



# **New OB Codes: Transition Plan for OB-Gyns**

**ACOG**

## Background/Introduction

Prenatal care is among the most common preventive services in the United States—but despite myriad advancements in health care technology and advocacy from major organizations, the foundational models for its delivery had remained largely unchanged since their introduction in the 1930s. Nearly a century later, ACOG made a twofold push to revolutionize prenatal care delivery: creating guidance for [tailoring a prenatal care visit schedule](#) that aims to transform prenatal care as it concerns addressing patients’ unmet social needs, the frequency of visits and monitoring, and incorporating telemedicine and alternative care modalities; and successfully advocating for the American Medical Association to delete the global maternity codes and create a new CPT® code set for all health plans.

The new CPT codes go into effect January 1, 2027, across all health plans. With more than half of the approximately 3.6 million births annually in the United States financed by commercial health plans, it’s critical that ob-gyns understand and prepare for this upcoming transition.

Contract changes are inevitable. ACOG has created this transition plan, which includes evaluation and management (E/M) codes, consistent with current CPT guidance, to ease the burden on ob-gyns and payers alike. We recommend setting transition plans in place now to be ready for the new codes to go into effect in 2027.

## Why use the CPT E/M Codes in 2026?

- E/M codes for antepartum services are already incorporated into existing contracts, claims processing systems, and electronic health records
- CPT rules already exist that allow for E/M codes when health care professionals provide only one to three visits for antepartum services
- Using E/M codes allows for a defined education and transition period for antepartum services while minimizing disruption for health plans, ob-gyns, and coding staff
- Ob-gyns are already trained in E/M coding and ACOG has established educational resources
- Certain Medicaid programs already use E/M codes for prenatal visits
- Health plans may operationalize this transition through straightforward claims edits that recognize E/M codes when submitted with pregnancy diagnosis codes (O00–O09A or Z33–Z34) or by requiring use of a –TH modifier
- This approach reduces reliance on retrospective, end-of-year billing for bundled prenatal care codes and mitigates the administrative burden associated with high volumes of year-end claims
- Interim use of E/M codes for prenatal visits will generate valuable insights to inform education and operational readiness ahead of the 2027 implementation
- ACOG has already recommended this in our [Statement of Policy](#).

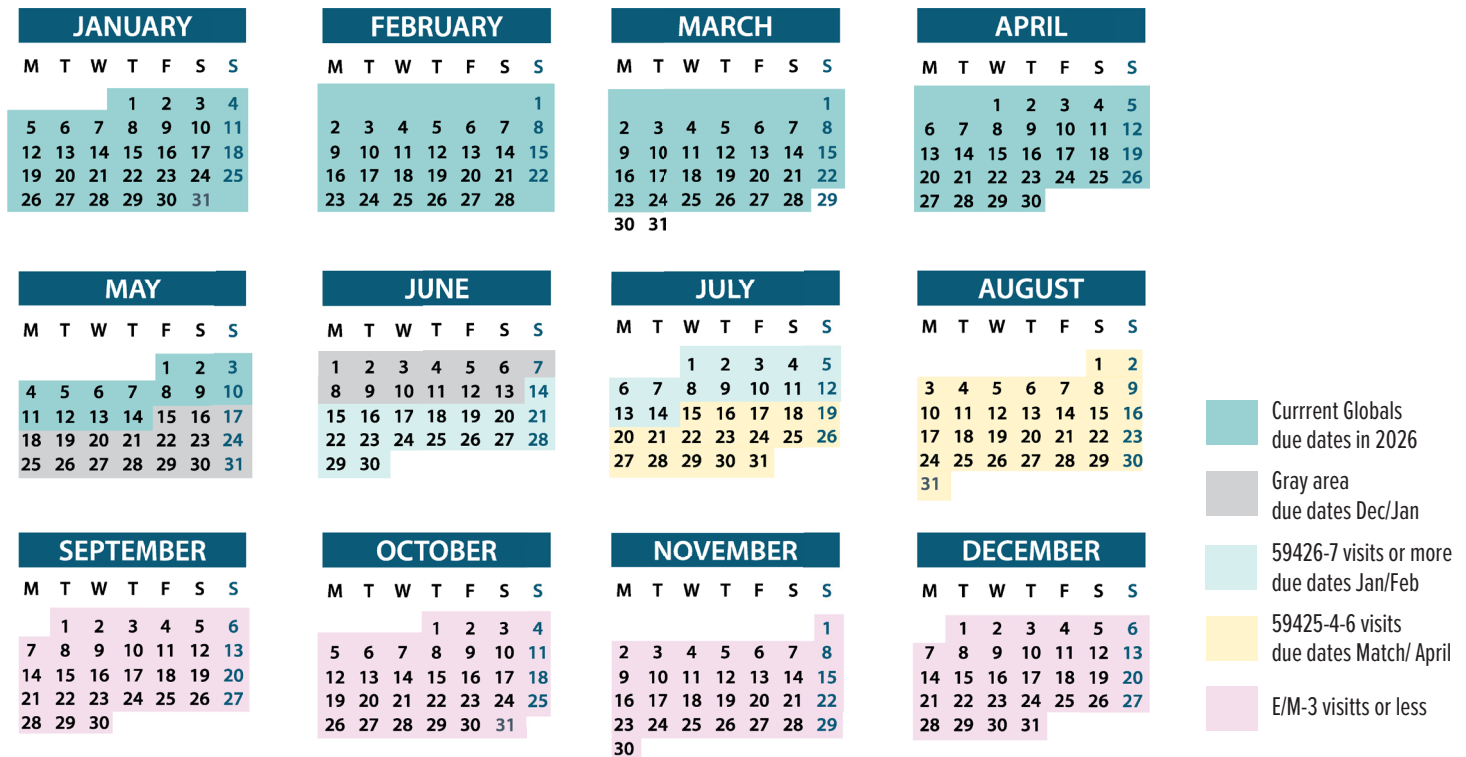
## Coding through the Transition from Global Obstetric Payment

The first antepartum visit is typically at 8 to 10 weeks gestation. Based on the date of the first visit and assuming a typical antepartum visit schedule and normal gestation, physicians, and other obstetric providers will likely vary the codes they use for patients who present for their first antepartum visit in the following date ranges:

1. **Before May 15:** Use the current global obstetrics codes, as the patient will deliver in 2026
2. **May 15–July 14:** Prepare for payers to request to use code 59436 (7 antepartum visits or more) with the delivery-only code in December or the new codes in 2027, as the patient will deliver between December and February



- July 15–September 1:** Payers may want to use code 59425 (4–6 antepartum visits) in 2026, as the patient will deliver in 2027 but will likely have between 4–6 visits in 2026
- September 1 onward:** Transition to using E/M codes for less than 3 visits, consistent with current CPT guidelines



### Speaking to Your Payers

As the ob-gyn care community transitions to using the new codes in January 2027, you may need address some of the following topics with payers.

### E/M Codes and Modifiers

The transition to the new obstetrics codes must start with using the E/M codes for prenatal visits, beginning with patients who come for their first prenatal visit after confirmation of pregnancy on or after September 1, 2026. This is consistent with current CPT guidelines.

ACOG recommends using the entire catalog of E/M codes (CPT 99202–99499) without limitations or preauthorization requirements for all prenatal and postpartum visits. However, you should confirm that you are allowed all of the E/M codes for the visits, and not just one code (eg, 99213).

ACOG recommended to payers that they adopt the HCPCS modifier “TH,” which would be appended to the E/M code to differentiate the visit as related to the prenatal or postpartum visit. The TH modifier may be used with existing codes that recognize the complexity of medical decision making specific to obstetrics care and the E/M of two unique patients. Using the TH modifier will flag maternity services. Check with your payer to see if they are adopting this modifier.

Find codes 99202–99499 below for your reference.

| Office/Other Outpatient | Hospital Inpatient/Observation | Telemedicine (Audio-Video/Audio Only) | Hospital Inpatient (Admission/Discharge) |
|-------------------------|--------------------------------|---------------------------------------|--|
| 99202–99205             | 99221–99223                    | 98000–98007                           | 99234–99236                              |
| 99211–99215             | 99231–99233                    | 98008–98015                           |  |

\*Antepartum care is reported using appropriate E/M codes based on specific location.

## Prior Authorization and Limits

Payers should not require prior authorization for the newly established maternity care codes. These codes typically fall under global obstetric services, which do not require prior authorization under current policy requirements. Reiterate to your payers that there should not be any prior authorization or use limits for the E/M codes.

## Claims Submission

Your claims submissions should be subject to the same rules and requirements as the other claims in your practice; you should not be required to hold your claims and there should be a timely filing and adjudication process. Ensure with your administrative team that your claims are subject to the same requirements as your other claims.

## Downcoding

Downcoding is when a health plan assumes the service you billed for is not what you provided and they replace the E/M code with a lower level. For example, your documentation and/or time supports a 99214, which you submit on the claim, and the health plan changes the submission to a 99213 and pays you for the 99213. As you transition to the new codes, take the opportunity to ensure that your contracts include a provision to protect you from downcoding, or at least let your plans know you are watching for this. Try to have a conversation with your health plans about the importance of not downcoding for prenatal care claims. Downcoding should not occur without a denial or appeals process.

## Global Payment vs. Unbundled Payment

While you are discussing the E/M transition with your payers, more discussions about global payment versus unbundled payment will likely come up. Be prepared to speak with payers about how unbundling the global allows you to provide your patients with the tailored, patient-centered care that they need—be it straightforward, complex, or anything in between—and that the global payment was a one-size-fits-all solution that did not suit the nuanced and varied experience of pregnancy. You may also want to review the new labor management and delivery codes (see AMA Relative-Value Scale Update Committee February 2026 recommendations, page 2,022) for your payment negotiations.

## Cost Sharing

Prenatal visits and screening are not subject to any cost sharing for ACA-compliant plans. Although an estimated 93% of people who have commercial health plans are in ACA-compliant plans and should therefore not be subject to copayments for prenatal visits or screenings, you should clarify that point with health plans and advise your patients to do the same. Rarely should a patient be subject to copayments for these visits (42 U.S. Code § 300gg–13).

## Resources from the CHEC and ACOG's Health and Payment Policy Department

Explore our currently available resources for more information. ACOG will publish additional educational resources once the AMA publishes the new codes.

1. [Payment in Practice podcast](#)
2. [Payment for Obstetric Services web page](#)
3. New Payment in Practice: [Clinical Coding On Demand course](#) anticipated November 2026

Have questions? Submit them through the ACOG [Payment Advocacy & Policy Portal!](#)

