EFFECTIVE DATE: 01|01|2027
POLICY LAST UPDATED: 11|19|2026

OVERVIEW
This policy reflects a transition from bundled to unbundled obstetrical coding and reimbursement as finalized by the American Medical Association/CPT/HCPCS coding effective January 1, 2027. Each obstetrical service is to be reimbursed individually based on the applicable CPT/HCPCS/Modifier codes and fee schedule for each individual servicing provider. Global obstetrical codes will no longer be recognized for reimbursement by January 1, 2027.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
No prior authorization is required for maternity services.

POLICY STATEMENT
Medicare Advantage Plans and Commercial Products
Effective January 1, 2027, each obstetrical service is reimbursed individually based on the applicable CPT/HCPCS/modifier code and fee schedule. Global obstetrical codes are no longer recognized for reimbursement. Each provider must code correctly and bill only for services personally rendered. Multiple providers may bill for distinct services within the same obstetrical episode.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable surgery and not medically necessary/not covered benefits/coverage.

BACKGROUND
In 2024, a workgroup led by the American Medical Association (AMA) and the American College of Obstetricians & Gynecologists (ACOG) was developed to "…a*ssess 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.*" Ultimately, a Code Change Application (CCA) was approved by the Current Procedural Terminology (CPT®) Editorial Panel in September 2025 for publication in the 2027 CPT Professional Edition code set. Meaning, **the following codes,** including the current global obstetric codes will be ***deleted*** for use starting January 1, 2027: 59050, 59400, 59409, 59410, 59425, 59426, 59430, 59510, 59514, 59415, 59525, 59610, 59612, 59614, 59618, 59620, 59622.

2026 TRANSITION CRITERIA
BCBSRI's position is that, for any pregnancy beginning in CY 2026 (as established by the confirmation of pregnancy visit and/or the first antepartum visit), the (*legacy*) **global** package maternity CPT codes***** will continue to be used through the end of the pregnancy episode into CY 2027.

*** Global package maternity (antepartum, delivery and postpartum care bundled) CPT codes:**
59400: vaginal delivery
59510: cesarean delivery
59610: VBAC delivery
59618: cesarean delivery after attempted VBAC

COMPLETE TRANSITION CRITERIA

Starting ***January 1, 2027,*** any pregnancy that starts in CY 2027 (as established by the confirmation of pregnancy visit and/or the first antepartum visit), the service must be billed with E/M codes and modifier TH. The primary ICD-10-CM codes for pregnancy state must be listed first on the claim, and the secondary ICD-10-CM code is to indicate the weeks of gestation (Z3A.xx). Documentation for the E/M service must support medical decision making (MDM) or time per the current CPT guidelines.

→ full transition to E/M CPT codes with modifier TH and ICD-10-CM codes for both antepartum and post- partum encounters

→ full transition to the labor management and delivery CPT codes

CODING

Modifiers

Modifier TH

Note: BCBSRI requires the TH-Modifier in the *first or primary modifier field*.

The HCPCS modifier TH must be appended to the E/M CPT code to differentiate the visit is related to antepartum (prenatal) or postpartum visit. Using the TH modifier indicates maternity services.

Modifier 22

The HCPCS modifier 22 may be appended to the delivery code for complicated/extreme cases that require more work and time and/or increased risk and complexity and is subject to individual consideration of review. Claim must be submitted with medical documentation and BCBSRI form. Click here: (IC form link)

Modifier 51

HCPCS modifier 51 is appended for each additional unit for vaginal births only-per fetus.

Modifier 51 indicates that two or more procedures (services) were performed during the same operative session or same day.

Modifier 25

HCPCS modifier 25 is appended when a problem focused visit (not related to the OB encounter) occurs during the same antepartum/postpartum visit. The E&M service must be submitted with modifier 25 along with the separately identifiable ICD-10-CM code.

Note: For Cesarean delivery care: one unit only is allowed during the same operative session or same day.

ICD-10-CM DIAGNOSIS

Antepartum Encounters

Primary Diagnosis

- **Routine/normal pregnancy** code encounter for supervision of normal pregnancy.
  ICD-10-CM codes: Z34.01, Z34.02, Z34.03, Z34.81, Z34.82, Z34.83, Z34.91, Z34.92, Z34.93.

or

- **High risk and/or with complications pregnancy** code encounter for supervision of high risk and/or with complications pregnancy.
  ICD-10-CM codes: O00–O9A.

and

Secondary Diagnosis

- **Weeks of gestation** ICD-10 CM code Z3A.*xx* code (weeks of gestation) as follows:
  Z3A.01 – Less than 8 weeks gestation
  Z3A.*08* – Z3A.*40* =Z3A. *xx* weeks gestation (8-40 weeks)

CPT E/M ANTEPARTUM CARE

E/M Antepartum care- medical care and supervision provided to a pregnant patient *before* labor and delivery. Antepartum care services are reimbursed per visit using appropriate E/M or CPT-designated prenatal service codes. Visit frequency must align with evidence-based clinical guidelines. BCBSRI may apply utilization management edits for excessive visit frequency.
Antepartum care is reported using appropriate evaluation and management (E/M) codes with modifier TH appended based on specific location:

Office/other Outpatient: 99202 -99205, 99211 - 99215
Hospital Inpatient/Observation: 99221- 99223, 99231 - 99233
Telemedicine (audio-video/audio only): 98000 -98007, 98008 - 98015
Hospital Inpatient (Admission/Discharge): 99234 -99236

CPT LABOR AND DELIVERY SERVICES

Labor and Delivery Services, effective January 1, 2027:
59080 Labor management – initial day*
59081 Labor management – subsequent day*
59082 Labor management – complex*
59083 Labor management – subsequent complex*
59431 Vaginal delivery care
59432 Vaginal delivery with additional obstetric service
59433 VBAC-related delivery service
59434 Additional vaginal delivery-related service
59502 Primary cesarean delivery care
59503 Repeat cesarean delivery care
59504 Hysterectomy following cesarean
59623 Uterine tamponade procedure
*Reported once per calendar date

Note: inpatient/observation E/M services and labor management services* are not separately reportable. When these services are billed together on the same date of service, by the same provider/group, the E/M service will deny as not separately reimbursed and are considered bundled with the labor management service.

In addition to the delivery, the following services may be considered:

- Separate multiple obstetric care professionals' services for multi-gestational deliveries
- Separate services provided at or near the point of delivery, including but not limited to the insertion of long-acting reversible contraception and management of hemorrhage
- Separate ongoing outpatient management and care coordination for postpartum conditions that require additional care, such as cardiac conditions or mental health conditions for example.

CPT E/M POSTPARTUM CARE

E/M Postpartum care - medical care and follow-up provided to the mother *after* delivery.
Postpartum care services are reimbursed separately and may include routine and extended postpartum care. Postpartum services may be reimbursed for up to 12 months when medically necessary. Frequency limits may apply to routine post-partum visits. Postpartum care is reported using appropriate evaluation and management (E/M) codes with modifier TH appended based on specific location:

Office/other Outpatient: 99202 -99205, 99211 - 99215
Hospital Inpatient/Observation: 99221- 99223, 99231 - 99233
Telemedicine (audio-video/audio only): 98000 -98007, 98008 - 98015
Hospital Inpatient (Admission/Discharge): 99234 -99236

ICD-10 CM DIAGNOSIS
Postpartum Encounters
Z39.x Encounter for postpartum care following delivery; routine
O85.x-O92.x Encounter for postpartum care for ongoing postpartum condition or complication

Note: When a problem focused visit occurs during the same antepartum/postpartum visit the E&M service must be submitted with modifier 25 along with the separately identifiable ICD-10-CM code.

ICD-10 CM DIAGNOSIS
Maternity Benefit Category
Confirmatory pregnancy code encounter
ICD-10-CM codes: Z32.01, Z33.1

- Preventive benefit (no cost share)

Routine/normal pregnancy code encounter for supervision of normal pregnancy
ICD-10-CM codes: Z34.01, Z34.02, Z34.03, Z34.81, Z34.82, Z34.83, Z34.91, Z34.92, Z34.93.

- Preventive benefit (no cost share)

High risk and/or with complications pregnancy code encounter for supervision of high risk and/or with complications pregnancy
ICD-10-CM codes: O00–O9A.

- Medical benefit (cost share)

TRANSFER OF CARE
Providers will bill only for services performed.

UTILIZATION MANAGEMENT CONTROLS
Providers must report services using valid CPT/HCPCS/Modifier codes effective for the date of service. Deleted global obstetrical CPT codes will be denied as invalid.

BCBSRI will apply utilization management controls, including but not limited to:

Prenatal visit frequency thresholds
Duplicate service edits
Review of high-frequency services

BCBSRI reserves the right to group obstetrical services into a "virtual episode" * for payment integrity and analysis. Prenatal visits >16 and/or postpartum visits >3 will be subject to review.
Note: limits aligned with current clinical practice and recommendation from ACOG.

***** BCBSRI may evaluate obstetrical services using a claims-based "virtual episode of care" methodology, which aggregates all pregnancy-related services rendered during the antepartum, delivery, and postpartum periods for analytic and payment integrity purposes. This includes services billed across multiple providers and settings. As part of this review, BCBSRI may apply automated and clinical validation edits to ensure:

- Appropriate utilization of antepartum visit frequency and thresholds (including assessment of unusually high or low visit counts relative to gestational age and clinical norms)
- Identification of duplicate or overlapping services, including evaluation and management services and diagnostic testing
- Review high-frequency or atypical services, including repeated ultrasounds, laboratory testing, or extended prenatal monitoring
- Consistency between reported gestational age (Z3A codes) and billed obstetric services
- BCBSRI may adjust, deny, or recoup payment where services are determined to be inconsistent with accepted billing standards, contractual OB rules, or documentation requirements.

FREQUENTLY ASKED QUESTIONS (*CLICK HERE*)
Frequently Asked Questions for OB Provider Offices | What's Changing January 1, 2027

RELATED POLICIES

Coding guidelines and Modifiers
Non-Reimbursable Health Service Codes

PUBLISHED

Provider Update December 2026
Provider Update November 2026

REFERENCES

1. ACOG Health and Payment Policy - Medicaid Team healthpolicy@acog.org
2. American Medical Association. CPT® Editorial Summary of Panel Actions: September 2025. American Medical Association; September 2025. https://www.ama-assn.org/system/files/sept-2025-summary-of-panel-actions.pdf. Accessed December 31, 2025.
3. https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes
4. https://www.cms.gov/files/document/cms-enforcement-discretion-maternity-care-services-cpt-guidance-letter.pdf

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