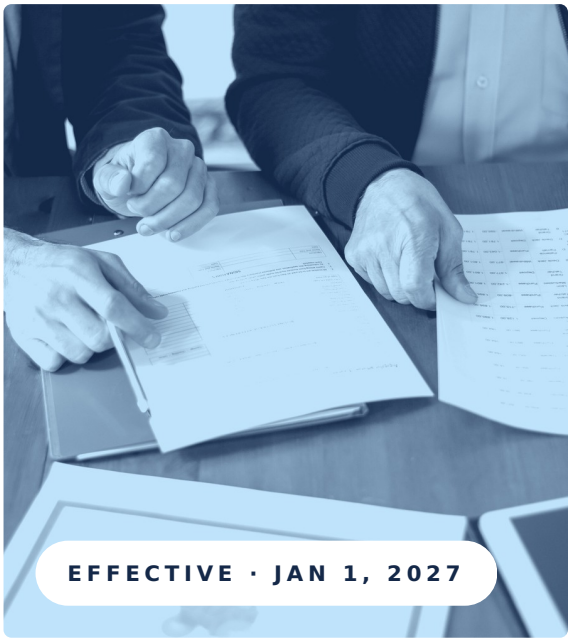
The 2027 OB CPT Reference.



Deleted codes, new codes, modifier TH, and the documentation standard behind each phase.

EFFECTIVE
January 1, 2027

FORMAT
Quick reference

FOR
Physician owners & billing leads

PAIRS WITH
OB Revenue Calculator

The AMA is eliminating the global OB package codes and replacing them with a fully unbundled billing structure. Every phase of maternity care is billed separately, with its own code, documentation requirement, and payer claim.

We built this so your team can read the change once, and code it right from day one. One page per topic, printable, ready for the billing lead and every provider on your service.

What is changing | Modifier TH | Antepartum | Labor management | Delivery | Postpartum | Transition timeline

SECTION 01 · DELETED CODES

What is Changing on January 1, 2027.

The old global package codes are gone. Every phase of maternity care, antepartum through postpartum, is billed separately from January 1 forward. Any claim submitted with a deleted code will be rejected.

CODE	FORMER DESCRIPTION	EFFECTIVE JAN 1, 2027
59400	Routine OB care, vaginal delivery, full global	DELETED **Replaced by unbundled E/M (ante/post) + 59431 (delivery)**
59510	Routine OB care, cesarean delivery, full global	DELETED **Replaced by unbundled E/M (ante/post) + 59502 (delivery)**
59425	Antepartum care only, 4 to 6 visits	DELETED **Replaced by individual E/M codes with modifier TH**
59426	Antepartum care only, 7 or more visits	DELETED **Replaced by individual E/M codes with modifier TH**
59430	Postpartum care only	DELETED **Replaced by individual E/M codes with modifier TH**

FOUNDATION

For pregnancies that span 2026 and 2027, begin using E/M codes for antepartum visits as of September 1, 2026 for any patient whose delivery is expected in 2027.

SECTION 02 · MODIFIER TH

What TH is, and When to use it.

Modifier TH identifies an E/M visit as maternity-related. It must be appended to every antepartum and postpartum E/M code starting January 1, 2027.

Examples of usage.

CODE	MEANING
99214-TH	Antepartum visit, moderate complexity, maternity-related
99213-TH	Postpartum visit, low complexity, maternity-related

A NOTE ON PAYER READINESS

September 1 is a testing date, not a guaranteed processing date.

There is no federal mandate requiring commercial payers to have modifier TH configured by September 1. Some payers may deny claims, attempt to rebundle them into the global code, or process them without modifier recognition.

What we recommend: submit a small batch of test claims to your top 3 payers before September. Watch what comes back. A denial in September is a payer contract conversation before Q4, not a reason to delay starting.

SECTION 03 · PHASE 1 OF 4

Antepartum care.

E/M codes plus modifier TH. Every antepartum visit is coded and billed individually. The level has to match the work the chart supports.

CODE	DESCRIPTION	DOCUMENTATION REQUIRED	MODIFIER
99213	Established, low complexity, routine antepartum straightforward	Routine vitals, fetal tones, standard urinalysis, uncomplicated assessment	**TH required**
99214	Established, moderate complexity, appropriate for routine pregnancy per ACOG	MDM reflects pregnancy as ongoing condition with monitoring. Per ACOG guidance: pregnancy is moderate complexity minimum.	**TH required**
99215	Established, high complexity, complicating conditions present	Must document: complicating diagnoses, complex MDM, additional monitoring or intervention. Cannot be used for routine visits without documented complexity.	**TH required**
99204	New patient, moderate complexity, first OB visit new to practice	Full history and exam. Appropriate for first visit when patient is new to the practice.	**TH required**
99205	New patient, high complexity, first OB visit with complicating conditions	High complexity MDM at first visit. Requires documented complexity at initial encounter.	**TH required**

ACOG GUIDANCE

For E/M coding purposes, pregnancy is treated as one or more chronic illnesses with exacerbation, progression, or side effects of treatment. This makes 99214 the minimum appropriate E/M level for a routine antepartum visit. Coding a routine visit to 99213 without a reducing factor is undercoding.

SECTION 04 · PHASE 2 OF 4

Labor management, billed per day.

New in 2027. No prior equivalent. These codes bill per calendar day. Each day of active labor management requires its own code and its own supporting documentation.

CODE	DESCRIPTION	WORK RVUS	DOCUMENTATION REQUIRED
59080	Labor management, initial day, straightforward	3.00	Standard labor documentation: contractions, vitals, cervical exam, fetal monitoring assessment, standard management plan
59081	Labor management, initial day, complex	4.50	Explicitly document: complicating diagnoses, MDM across multiple data sources, additional monitoring or intervention beyond standard, multi-provider coordination that day. Generic labor notes do not support this code.
59082	Labor management, subsequent day, straightforward	2.00	Separate note required for each subsequent day. Standard management documented per day billed.
59083	Labor management, subsequent day, complex	3.50	Complexity must be re-established in the note for EACH subsequent day billed at this level. A single admission note is not sufficient.

WHY NOTE QUALITY MATTERS

The 59080 vs 59081 gap is roughly $49 per day.

1.5 RVUs at the 2026 conversion factor. For a practice with 40 deliveries per month, that is **~$2,970 per month** from note quality alone. Multiply by every complex labor day you undercode, and the annual number matters.

SUPPORTS 59080 ONLY

A generic labor note with contractions noted, vitals stable, cervical exam, fetal tones present, plan to continue monitoring. No clinical complexity established.

SUPPORTS 59081 OR HIGHER

Explicitly documents complicating diagnoses, MDM across multiple data sources, additional monitoring or intervention beyond standard, or coordination across providers on that specific day.

SECTION 05 · PHASE 3 & 4 OF 4

Delivery, then postpartum.

Delivery codes cover the delivery event only. Postpartum is billed separately with modifier TH. Any postpartum visit not billed separately after January 1, 2027 will not generate revenue.

Delivery codes.

CODE	DESCRIPTION	WORK RVUS	NOTES
59431	Vaginal delivery only, new 2027 code	8.00	Delivery event only. Antepartum and postpartum billed separately as E/M + modifier TH.
59502	Primary cesarean delivery only, new 2027 code	12.00	Delivery event only. Antepartum and postpartum billed separately as E/M + modifier TH.

Postpartum codes.

CODE	DESCRIPTION	DOCUMENTATION REQUIRED	MODIFIER
99212	Postpartum, straightforward, brief encounter	Minimal assessment, no complications, limited MDM	**TH required**
99213	Postpartum, low complexity	Routine postpartum assessment, standard recovery monitoring	**TH required**
99214	Postpartum, moderate complexity		**TH required**

CODE	DESCRIPTION	DOCUMENTATION REQUIRED	MODIFIER
		Wound assessment, medication management, complication monitoring, or multiple concerns requiring MDM	

WATCH FOR

Every 2027 delivery claim must be paired with the antepartum and postpartum E/M charges. Delivery only means antepartum and postpartum revenue left on the table.

SECTION 06 · TRANSITION TIMELINE

Your Transition Countdown.

Five checkpoints between now and the January 1, 2027 effective date. Nothing here is optional if you want a clean revenue transition.

RIGHT NOW · Q3 2026

Prepare the templates.

Update EHR templates and audit recent charts.

- → Update EHR templates to prompt TH modifier and document MDM elements.
- → Train providers on complexity documentation requirements.
- → Audit recent L&D charts against the new criteria.
- → Baseline your top 20 payers on current global-code utilization.

BY SEPT 1, 2026

Test with payers.

Live-test E/M + modifier TH claims.

- → Begin using E/M codes with modifier TH on live claims for any patient expected to deliver in 2027.
- → Submit a small batch to top 3 payers to test payer readiness. Track denials by code.

BY SEPT 30, 2026

Notice your payers.

Send written notice of intent to renegotiate.

- → Written notice of intent to renegotiate contracts to top 3 commercial payers.
- → Queues fill in Q4. September puts you in front of the January 1 date.

Q4 2026

Configure and close.

Close renegotiations, load the charge master.

- → Close payer renegotiations before end of year.
- → Refresh revenue model when CMS publishes final rule in November.
- → Add the new 2027 codes to your charge master.
- → Configure claim edits to catch deleted codes and missing TH modifiers.

JAN 1, 2027

Go live.

Effective date. Every phase billed separately.

- → New codes live. Global codes deleted. Rejections start for non-compliant claims.
- → Every phase billed separately from this day forward. Weekly denial review from day 1.

A NOTE ON US

We built this so your team can run it without us.

Everything in this reference is yours to use, whoever manages your billing. If you want a second set of eyes on your model, your renegotiation number, or your documentation standard before January, we will sit down with you and look at your real data.

A CLOSING THOUGHT

Update once. Test early. Audit weekly.

UPDATE

01

EHR templates, charge master, claim edits. All configured before Q4 closes.

TEST

02

Live E/M + TH claims with top 3 payers starting September 1, 2026. Denials are data.

AUDIT

03

Weekly denial review in Q1 2027. Root-cause CO-16, CO-97, and TH-related rejections fast.

PAIRS WITH

OB Revenue Calculator	eligibility.natrevmd.com/ob-revenue-calculator
Labor Management Daily Note	documentation kit
Prenatal Note Templates	documentation kit

SOURCES

AMA CPT 2027 Manual	Maternity Care section
AMA/RUC RVU Recommendations	Feb 2026
ACOG Payment for OB Services FAQ	2026 edition
CMS Physician Fee Schedule	Nov 2026 final rule

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