NATREVMD

Revenue Cycle Management

AN OB/GYN TRANSITION WORKBOOK · OCTOBER 2026 TO JANUARY 1, 2027

The OB 90-Day Transition *Workbook*

On January 1, 2027, 59400 and 59510 are deleted, and maternity care unbundles into four separately billed phases. This is the plan, the math, and the worksheets your team works from.

Read the plan. Fill the worksheets with your real numbers. Run a checkpoint every two weeks. Bring it to your payer and team meetings.

$598

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

12 weeks

three milestones, six checkpoints, four teams, three worksheets

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 →**

START HERE

How to Use This *Workbook*.

This is a working document, not a white paper. The practices that come through the 2027 transition cleanly are the ones who filled something like this in during October, not the ones who read about it in December.

1 Read the plan

Walk the three milestones and the four-phase change so the whole team shares one picture of what is coming.

2 Fill in the worksheets

Three worksheets turn the plan into your numbers: your revenue at risk, your top payers, your chart-audit log.

3 Run the checkpoints

Every two weeks, run the one-line checkpoint. A no is not a failure, it is a flag for where to spend the week.

4 Bring it to the table

Take your filled worksheets into payer renegotiations and team huddles. The numbers do the arguing.

INSIDE

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Built on AMA RUC values submitted February 2026.
CMS final values publish November 2026. Refresh the model when they land.

WHAT CHANGES

One Global Code Becomes *Four Billed Phases*.

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

01 **Antepartum** E/M · TH*

Billed visit by visit. The level has to match the work the chart supports, every visit.

02 **Labor** 59080–59083

Billed per calendar day. Straightforward versus complex is a real RVU swing, with no denial to flag it.

03 **Delivery** 59431–59503

The delivery itself, plus repairs. Codes like 59433 and 59434 are separately billable now.

04 **Postpartum** E/M · TH*

Billed visit by visit. The global rate does not carry over with the code when it retires.

ONE GLOBAL CODE · FOUR BILLED PHASES

The pregnancy care journey, each phase coded and paid on its own from January 1, 2027

*TH modifier applies to commercial and Medicaid payers, not Medicare, and is not universally required by all commercial payers.

THE MONEY AT STAKE

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

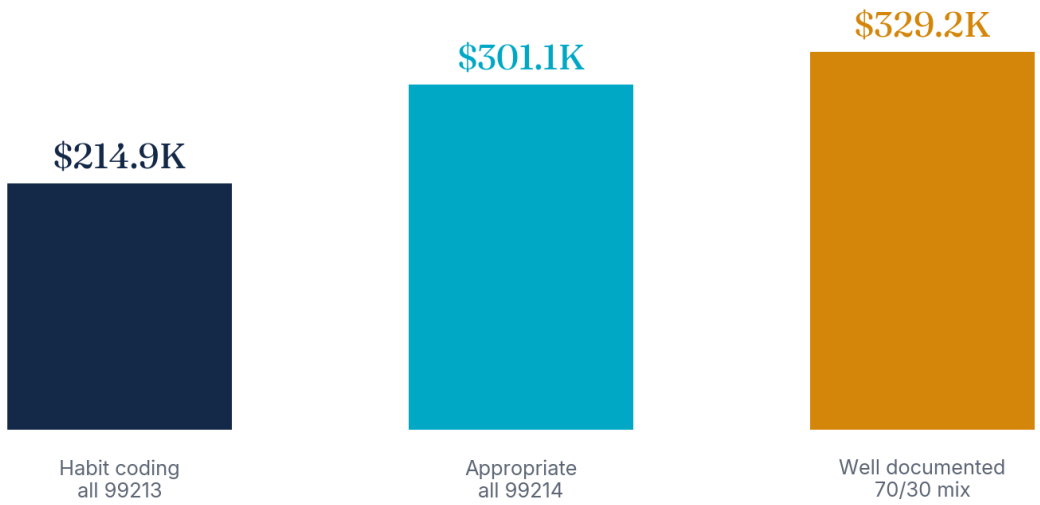
THE BASELINE AT RISK

$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.

The Same 100 Deliveries, Three Different *Paychecks*.



Annual OB revenue at 100 deliveries, 125% of Medicare. Same patients, same visits. The only difference is whether the note carries the level the work already supports. Illustrative, built on 2026 benchmarks.

You build your own version of this in **Worksheet 1**. That single figure, your annual OB revenue at risk, is what you carry into every payer conversation.

THE PLAN AT A GLANCE

Three Milestones, Six *Checkpoints*.

Each milestone is one month of work. At the end of every two weeks, a checkpoint gives you a single, plain test of whether you are on track. The week-by-week detail for each milestone follows later in this workbook.

DAYS 1–30

Know Your Number

October 2026

Pull your global rates by payer and audit ten delivery charts, so you know what you earn today and what your documentation supports.

DAYS 31–60

Understand the Gap

November 2026

Build the three-scenario model, open payer conversations, and begin retraining notes to the level the work supports.

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 before January 1.

EVERY TWO WEEKS

The Six *Checkpoints*.

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.

WHO OWNS WHAT

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.

THE THROUGH-LINE

Three Questions, Five *Truths*.

Everything in this workbook 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.

DAYS 1–30 · MILESTONE ONE

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.

WORKSHEET 1 · KNOW YOUR NUMBER

Your Revenue-at-Risk *Model*.

Fill this in with your real billing data and the audit numbers from Worksheet 3. The figure at the bottom, your annual revenue gap, is what you carry into every payer renegotiation. Build it in October, refresh it the day CMS publishes final values in November.

YOUR CURRENT GLOBAL BASELINE

TOTAL ANNUAL OB DELIVERIES

TOTAL ANNUAL GLOBAL REVENUE, 59400 + 59510 ($)

AVERAGE CURRENT REVENUE PER GLOBAL DELIVERY ($)

THE 10-DELIVERY AUDIT PROJECTION · PULLS FROM WORKSHEET 3

AVG UNBUNDLED REVENUE / DELIVERY, CURRENT DOCUMENTATION ($)

AVG UNBUNDLED REVENUE / DELIVERY, OPTIMIZED DOCUMENTATION ($)

THE GAP

PER-DELIVERY GAP, CURRENT GLOBAL VS OPTIMIZED UNBUNDLED ($)

ESTIMATED ANNUAL REVENUE GAP ($)

The gap between your current global revenue and your optimized unbundled revenue is what payer renegotiation has to close. Even at optimized documentation, expect a gap. That is structural, not a billing error.

DAYS 31–60 · MILESTONE TWO

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.

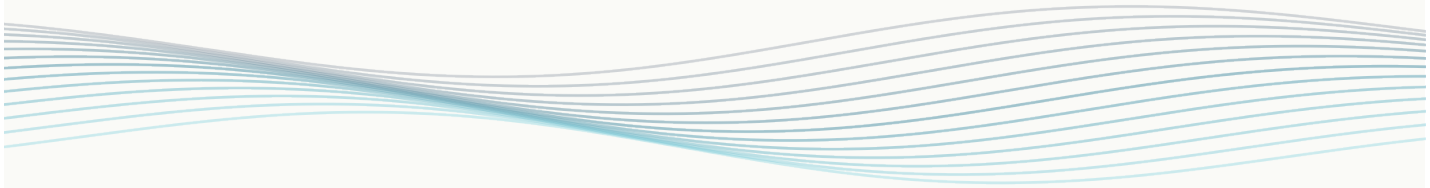
WORKSHEET 2 · UNDERSTAND THE GAP

Your Top Three *Payers*.

List your highest-volume OB payers first. These are where renegotiation earns its keep. Record what each pays today and the 2027 replacement rate you will target, then track each one from notice through a signed January 1, 2027 effective date.

PAYER	ANNUAL DELIVERY VOLUME	CURRENT GLOBAL RATE	TARGET 2027 REPLACEMENT RATE	NOTICE DEADLINE	STATUS	NEW RATE AGREED

Reminder: a verbal yes is not a rate. Where a payer agrees, get it in writing with an effective date before you mark the status closed.



DAYS 61–90 · MILESTONE THREE

December: Test, Load, and Go *Live*

Goal: rehearse the new workflow on real charts, load agreed rates, and run a go or no-go review so January 1 is steady, not improvised.

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.

WORKSHEET 3 · THE 10-DELIVERY AUDIT

10-Delivery Audit *Log*.

Pull 10 recent delivery cases. Audit the full episode of care, antepartum through delivery, to see what your current documentation actually supports under the 2027 rules. The modeled revenue and gap columns feed straight into Worksheet 1.

CHART # / PAYER	DELIVERY TYPE	LABOR CRITERIA MET?	SUPPORTED LABOR CODE	ANTEPARTUM E/M MIX	MODELED UNBUNDLED REV ($)	GAP VS CURRENT GLOBAL ($)

Delivery type: Vaginal, VBAC, Primary C, Repeat C. Supported labor code: Straightforward, Complex, or None. The audit answers one question for each case, what does the note actually prove.

BEFORE JANUARY 1

The Readiness *Checklist*.

Work through this with your whole team. Check the boxes as you go, on screen or on paper. If every box is checked by Checkpoint 6, you are ready for go-live.

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

TAKE THESE TO THE TABLE

Questions to *Bring*.

Two short lists: what to ask your payers, and what to settle with your own team. Write your answers in as you get them. The blanks are the point.

TO YOUR TOP PAYERS

1. What rates will you map our deleted globals to on January 1, and how did you set them?

2. Will you commit to a January 1, 2027 effective date on any renegotiated rate, in writing?

3. How are you pricing the new labor codes 59080 to 59083 on a per-calendar-day basis?

TO YOUR TEAM

1. Who owns each of the four phases on a live claim, and who is the backup?

2. What does a complex labor note have to contain for us to bill it as complex?

3. Where will the one-page January cheat sheet live so every coder can see it?

4. What is our average current global rate, by payer?

5. What is our modeled 2027 revenue per delivery under current documentation?

6. Which note templates change first, and who owns implementation?

KEEP GOING

Next Steps and *Resources*.

Everything here is yours to use, whoever manages your billing. Start with whichever one matches where you are right now.

PRIMARY PLAN

30-Day Revenue Recovery Plan

Our flagship plan. A focused thirty-day path to find and recover the revenue your practice is already leaking, one step at a time.

Get the plan →

`eligibility.natrevmd.com/nrc/-30day-revenue-recovery-plan`

DIAGNOSTIC

RECOVER Diagnostic Quiz

Six questions, ninety seconds. It shows you where your revenue is leaking before it leaves the practice.

Run the diagnostic →

`eligibility.natrevmd.com/recover-diagnostic`

CHECKLIST

Payment Posting Checklist

The step-by-step checklist we use to keep payment posting clean, accurate, and reconciled.

Get the checklist →

`eligibility.natrevmd.com/payment-posting-checklist`

ALL OUR TOOLS

Resource Library

Every free diagnostic we built, plus the podcast and the book, together in one place on our site.

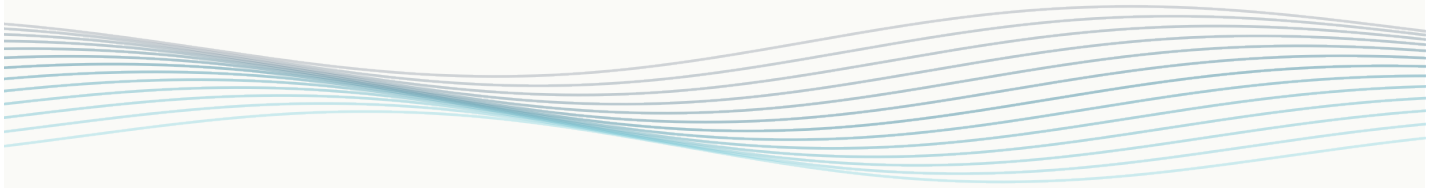
Browse all our tools →

`natrevmd.com/trusted-resources`

Want a Second Set of Eyes on Your Model?

We will sit down with your real data and your renegotiation number. No pitch, just the math.

Book a call with Heather →



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Do the Work in *October*.

The practices that prepare now are the ones negotiating from strength in Q4 and billing cleanly in January. You have the plan, the math, and the worksheets. The rest is doing it, two weeks at a time.

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Physician-Led Revenue Cycle, Built for Independent Practices

Resource library →
natrevmd.com