BlueCross BlueShield of Alabama

Obstetrics Coding and Documentation Reference Guide



Effective January 1, 2027, CPT introduces a phase-specific approach to maternity care reporting. Obstetric services will be reported separately for antepartum care, labor management, delivery and postpartum care based on the services provided and documented for each encounter.

At A Glance: What Changed?

Prior to January 1, 2027	Effective January 1, 2027
Global maternity package	Phase-specific reporting
Antepartum package codes **59425/59426**	Deleted
Postpartum package codes	Deleted
Routine prenatal visits included in package	E/M coded per encounter
Postpartum visits included in package	E/M coded per encounter
Labor included in delivery package	Labor management reported separately

2027 Obstetric Coding Snapshot

Phase	CPT Code/Description	
Phase 1: Antepartum Care	Appropriate E/M per encounter with modifier TH appended	
Phase 2: Labor	**59080** – Initial / straightforward **59081** – Initial / complex **59082** – Subsequent / straightforward **59083** – Subsequent / complex	
Phase 3: Delivery	**Vaginal**	**59431** – Vaginal **59432** – Vaginal after previous C-section **Laceration** 1st/2nd degree – included in delivery **59433** – 3rd degree **59434** – 4th degree
	Cesarean	**59502** – Primary **59503** – Repeat **59504** – Cesarean Hysterectomy
Phase 4: Postpartum	**Uterine Tamponade**	**59623** – Uterine tamponade for postpartum hemorrhage management
	Appropriate E/M per encounter after delivery with modifier TH appended	

2027 Obstetric Coding Detail

Phase 1: Antepartum Care (Encounter-Based)

Effective January 1, 2027, the current antepartum care-only codes 59425 and 59426 will be deleted. Antepartum care will no longer be reported as a package based on the number of routine prenatal encounters. Instead, **each antepartum encounter is reported separately using the appropriate E/M service code based on the service provided and the location of the patient.**

- **TH Modifier:** Modifier TH (obstetrical treatment/services, prenatal or postpartum) should be used, when applicable, to identify maternity-related services. The appropriate pregnancy-related diagnosis codes should also be reported to identify the antepartum condition or reason for the encounter.

  Note: For Blue Cross and Blue Shield of Alabama, applicable antepartum and postpartum maternity-related E/M services should be reported with the TH modifier.

- **E/M Code Selection:** Each antepartum encounter must be evaluated individually. Select the E/M level based on either of the following:
  - **Medical decision-making;** or
  - **Total time spent on the date of the encounter.**

Provider Documentation Reminder: You will need documentation that supports E/M level selection at every antepartum encounter. The level does not automatically stay the same throughout pregnancy; each encounter is evaluated based on the service provided that day.

Antepartum services such as laboratory tests (excluding dipstick urinalysis), diagnostic ultrasounds, amniocentesis, cordocentesis, chorionic villus samplings, fetal stress tests and fetal non-stress tests should be billed separately, under the 2027 structure.

Important E/M Considerations: For E/M medical decision-making purposes, a normal pregnancy is considered a condition addressed during the encounter and is not classified as an acute, uncomplicated illness. When medical decision-making is used for code selection, documentation must support the applicable level based on all three medical decision-making elements: problems addressed, data reviewed and analyzed, and risk of complications and/or morbidity or mortality.

Note: Pregnancy-related E/Ms can be billed with:

- **Appropriate ICD-10-CM codes** (Pregnancy diagnosis codes)
- **TH modifier** (Obstetrical treatment/services, antepartum/postpartum)

What E/M codes should providers use?

Office/Outpatient E/M Examples:

- **New patient:** 99202-99205
- **Established patient:** 99211-99215

Hospital Inpatient/Observation E/M Examples:

- Use applicable inpatient/observation E/M codes based on place of service and documentation.

Phase 2: Labor Management (Per Day and Complexity Tiers)

Beginning January 1, 2027, labor management will be reported separately from delivery service. Labor management is reported **once per calendar date** based on whether it is the initial or subsequent day of management and whether the clinical management is **straightforward or complex**.

Labor Management Codes	
Code	**Description**
59080	Initial day labor management; straightforward, per day
59081	Initial day labor management; complex, per day
59082	Subsequent day labor management; straightforward, per day
59083	Subsequent day labor management; complex, per day

Coding Guidelines:

- Report **one labor management code per calendar date**, regardless of the number of fetuses. For multiple gestations, labor management is reported only once per calendar date.
- **Initial day** refers to the first calendar date during the facility admission on which the physician or other Qualified Healthcare Professional (QHP) begins labor management.
- **Subsequent day** applies to each following calendar date on which labor management continues.
- Select the **highest level of labor management performed during the calendar date**. If management changes from straightforward to complex during the same day, report only the complex code for that date.
- Labor management includes services such as interim physical examinations, collection and interpretation of physiologic data and management of induction or augmentation.
- A planned or **scheduled cesarean** would **not** have a labor management code associated with the service.

Levels of Labor Management	
Straightforward	**Complex**
ALL criteria must be met	**ANY of the following may support complex management**
• Singleton Vertex Presentation • Routine maternal/fetal monitoring • Fetal monitoring not requiring physician/ QHP intervention • Normal progression of labor or routine labor induction or augmentation • Stable medical conditions (e.g., well-controlled hypertension, diet-controlled diabetes) that do not require additional management during labor • No previous cesarean delivery	• More than one fetus • Fetal monitoring abnormalities requiring a change in management requiring physician/QHP intervention • Prolonged first or second stage of labor • Labor complications (e.g., intraamniotic infection and/or inflammation, preeclampsia) • Severe maternal morbidity indicators (e.g., acute renal failure, eclampsia) • Maternal medical conditions requiring additional medical management during labor • Previous cesarean delivery
Note: The examples listed are not intended to cover every possible situation. See the American Medical Association's Maternity Care Services webpage for additional details.	

The complexity level is based on the **condition of the patient and fetus(es), the medical decision-making, and associated service required during labor**. The duration of labor alone does not determine complexity unless prolonged labor is diagnosed.

When the physician/QHP managing the labor performs fetal monitoring as part of labor management, the monitoring is included in the labor management service and is not separately reportable.

Provider Documentation Reminder: Labor management and delivery are separate services under CPT 2027. When the same physician/QHP performs both labor management and delivery on the same date, both services may be reported when the CPT requirements are met.

Phase 3: Delivery Care-Standalone Delivery Services

Beginning January 1, 2027, delivery services will be reported separately from antepartum and labor management services. The delivery codes describe the delivery procedure itself, including delivery of the placenta and routine same-day postpartum care, as applicable. Labor management is reported separately when performed and supported by the CPT guidelines.

Delivery Code Selection

Select the delivery code that accurately reflects the **method of delivery and the patient's prior cesarean history**:

Delivery Codes	
Code	**Description**
59431	Vaginal delivery, with or without episiotomy
59432	Vaginal delivery, with or without episiotomy; after previous cesarean delivery
59502	Cesarean delivery; primary
59503	Cesarean delivery: repeat
59433	Repair of episiotomy or laceration; third-degree laceration
59434	Repair of episiotomy or laceration; fourth-degree laceration
59504	Subtotal or total hysterectomy after cesarean delivery

Coding Guidelines:

- **Multiple Gestations –** Delivery reporting depends on the mode of delivery:
  - **Cesarean Delivery:** Report one cesarean delivery code regardless of the number of fetuses delivered by cesarean.
  - **Vaginal Delivery:** Report one vaginal code **per fetus delivered vaginally.**
  - **Mixed-mode Delivery:** When some fetuses are delivered vaginally and others by cesarean during the same session, report the applicable vaginal delivery code(s) and cesarean delivery code. Modifier 51 may apply to the secondary procedure as appropriate.
- **Code 59504** may be reported when a subtotal or total hysterectomy is performed during the same encounter as a cesarean delivery. It may be reported by the same physician who performs the cesarean or by a different physician. When the same physician performs both procedures, modifier 51 is appended to 59504.

Provider Documentation Reminder: Document the delivery method, prior cesarean history, number of fetuses delivered by each method and any separately reportable procedures or complications. Documentation should support the CPT codes reported.



Phase 4: Postpartum Care (Encounter-Based Reporting)

All current postpartum care codes are deleted effective January 1, 2027. Postpartum care will be reported per encounter using the appropriate E/M service.

Coding Guidelines:

- **Same-day postpartum care:** Routine postpartum care provided on the same calendar date as delivery is included in the delivery code and is not reported separately.
- **Inpatient postpartum care:** For facility births, report the appropriate subsequent hospital inpatient or observation E/M code for each postpartum management day after the delivery date, followed by the appropriate discharge-day management code when applicable.
- **Outpatient postpartum care:** After discharge, report each postpartum encounter using the appropriate E/M service based on the location and services provided.
- **Telehealth or home-based postpartum care:** Report the appropriate E/M service for the modality and location of the encounter. Refer to the Blue Cross and Blue Shield of Alabama Telehealth Billing Guide for Providers for additional information about telehealth services.

Postpartum Hemorrhage/Uterine Tamponade:

CPT 59623-Uterine tamponade for management of postpartum hemorrhage

- When uterine tamponade is performed to manage postpartum hemorrhage, **report 59623 separately when the CPT requirements are met**. This may include tamponade using a balloon, catheter, vacuum device, or packing material.
- Documentation should identify:
  - The postpartum hemorrhage
  - The clinical indication for tamponade
  - The procedure performed and relevant findings.
  - The patient's response to treatment.
- Uterine tamponade is separately reportable when performed and supported by the documentation. Do not include this information under the routine postpartum E/M section.

Provider Documentation Reminder: Document each postpartum encounter and the services provided. Blood pressure checks, postpartum assessments, mental health screening and evaluation, wound/incision checks, breastfeeding concerns, contraception counseling, and other postpartum concerns should be documented according to the services performed and coded using applicable E/M or procedure code.

Important E/M Considerations: For E/M (MDM) purposes, a normal pregnancy is considered a condition addressed during the encounter and is not classified as an acute, uncomplicated illness. When MDM is used for code selection, documentation must support the applicable level based on all three MDM elements: problems addressed, data reviewed and analyzed, and risk of complications and/or morbidity or mortality.

Note: Pregnancy related E/Ms can be billed with:

- Appropriate ICD-10-CM codes pregnancy diagnosis codes
- TH modifier (Obstetrical treatment/services, antepartum/postpartum)

Additional Resources:

- CPT® 2027 Maternity Care Services code changes
- 2027 ICD-10-CM files

Quality Reporting

For quality tracking and in accordance with Healthcare Effectiveness Data Information Set (HEDIS) and guidelines, Blue Cross and Blue Shield of Alabama requires that claims be submitted with both of the following:

- **Date of first prenatal visit –** Submit a claim reflecting the actual date of the first visit for prenatal care. Use CPT Category II code 0500F (Initial prenatal care visit) or 0501F (Prenatal flow sheet documented in medical record by first prenatal visit).
- **Date of postpartum visit –** The postpartum visit should occur 4-6 weeks after delivery. Use CPT II code 0503F (postpartum care visit) and ICD-10 diagnosis code Z39.2 (routine postpartum follow-up).

Frequently Asked Questions

1. **Can labor management and delivery be billed on the same day?**
   Yes, when CPT requirements are met and documentation supports both services.
2. **Is a scheduled cesarean assigned a labor management code?**
   No.
3. **Are prenatal visits still billed as a package?**
   No. Each encounter is reported with the appropriate E/M code.
4. **Are postpartum visits included in delivery?**
   Only routine same-day postpartum care on the date of delivery is included.

Note: This Quick Reference Guide is for informational purposes only. Providers should reference the Current Procedural Terminology (CPT®) manual for the most current updates and for any additional maternity related service codes. The most current codes should be submitted on a claim. Member eligibility and benefits should be determined before medical guidelines, and reimbursement guidelines are applied.

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ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

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