E/M code reported will be determined based on services provided during that encounter:
  - 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

MDM: Pregnancy as a condition will be evaluated under "Problem(s) Addressed"

Points to Ponder: Antepartum Care

ACOG Clinical Consensus



[Tailored Prenatal Care Delivery for Pregnant Individuals | ACOG]

Antepartum Encounters With E/M – Varying Levels Expected

- Each antepartum encounter will be coded using E/M guidelines → expect variations in E/M codes based on services provided at each encounter, as it has always been.
- Historically this was taken from the “typical” patient but as patient populations and needs have shifted so will E/M code levels and the types of services needed (e.g., nurse-only and telemedicine).
- Variation is implied in current bundled codes; actual variation will now be visible and trackable.

How to Identify a "Pregnancy-Related" E/M Service

- Use *ICD-10-CM* Codes Specific to Pregnancy:
  - Normal Pregnancy (e.g., Z34)
  - Abnormal Pregnancy (O00-O9A)

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

Labor Management

Labor Management – A New Section

How was labor previously coded?

- No separate code(s) for labor management
- Was bundled under either the full global maternity care or part of the delivery care code reported (if a different physician)

Now:

- Because labor management has becoming increasingly complex and varied—it was only appropriate to designate separate codes to accurately identify the types and length of labor "managed"

Labor Management – Codes Included

Code	Descriptor
●59XX1	Initial day labor management; straightforward, per day
●59XX2	complex, per day
●59XX3	Subsequent day labor management; straightforward, per day
●59XX4	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

Overarching Labor Management Guidelines

- Labor Management:
  - Daily reporting: Reported once per calendar date
  - Facility reporting: “Initial Day” is reported once per facility admission unless there is a unique provider
  - Reporting follows *guidelines* for Hospital Care
  - Codes created for **Initial and Subsequent Days**
    - Further divided into 2 levels: **Straightforward (SF) and Complex**
  - **May not** typically be reported on the same day as Hospital Care codes by same physician

Four new Labor Management codes were created

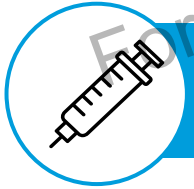
Overarching Labor Management Guidelines

- 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)
    - Only exception would be 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

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)

Initial Day Versus 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

Straightforward Versus Complex

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

Straightforward:

- 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

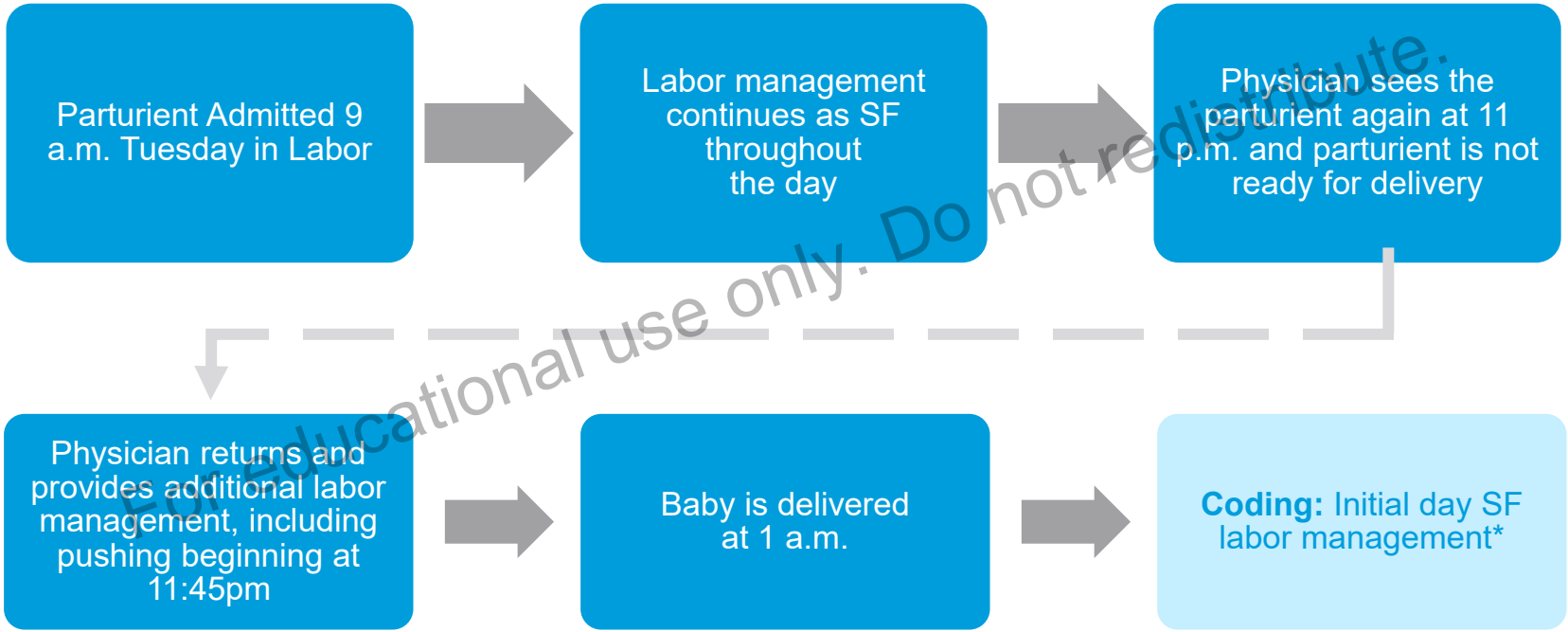
Straightforward Versus Complex

- An increase in complexity throughout the calendar date will result in an increase in the labor management reported.
- Only one labor management code is reported per physician per parturient per day.

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

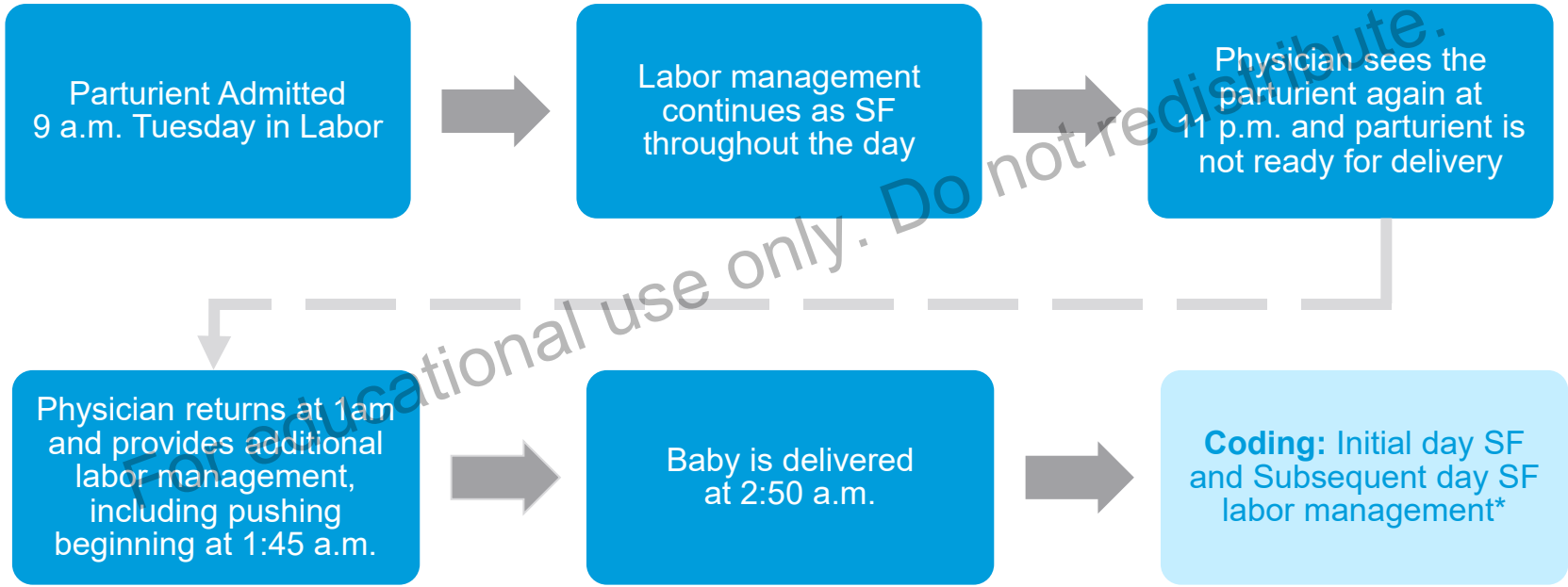
- *Only* exception is when an increase in complexity of labor requires a care transfer from one group to another.
  - <u>Example</u>: A CNM who is part of a small group is managing a parturient. Throughout the day the parturient's condition deteriorates and the CNM transfers the parturient's care to a physician in a separate group practice.

Labor Management (Only) Examples



*Delivery Care may be reported in addition and will be discussed later.

Labor Management (Only) Examples



*Delivery Care may be reported in addition and will be discussed later.

Delivery Care

Delivery Care: Current Coding

- Currently the coding mechanisms are based on:
  - Physician performing the delivery (same as global or unique)
    - Will same physician be reporting postpartum care?
  - Cesarean versus Vaginal
  - Was there a previous cesarean (?)
    - VBAC

Summary of Changes

- Codes not dependent on “who” performs
- Codes for “attempted VBAC after cesarean that led to a cesarean” were **not** carried over
    - Rationale was that “work” for increased complexity would be captured under the new labor management codes

Delivery Care: Changes for 2027

- No longer part of global care
- 4 New Delivery Care codes—2 Vaginal delivery, 2 Cesarean delivery

Vaginal Delivery

Code	Descriptor
●59XX5	Vaginal delivery, with or without episiotomy;
●59XX6	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)
●59X11	Repair of episiotomy or laceration; third-degree laceration
●59X12	fourth-degree laceration

Cesarean Delivery

Code	Descriptor
●59XX7	Cesarean delivery; primary
●59XX8	repeat
●59XX9	Subtotal or total hysterectomy after cesarean delivery

Defining Delivery Care

- Begins when labor is complete (i.e., 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

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

Vaginal Delivery Coding

- 2 New Codes
  - 59XX5 Vaginal Delivery with or without episiotomy
  - 59XX6 Vaginal Delivery with or without episiotomy *after previous cesarean*

Episiotomies/Laceration

- Vaginal delivery services historically included the work of the 1st and 2nd degree lacerations/episiotomies, but never accounted for the increased work and management for more complex 3rd and 4th degree lacerations/episiotomies—so new codes were added.
- The existing code 59300 was revised to clarify that it could also be a qualified health care professional performing the service and that it was specific to a 1st or 2nd degree laceration repair only.

1 code was revised and 2 new codes were added

Vaginal Delivery-Related Procedures

Any Physician May Separately Report	Only an Unrelated Physician May Report
• Repair of 3rd degree episiotomy or laceration • Repair of 4th degree episiotomy or laceration	• Delivery of placenta (bundled into the vaginal delivery codes) • Repair of 1st or 2nd degree episiotomy or laceration (bundled into the vaginal delivery codes)

Labor and Vaginal Delivery Coding Example

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 59XX1
- Vaginal Delivery (no previous cesareans) 59XX5
- Placenta delivery No code
- Repaired 3rd degree laceration 59X11

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
- For **multiple gestations**, report cesarean delivery in addition to a vaginal delivery code(s) when subsequent fetus(es) are delivered via cesarean

Cesarean Delivery Coding

- **59XX7 Primary** cesarean delivery
  - Reported when the parturient has never had a previous cesarean
  - Typically, the patient will labor before a primary cesarean therefore labor management may be reported separately
  - If a primary cesarean is planned or scheduled and NO labor management is performed an E/M service code (e.g., hospital/observation care) may be reported in addition

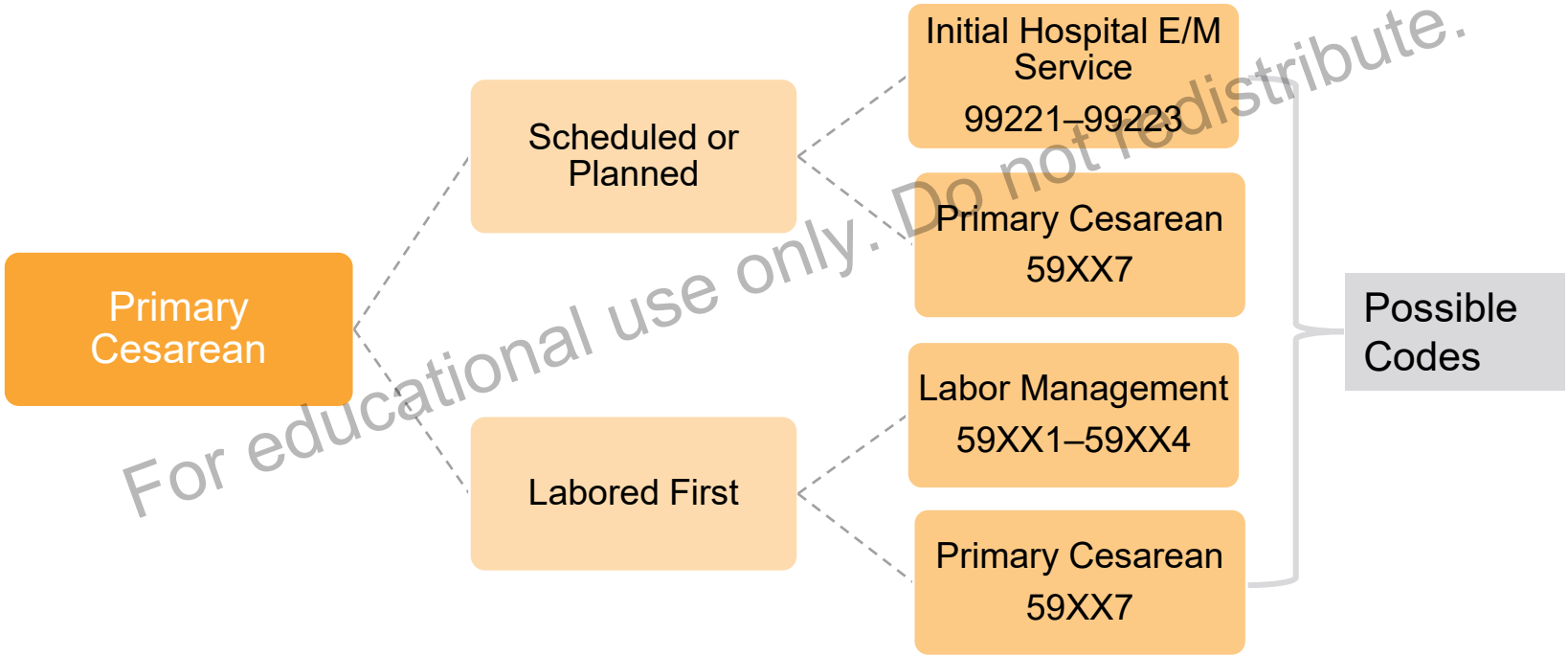
Rationale: 59XX7 was not valued with "admission" or "intake" work that would typically be included in labor management. Since no labor management code is being reported the admission work is captured under an initial hospital care code

Cesarean Delivery Coding

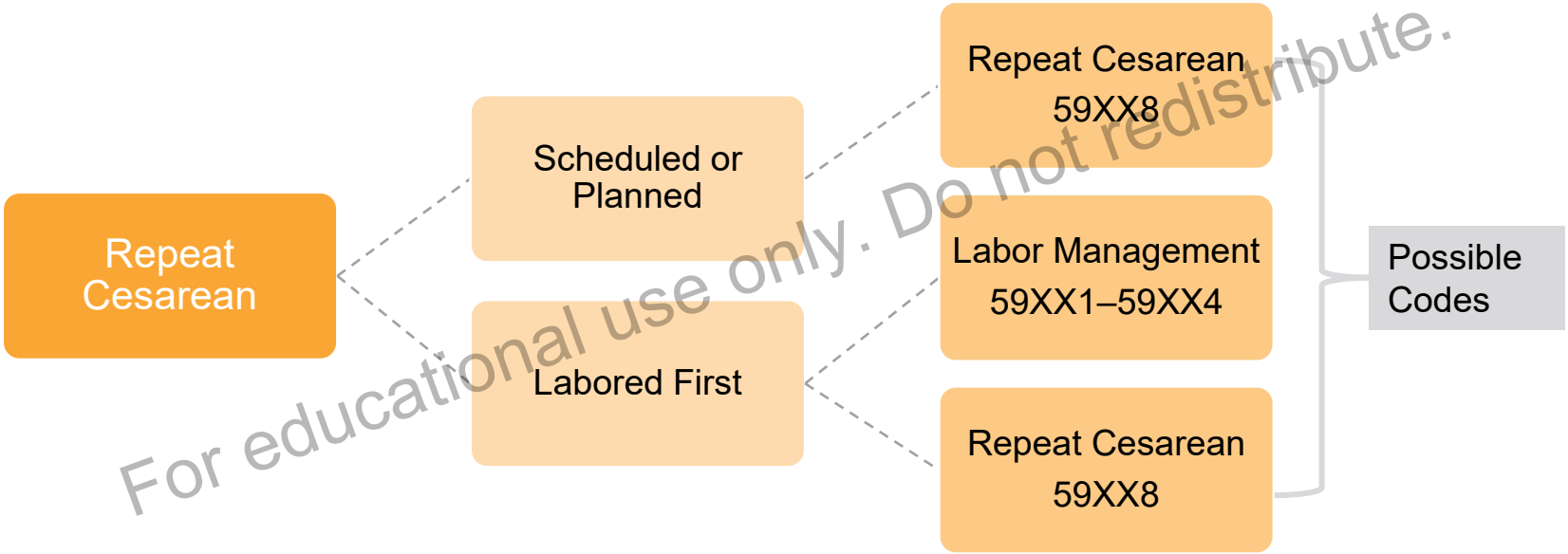
- **59XX8 Repeat** cesarean delivery
  - Reported when the parturient **has** had a previous cesarean
  - Typically, this will be scheduled or planned
  - If labor management is performed (i.e., TOLAC, Trial of Labor After Cesarean) in anticipation of a VBAC, a labor management code may be reported
  - Do not report an E/M service (e.g., hospital E/M care) with a repeat cesarean

Rationale: A repeat cesarean is typically a "planned" event without labor management. The code was valued with "admission" or "intake" work and that is not separately reported.

Primary Cesarean Delivery



Repeat Cesarean Delivery



Cesarean Delivery Procedures

Deleted Code:

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

New Code:

- 59XX9 Subtotal or total hysterectomy after cesarean delivery
  - Code may be reported by the same or different physician who reports the cesarean.

Rationale: Typically, no longer performed by the same physician performing the delivery of the fetus(es).

Multiple Births

Labor Management	Vaginal Delivery	Cesarean Delivery	Mixed Vaginal and Cesarean Delivery
• 1 code regardless of number of fetuses • Complex by default	1 code "per" fetus(es) delivered vaginally	1 code regardless of number of fetus(es) delivered	• 1 code "per" fetus(es) delivered vaginally • 1 code regardless of number of fetus(es) delivered by cesarean

Twin Labor and Delivery

Scenario: Laboring parturient with twins

• Labor management, Initial Day, Complex	59XX2
• Vaginal Delivery Twin A	59XX5
• Vaginal Delivery Twin B	59XX5 59
• Placentas delivered	No code
• 2nd Degree laceration repair	No code

Scenario: Laboring parturient with twins, turns into a primary cesarean

• Labor management, Initial Day, Complex	59XX2
• Primary Cesarean (Twin A and Twin B)	59XX7

Triplet Delivery

Scenario: Laboring parturient, delivered one fetus vaginally but primary cesarean delivery was necessary to deliver remaining two fetuses

Labor Management, Initial Day, Complex	59XX2
Vaginal Delivery (Triplet A)	59XX5
Primary Cesarean Delivery (Triplet B and Triplet C)	59XX7 59

Postpartum Care

Current Coding for Postpartum Care

Global	Delivery + Postpartum	Postpartum Care Only
59400	59410	59430
59510	59515	
59610	59614	
59618	59622	

Summary of Changes

- All current postpartum care codes will be deleted
- Routine postpartum care may not be reported on the same calendar day as the delivery care
- For a facility birth, postpartum care will be reported as follows:
  - Appropriate 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

Postpartum care may span inpatient to outpatient

New: Postpartum Procedures

Uterine Tamponade

May not be reported for pharmacological management only

- 59X10 Uterine tamponade (eg, balloon, catheter, vacuum, packing material) (Do not report 59X10 for pharmacologic management of hemorrhage)

Postpartum Procedures

Code	Descriptor
● 59X10	Uterine tamponade (eg, balloon, catheter,vacuum, packing material)
59160	Curettage, postpartum
59350	Hysterorrhaphy of ruptured uterus

Points to Ponder: Postpartum Care

Claim Edits

Commonly Reported Services on Same Day/Same Physician

- Labor Management and Vaginal Delivery

  59XX1, 59XX2, 59XX3, 59XX4 and 59XX5, 59XX6

- Labor Management and Primary Cesarean Delivery

  59XX1, 59XX2, 59XX3, 59XX4 and 59XX7

- Vaginal Delivery and 3rd or 4th Degree Laceration/Episiotomy Repair

  59XX5, 59XX6 and 59X11, 59X12

- Vaginal Delivery and Uterine Tamponade

  59XX5, 59XX6 and 59X10

Less Commonly Reported Services on Same Day/Same Physician

While less common, services below *may* be reported on the same day under appropriate circumstances

- Office-Based E/M Service and Labor Management

99211-99215	**and**	**59XX1, 59XX2, 59XX3, 59XX4**

- Initial or Subsequent Hospital Care and Primary Cesarean

99221-99223, 99231-99233	**and**	**59XX7**

- Labor Management and Repeat Cesarean

59XX3, 59XX4	**and**	**59XX8**

Less Commonly Reported Services on Same Day/Same Physician

While less common, services below *may* be reported on the same day under appropriate circumstances

- Vaginal Delivery and Cesarean Delivery

59XX5, 59XX6	**and**	**59XX7, 59XX8**

- Cesarean Delivery and Hysterectomy After Cesarean

59XX7, 59XX8	**and**	**59XX9**

Codes that Should Not be Reported Together on Same Day/Same Physician

- Straightforward Labor Management and Complex Labor Management

  59XX1, 59XX2 and 59XX3, 59XX4

- Initial or Subsequent Hospital Care and Labor Management

  99221-99223, 99231-99233 and 59XX1, 59XX2, 59XX3, 59XX4

- Initial or Subsequent Hospital Care and Repeat Cesarean Delivery

  99221-99223, 99231-99233 and 59XX8

- Vaginal Delivery and Placental Delivery

  59XX5, 59XX6 and 59414

- Vaginal Delivery and 1st or 2nd Degree Repair

  59XX5, 59XX6 and 59300

Preparing for the Transition

Coding Recap

Start to Finish: (Examples for Management)

Antepartum Care

8 E/M services (6 visits with the physician, 1 telehealth visit with NP and 1 nurse only visit)

Visit 1 9921x
Visit 2 9921x
Visit 3 99211
Visit 4 9921x
Visit 5 9800x
Visit 6 99211
Visit 7 9921x

Labor Management

Parturient labored (hospital): Straightforward

Over 1 calendar date:

59XX1

Over 2 calendar dates:

59XX1
59XX3

Delivery Care

Vaginal

59XX5

Postpartum Care

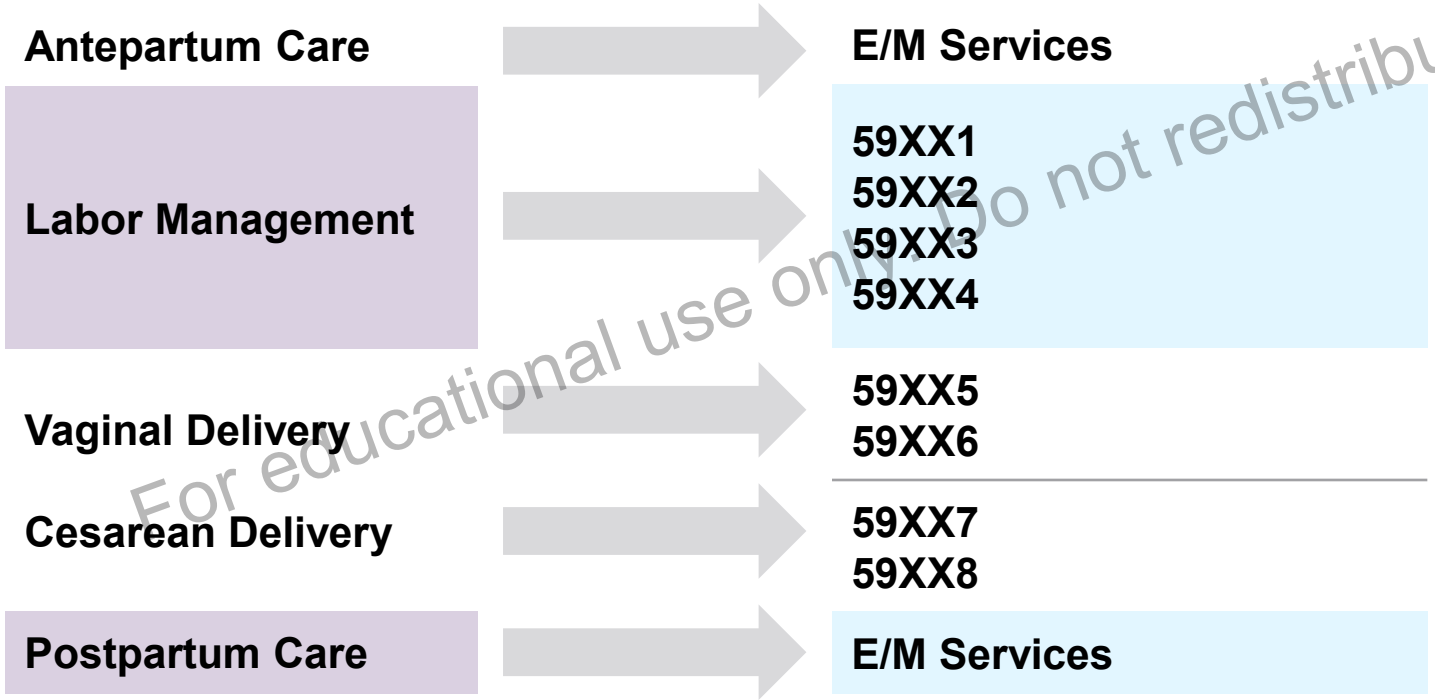
3 E/M services*: 1 hospital; 1 outpatient

Visit 1 9923x
Visit 2 99238 or 99239
Visit 3 9921x

*Do not report routine postpartum care on day of delivery

9921x represents the range of codes 99212-99215
9923x represents the range of codes 99231-99233

Coding Recap



Q&A

What we covered:

- Rationale behind revising the maternity care services CPT® codes
- The new coding framework's structure and approach
- Key considerations for planning for future implementation

Next Steps

Stay tuned for coding resources

This is the first of many AMA communications and educational resources on maternity care coding updates that will take effect Jan. 1, 2027.

Watch your inbox for additional webinars and materials to inform your work!

Tell us what you think

Please complete our **post-webinar survey**.

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