

2027 Maternity Care CPT Code Restructuring

The First Comprehensive Overhaul in More Than 30 Years

If approved, these updates will take effect January 1, 2027, fundamentally changing how obstetric services are reported across all phases of care – including antepartum, labor, delivery, and postpartum.



Maternity Care Reimbursement is at a Crossroads

For decades, routine maternity care has been billed through four bundled global obstetrics codes – 59400, 59510, 59610, 59618 – under a Maternity Medical Management (MMM) global period. The 2026 AMA/Specialty Society RVS Update Committee (RUC) restructuring and revised ACOG visit guidance have prompted CMS to put two mutually exclusive paths out for comment.

TWO OPTIONS

A

ADOPT & REVALUE

Implement the new/revised CPT codes and unbundle global into itemized components.

CMS refinement: removes **4 prenatal E/M visits** from the utilization estimate and reallocates wRVUs to the new labor & delivery codes – a **+15% lift on each**.

B

MAINTAIN TODAY'S STRUCTURE

Keep the current coding and payment by creating new HCPCS G-codes in lieu of the new CPT codes.

15 new G-codes mirror the prior MMM global structure and preserve the global period and conditions of payment – calibrated to today's global wRVUs.

How a Coding Restructure Became a Payment Question

At its January 2026 meeting, the RUC's math revised the maternity global family – deleting 17 legacy CPT codes, creating 12 new codes, and revising 9 – moving from a bundled MMM global period toward individually reported services.

1**May 2025**

ACOG guidance

2**September 2025**

AMA endorses new CPT Structure

3**January 2026**

RUC valuation

4**July 2026**

Proposed rule published

Why CMS is Weighing Two Very Different Approaches

The dispute is about a single assumption buried in the valuation: How many prenatal visits a typical pregnancy **actually** generates.

THE OLD BUNDLE



The MMM global (59400/59510/59610/59618) folded ~12 prenatal E/M visits into a single fixed payment, regardless of how many visits actually occurred.



THE RUC'S MATH



To keep the restructure budget-neutral, the RUC still valued the new codes assuming all 12 prenatal visits would be reported (2 level-2, 8 level-3, 2 level-4).



CMS'S CONCERN



With ACOG now describing 8 visits as typical, assuming 12 overstates utilization – which overvalues antepartum work and undervalues the actual labor & delivery services.

Maternity Care Coding Restructure

Proposed wRVUs for Maternity Services

CPT	Long descriptor	RUC rec. wRVU	CMS prop. wRVU
Antepartum care			
59320	Cerclage of cervix, during pregnancy; vaginal	3.02	3.02
59325	Cerclage of cervix, during pregnancy; abdominal	6.34	6.34
59412	External cephalic version	2.63	2.63
59871	Removal of cerclage suture under anesthesia (other than local)	2.15	2.15
Labor management and delivery – CMS proposed reflects the +15% reallocation			
59XX1	Initial day labor management; straightforward, per day	3.50	4.03
59XX2	Initial day labor management; complex, per day	4.50	5.18
59XX3	Subsequent day labor management; straightforward, per day	3.00	3.45
59XX4	Subsequent day labor management; complex, per day	4.20	4.83
59XX5	Vaginal delivery, with or without episiotomy	8.00	9.20
59XX6	Vaginal delivery, with or without episiotomy; after previous cesarean delivery	9.00	10.35
59XX7	Cesarean delivery; primary	12.00	13.80
59XX8	Cesarean delivery; repeat	14.66	16.86

Labor Procedures, Other Procedures, and Postpartum

CPT	Long descriptor	RUC rec. wRVU	CMS prop. wRVU
Labor procedures, other procedures, and postpartum			
59030	Fetal scalp blood sampling	0.90	0.90
59051	Fetal monitoring during labor by consulting physician (non-attending) or other QHP, with interpretation and report	0.93	0.93
59414	Delivery of placenta only (separate procedure)	1.61	1.61
59300	Repair of first- or second-degree episiotomy/laceration, by other than the attending or QHP performing delivery (separate procedure)	1.76	1.76
59X11	Repair of episiotomy or laceration; third-degree laceration	2.47	2.47
59X12	Repair of episiotomy or laceration; fourth-degree laceration	4.14	4.14
59XX9	Subtotal or total hysterectomy after cesarean delivery	15.56	15.56
59X10	Uterine tamponade (eg, balloon, catheter, vacuum, packing material)	2.15	2.15
59160	Curettage, postpartum	2.93	2.93

Compare & Contrast

What each option means where it counts.



Provider Credit

Winners / Losers

Compensation Administration

Benchmarking / Fair Market Value

Operational Lift

OPTION A - Adopt & Revalue

Follows documented activity – each prenatal visit, labor day, and delivery earns its own wRVU

Rewards labor & delivery (+15%); antepartum credit scales with actual visits (up for high-risk, down for low)

Global-split attribution becomes largely unnecessary; component codes credit providers directly

Historical global productivity no longer maps 1:1 – wRVU benchmarks and \$/wRVU need recalibration

Higher – EHR, charge capture, and coder workflows must shift to itemized reporting

OPTION B - Maintain via G-Codes

Fixed per episode – the global bundle earns the same wRVU regardless of visit count

Neutral – preserves current relativities across antepartum, delivery, and postpartum

Existing wRVU-split methodologies for shared global care stay in place, unchanged

Continuity preserved – survey benchmarks built on global codes remain comparable

Lower – largely a code-set swap; workflows and global logic remain familiar

Implications for Physician Pay and Valuation



Work RVU-Based Pay: Under Option A, wRVU credit becomes activity-based and tilts toward delivering physicians (the +15% L&D lift) and whoever renders each prenatal visit. Global-split attribution largely falls away.



Attribution Models: Option B preserves the need for wRVU-split methodologies across antepartum, delivery, and postpartum in shared-care and midwife-inclusive models. Option A credits components directly.



Benchmark Continuity: Survey benchmarks (e.g., SullivanCotter, MGMA) are built on historical global productivity. A shift to component coding can break wRVU comparability and \$/wRVU calibration until data re-baselines.



Payer Ripple: Medicare is a minor OB payer, but commercial and Medicaid plans often track CMS structure. Watch downstream adoption before assuming the CMS choice is contained to Medicare.

Looking for more guidance on the upcoming changes? SullivanCotter can help you navigate the potential impact!

Let's Connect

Status and What to Watch

Nothing is final until November

NOV 2026

Final Values

CMS finalizes work RVUs and the chosen structure in the Final Rule.

JAN 1, 2027

Effective

Finalized coding and payment take effect for the calendar year.



Watch for final placeholder-to-real CPT number assignments, whether CMS chooses adoption vs. G-codes, the final labor & delivery values, and any commercial-payer signals on which structure they will follow.