



NATREVM D

Revenue Cycle Management

INDEPENDENT OB/GYN PRACTICES · OCTOBER 2026 TO JANUARY 1, 2027

The OB 90-Day Transition *Roadmap*

On January 1, 2027, 59400 and 59510 are deleted, and maternity care unbundles into four separately billed phases. This is the week-by-week plan that gets your clinical, billing, admin, and contracts teams ready before the date, not after it.

\$598

per pregnancy at risk in contract rates alone, if you do not renegotiate

12 weeks

three milestones, six checkpoints, four teams, one deadline

Covers October · November · December 2026, ending January 1, 2027

This is a guide you can run on your own. Whenever you want a second set of eyes on your numbers, we are here. **Book a 1:1 with Heather anytime →**

One Global Code Becomes *Four Billed Phases*.

For thirty years, maternity care billed under a single global code. From January 1, 2027, each phase is coded and paid on its own. The work does not change. The way it is documented, billed, and paid does. Here is the shape of it.

Antepartum E/M • TH* Billed visit by visit. The level has to match the work the chart supports.	Labor 59080-59083 Billed per calendar day. Straightforward and complex are a real RVU swing.	Delivery 59431-59503 Plus repairs. Codes like 59433 and 59434 are separately billable.	Postpartum E/M • TH* Billed visit by visit. The global rate does not carry over with the code.
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*TH modifier applies to commercial and Medicaid payers, not Medicare, and is not universally required by all commercial payers.

HOW TO USE THIS ROADMAP

Three Milestones. Six Checkpoints. *Four Teams*.

Each milestone is one month of work, broken into weeks. Tasks are tagged by the team that owns them, so nothing falls between roles. At the end of every two weeks there is a checkpoint: a single, plain test of whether you are where you need to be. Run the weekly tasks, hit the checkpoints, and January 1 is a date on the calendar rather than an event.

DAYS 1-30 Know Your Number October 2026 Pull your global rates by payer and audit ten delivery charts, so you can state what you earn today and what your current documentation actually supports.	DAYS 31-60 Understand the Gap November 2026 Build the three-scenario model, current global versus unbundled at current and at optimized documentation, open payer conversations, and begin retraining notes.	DAYS 61-90 Test, Load, Go Live December 2026 Rehearse the new workflow on real charts, load agreed rates, and run a go or no-go review so the first week of January is steady, not improvised.
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Built on AMA RUC values submitted February 2026.
CMS final values publish November 2026. Refresh the model when they land.

October: Know Your *Number*

Goal: walk out of October knowing your average contracted global rate per delivery by payer, and what your current documentation actually supports.

WEEK 1

Oct 6-10

Pull the data, do not guess

CLINICAL

Pull **ten recent delivery cases**, a mix of vaginal and cesarean. For each, audit whether the note documents the six criteria that separate straightforward from complex labor management. The question is whether the note proves it, not whether the work was complex.

BILLING

Export **twelve months of maternity claims** for 59400 and 59510. Tag every claim by payer so the model can split out where the money sits.

ADMIN

Build the project tracker. Name **one owner per team**, and put the January 1 go-live and all six checkpoints on one shared calendar.

CONTRACTS

Inventory **every OB payer contract**. Record the contracted global rate and the renegotiation or notice window written into each one.

WEEK 2

Oct 13-17

Build the model

CLINICAL

Map your current antepartum pattern. What share bills 99213 versus 99214 today. Pull the figure rather than estimating it.

BILLING

Build the **global-versus-unbundled model**. Map each current global to its four-phase equivalent using the proposed values, and hold the result in dollars per delivery and per year.

ADMIN

Confirm your EHR and PM vendor's timeline for loading the 2027 codes. **Get it in writing.**

CONTRACTS

Identify your **top three OB payers by volume**. These are where the renegotiation effort earns its keep.

CHECKPOINT · WK 2

You can state your annual OB revenue at risk as one number. If you cannot, the model is not done. Everything that follows leans on it.

WEEK 3

Oct 20-24

Pressure-test it

CLINICAL

Walk the **complexity criteria** with your providers and agree, in writing, on what a complex labor note must contain.

BILLING

Stress-test the model against **two payers' actual fee schedules**, not Medicare alone. Most payers default-map the new 2027 codes to Medicare rates unless you have a negotiated contract, so verify each payer's crosswalk individually and do not assume your commercial rates carry over.

ADMIN

Draft the internal brief: what is changing, who owns what, and the dates that matter. One page.

CONTRACTS

Confirm each top payer's **renegotiation process, notice format, and decision timeline**. Know the rules before you play.

WEEK 4

Oct 27-31

Lock it and send notice

CLINICAL

Run a gap review on **ten antepartum charts**. Where the work and ACOG guidance support 99214 but the note says 99213, flag the pattern, not the person.

BILLING

Finalize the model. Lock the dollar figure you will carry into renegotiation.

ADMIN

Circulate the brief and **book December training time now**, before Q4 calendars fill.

CONTRACTS

If renegotiation notice has not gone out, **send it this week** to your top three payers. If it went out in September, chase a meeting date. Q4 queues fill fast.

CHECKPOINT · WK 4

Model locked, notice sent, training booked. You enter November negotiating from a number, not a worry.

November: Understand the *Gap*

Goal: make the gap visible in a three-scenario model, open payer conversations with data in hand, and begin retraining documentation.

WEEK 5

Nov 3-7

Open the conversations

CLINICAL

Start coaching antepartum documentation to the level the work supports. **Short, weekly, chart-based.** Habits beat memos.

BILLING

Build the **2027 fee schedule** for the four phases, per payer. Include separately billable repairs such as 59433 and 59434.

ADMIN

Stand up a **weekly thirty-minute transition huddle**, running through January 1.

CONTRACTS

Open renegotiation with your top three payers. Lead with your model and your number.

WEEK 6

Nov 10-14

Test the plumbing

CLINICAL

Audit **five labor notes** against the agreed complex-note standard. Share results without names.

BILLING

Map each new code to your **clearinghouse** and confirm it will accept them. Run one of each in a non-production batch if your system allows.

ADMIN

Track the **CMS final rule**. It publishes this month. Plan to refresh the model the day it lands.

CONTRACTS

Log each payer's first response. Note **who is willing to move** and who is stalling.

CHECKPOINT · WK 6

Coaching live, fee schedule drafted, CMS values being tracked. The pipes are tested before any real claim runs through them.

WEEK 7

Nov 17-21

Refresh on final values

CLINICAL

Re-audit the **same antepartum sample** from October. Is the 99214 share rising where the work supports it.

BILLING

Refresh the model with CMS final values. Update the fee schedule and the renegotiation number.

ADMIN

Update the internal brief with the final-rule changes and re-brief each team.

CONTRACTS

Send updated numbers to any payer mid-negotiation. The **final rule is your reason to reopen** the conversation.

WEEK 8

Nov 24-28

Short week, hold the line

CLINICAL

Keep documentation habits steady through the short Thanksgiving week.

BILLING

Reconcile the model against final values **one more time**. Confirm no code or rate moved since the refresh.

ADMIN

Light week. **Protect the December training dates** and confirm attendance.

CONTRACTS

Where a payer has agreed, **get it in writing with an effective date**. A verbal yes is not a rate.

CHECKPOINT · WK 8

Final-rule model locked, payer positions documented, December training confirmed. December is for rehearsal, not catch-up.

December: Test, Load, and Go *Live*

WEEK 9

Dec 1-5

Dry run on real charts

CLINICAL

Run a **full dry run**. Code three recent deliveries end to end under the four-phase model: antepartum, labor, delivery, postpartum.

BILLING

Shadow-bill the dry-run cases. Confirm each phase routes and prices correctly before any of it is real.

ADMIN

Train the full team on the new workflow: **who codes what, in what order, by when.**

CONTRACTS

Close out the renegotiations. Anything unsigned by **mid-December** likely starts January at old rates, so plan for it.

WEEK 10

Dec 8-12

Fix what broke, load rates

CLINICAL

Review dry-run results with providers and **fix the two or three things** that broke.

BILLING

Build the **day-by-day labor routine**. Labor bills per calendar day now, so the workflow has to capture each day it runs.

ADMIN

Write the **one-page January cheat sheet**, including the cesarean and midlevel scenarios that trip teams up, and put it where every coder can see it.

CONTRACTS

Load every agreed 2027 rate into the PM system, and verify the loaded rate matches the signed contract.

CHECKPOINT · WK 10 Dry run passed, labor routine built, rates loaded. What is left is verification, not construction.

WEEK 11

Dec 15-19

Final checks

CLINICAL

Final provider Q and A. Clear the last documentation questions before the holidays.

BILLING

Confirm the clearinghouse and PM system **accept the new codes on January 1**, and that the old globals are retired.

ADMIN

Confirm coverage for the first billing week of January. Do not go live short-staffed.

CONTRACTS

Document which payers **start January at old rates** so you can true them up later.

WEEK 12

Dec 22-26

Go or no-go

CLINICAL

Quiet week. Keep documentation steady on any deliveries that come in.

BILLING

Final systems check. Code mapping, fee schedule, and the labor per-day routine are live and tested.

ADMIN

Run the **go or no-go review** against the checklist. Everything green, or a named owner and date for anything that is not.

CONTRACTS

Confirm **effective dates** on every signed agreement read January 1, 2027.

CHECKPOINT · WK 12 Go or no-go complete. You are ready, or you know exactly what is not and who owns it.

WEEK 13

Dec 29 – Jan 1

GO LIVE

The new codes go live January 1, 2027. The global codes are deleted. Work your January cheat sheet, hold a fifteen-minute daily check-in for the first week, and route every question to your billing lead. The practices that prepared in October are the ones billing cleanly in January.

Four Teams, *No Gaps.*

The transition fails in the seams between roles. Here is the standing ownership across all twelve weeks, so each team knows its lane and nothing waits on someone assuming it was handled.

TEAM	WHAT THEY OWN, START TO FINISH
CLINICAL	The documentation standard and the complexity criteria. Antepartum E/M accuracy, the complex-labor note, and provider buy-in. The note has to carry the level the work supports, every day.
BILLING	The global-versus-unbundled model and the 2027 fee schedule. Code mapping and clearinghouse testing, and the per-calendar-day labor routine that did not exist under the global.
ADMIN	The project tracker, the checkpoint calendar, and training. The weekly huddle, go-live staffing, and the one-page January cheat sheet that keeps the first week calm.
CONTRACTS	The contract inventory and renegotiation with your top payers. Loading agreed rates into the PM system and confirming a written January 1 effective date on every signed agreement.

EVERY TWO WEEKS

Six Checkpoints, One *Plain Test Each.*

If you read nothing else, read these. Each is a yes or no. A no is not a failure, it is a flag telling you where to put this week's attention.

CHECKPOINT 1 · OCT, WK 2

You can state annual OB revenue at risk as a single number.

CHECKPOINT 2 · OCT, WK 4

Model locked, renegotiation notice sent, December training booked.

CHECKPOINT 3 · NOV, WK 6

Documentation coaching live, fee schedule drafted, CMS values tracked.

CHECKPOINT 4 · NOV, WK 8

Final-rule model locked, payer positions documented, training confirmed.

CHECKPOINT 5 · DEC, WK 10

Dry run passed, labor per-day routine built, agreed rates loaded.

CHECKPOINT 6 · DEC, WK 12

Go or no-go complete, every open item has an owner and a date.

Three Questions, Five *Truths*.

Everything in this plan serves three questions. Answer them before January 1, and keep five things in mind no matter how your practice bills.

THREE QUESTIONS EVERY PRACTICE ANSWERS BEFORE JANUARY 1

1. What do we earn per OB patient today, under the global model?
2. What would we earn under the new model if we documented appropriately right now?
3. What is the gap, and what do we do about it?

FIVE THINGS THAT ARE TRUE NO MATTER WHAT

1 · THE GAP IS STRUCTURAL

Even with appropriate documentation and correct E/M leveling, expect a per-delivery decrease versus today's global rates. It is not a billing error. Close it through payer renegotiation, which takes time, so open the conversation in November.

2 · THE NOTE SETS THE PAYMENT

A provider who does complex work but writes a brief note is paid for straightforward work. The templates capture what was actually done. They are not about adding length.

3 · SOME PAYERS WILL NOT BE READY

A few payers will not accept the new codes cleanly on January 1. Plan for claims that reject in Q1 and hold a cash reserve for the delay. A known transition risk, not a failure.

4 · MIDLEVELS ARE THE SAME SPECIALTY

CNMs, NPs, and PAs working with physicians code the same way. A CNM-managed labor with a physician delivery follows the same workflow as one provider. Map your split before go-live.

5 · MIND THE CESAREAN RULES

A planned cesarean without a labor trial bills no labor code, use hospital inpatient E/M instead. Repeat cesarean (59503) bundles hospital E/M into the delivery; primary cesarean (59502) without labor can report it separately.

WHAT THIS PROTECTS

The Money Leaves *Quietly*.

When a code retires, the contracted rate attached to it retires too. There is no denial to flag it, which is exactly why it goes unnoticed. Three figures worth keeping in front of the team.

HEADLINE · THE NUMBER THAT MATTERS

\$598

per pregnancy in **contract risk alone**, if rates are not renegotiated before the globals retire

THE DEFAULT DROP

12–20%

lower per delivery **by default**, when payers map the new codes to their standard rates

THE BASELINE AT RISK

\$2,408

in base revenue **at risk per delivery** across the four phases through the transition

Figures are illustrative, built on AMA RUC values submitted February 2026 and current Medicare benchmarks. Your real exposure depends on your contracts and your documentation. CMS publishes final values in November 2026, so refresh the model when they land.

BEFORE JANUARY 1

The Readiness *Checklist*.

A short list your whole team can work through. If every box is checked by Checkpoint 6, you are ready.

CLINICAL

Documentation Ready

- ☐ Complex-labor note standard agreed and shared with every provider
- ☐ Antepartum 99214 share rising where the work and documentation support it, per ACOG guidance
- ☐ Final provider questions cleared before the holidays

BILLING

Systems Ready

- ☐ Global-versus-unbundled model refreshed on CMS final values
- ☐ 2027 fee schedule built per payer, repairs included
- ☐ New codes accepted by clearinghouse and PM system, old globals retired
- ☐ Per-calendar-day labor routine built and tested in a dry run

ADMIN

Team Ready

- ☐ Full team trained on the new workflow and order of operations
- ☐ One-page January cheat sheet written and posted
- ☐ First billing week of January staffed and covered

CONTRACTS

Contracts Ready

- ☐ Renegotiation closed or status documented for top three payers
- ☐ Agreed rates loaded into the PM system and verified against signed contracts
- ☐ Effective dates confirmed as January 1, 2027 on every agreement

WHERE WE COME IN

We Built This So Your Team Can Run It Without Us.

Everything here 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. No pitch, just the math.

[Book a call with Heather →](#)

Or start with the model. We will send the global-versus-unbundled worksheet on request at natrevmd.com

WHO BUILT THIS

A Physician and a Coder, in the Same *Room*.

We are a physician-led revenue cycle team built for independent practices. This roadmap was written by the people who work the change, not by people describing it from a distance.

Dr. Heather Signorelli, DO

FOUNDER · PHYSICIAN ADVISOR

A practicing physician who frames every change around what it means for your bottom line, and what to do about it this quarter.

Amy Hicks, CPC, COBGC

AVP OF OPERATIONS

An OB/GYN billing specialist and certified coder. She walks the new codes line by line and owns the documentation standard in this plan.

Our OB Coding Lead

CODING · DOCUMENTATION

Built the four-phase mapping and the per-calendar-day labor routine that sit underneath every week of this roadmap.



NATREVMD

Revenue Cycle Management

Physician-Led Revenue Cycle, Built for Independent Practices
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