Healthcare Regulatory Roundup #119

2027 Maternity Care Coding Changes:
Reimbursement, Productivity, and Compensation

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Introductions



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Today's Agenda

1. A Fundamental Shift

- Understand the 2027 coding changes reshaping maternity care

2. Why It Matters

- Recognize the ripple across operations, contracts, and pay

3. Care Models and Their Compensation Impact

- Follow each model from coding change to wRVUs to compensation

4. Influencing Factors

- Weigh labor complexity, prenatal volume, and benchmark noise

5. What to Do Next

- Build a plan for January 1, 2027

Each section pairs specific changes with their impact on work effort measurement and physician pay.

1. A Fundamental Shift

Maternity Care Journey

CMS in 2026

One Global Maternity Code, Single Payment

A single bundled payment covers the full episode, regardless of how many visits occurred or which clinician provided them.

- Prenatal Care
- Delivery
- Postpartum Care

Operational and Financial Impact: Inexact attribution of work effort and reimbursement

CMS in 2027

Separate Codes and Payments

Separate codes and payments for prenatal care, labor management, the delivery and initial postpartum visit, and postpartum care.

- Prenatal Care
- Labor Management, Delivery, and Discharge
- Postpartum Care

Impact Goal: Precision in allocating work effort and reimbursement to the rendering provider

2026 to 2027: CPT Codes Side by Side

CPT Code	Description	2026 wRVUs	2027 Proposed wRVUs	2027 Code
59400	Global vaginal maternity care	37.00		Deleted
59409	Vaginal delivery only	14.37		Deleted
59426	Antepartum care, 7+ visits	14.30		Deleted
59430	Outpatient postpartum care	3.22		Deleted
99212	Established office E/M, level 2	0.70	0.70	99212
99213	Established office E/M, level 3	1.30	1.30	99213
99214	Established office E/M, level 4	1.92	1.92	99214
99215	Established office E/M, level 5	2.80	2.80	99215
99238	Discharge management, ≤30 min	1.50	1.50	99238
99239	Discharge management, >30 min	2.15	2.15	99239
59080	Initial straightforward labor management		4.03	59XX1
59081	Initial complex labor management		5.18	59XX2
59082	Subsequent straightforward labor management		3.00	59XX3
59083	Subsequent complex labor management		4.83	59XX4
59431	Vaginal delivery, no prior cesarean		9.20	59XX5

2027 values are proposed. New-code numbers shown are placeholders pending final CPT assignment.

2026 to 2027: CPT Codes by Service Phase

Service Phase	2026 Code(s)	2026 wRVUs (Estimated, using sum of individual codes as a percent of the global value.)	2027 Code(s)	2027 Proposed wRVUs	wRVU Change (Subject to change, based on actual care provided.)
Office: prenatal + postpartum	59426 × 1	19.41	99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2	18.24	(1.17)
Hospital, separate discharge	59409 × 1 + 99238 × 1	17.59	59080 × 1 + 59431 × 1 + 99238 × 1	14.73	(2.86)
Complete episode, global	**59400 × 1**	**37.00**	**All of the Above**	**32.97**	**(4.03)**

Straightforward labor, two-day hospital stay, 12 prenatal visits. 2027 values are proposed.

Overall impact will vary by the care provided and we would not assume a universal gain or loss. Evaluate your organization's specific mix of cases and which portions of care your providers perform.

2. Why It Matters

Why Should I Pay Attention?

Unbundling ripples across patient care, practice management, hospital episode, finance, IT, legal, and regulatory compliance.

Physician Compensation
Employed plan design and wRVU credit

OB Hospitalist Contracting
OB hospitalist and call coverage terms

Care Model Design
Facility and clinic staffing models

Productivity Methods
Measurement and calculation methodology

Provider Documentation
Each service element must stand on its own

Hospital Support Terms
Subsidy and support arrangements

If your plan credits a global code today, it will not describe the work in 2027.

3. Care Models and Their Compensation Impact

From Coding Change to Compensation Change

What Changes Mechanically

- wRVU credit follows the clinician who personally performs each phase.
- One global claim becomes four separately reported events.
- Episode totals shift with visit count, complexity, and length of stay.

What It Means for Compensation Plan Design

- Plan language written around global codes no longer describes the work.
- Coverage stipends priced on delivery volume need separate treatment.
- Historical trends and survey benchmarks lose comparability at go-live.

Overarching Impact: Physicians will appear to underperform against unchanged targets and historical benchmark data which were likely based on a global code. The economics around laborist models become clearer.

Common Compensation Models Today *(not all-inclusive)*

Individual Productivity Model

Provider compensation is based on or reconciled to individual productivity.

Individual Model Impact: Individual changes due to care model CPT code and related wRVUs.

Group Productivity Model

Global codes are pooled and related wRVUs are allocated evenly, by on-call days worked or some other defined methodology.

Group Model Impact: What does the future pool represent?

Proxy Productivity Model

Proxy wRVUs are created to break up the global codes for individual compensation determination.

Proxy Model Impact: How does the proxy compare with the new actual?

Care Model #1: Single Obstetric Physician (OB), One TIN

Single OB, one Tax Identification Number (TIN)

The OB performs the entire episode of care.

PHASE 1 — OFFICE

OB

Performs prenatal care

PHASE 2 — HOSPITAL

OB

Manages labor

Performs the delivery

Discharge management

PHASE 3 — OFFICE

OB

Performs postpartum care

Every element must now be captured on its own, and the level of service can vary with complexity and risk.

Operational Impact: Accurate capture of each service element becomes more important now that items are split out.

Care Model #1 wRVUs: Single OB, One TIN

Provider / Billing Unit	2026 Code(s)	2026 wRVUs	2027 Code(s)	2027 Proposed wRVUs	wRVU Change
OB, complete care	59400 × 1	37.00	99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2 (postpartum) 59080 × 1 + 59431 × 1 + 99238 × 1	32.97	(4.03)

Care Model #1 Compensation Implications: Single OB, One TIN

Full Episode, One OB

2026 baseline 37.00 → Estimated 2027 32.97 wRVUs

(4.03)

An 11% decline against the 37.00 global baseline, for identical work

Documentation Now Drives wRVU Credit

E/M level selection, labor management complexity, and length of stay each move the episode total.

Complexity is not subjective.
The proposed guidelines are clear.

Targets Should Be Restated

wRVU thresholds, tier breakpoints, and productivity guarantees were all built on global code volume.

Individual Model Impact: Individual compensation may change due to a reduction in wRVUs for identical work.

Group Model Impact: What does the future pool represent?

Proxy Model Impact: How does the proxy compare with the new actual?

Care Model #1a: Advanced Practice Provider (APP) and OB/Midwife, One TIN

APP and OB/Midwife – one TIN
APP performs prenatal care and postpartum care in the office. OB or midwife manages in-hospital care.

PHASE 1 — OFFICE

APP

Performs prenatal care

PHASE 2 — HOSPITAL

OB or Midwife

Manages labor
Performs the delivery
Discharge management

PHASE 3 — OFFICE

APP

Performs postpartum care

Operational Impact: APP work effort is separately identified, enabling better resource utilization.

Care Model #1a wRVUs: APP and OB/Midwife, One TIN

Provider / Billing Unit	2026 Code(s)	2026 wRVUs	2027 Code(s)	2027 Proposed wRVUs	wRVU Change
APP	Included in group 59400 × 1	19.41	99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2 (postpartum)	18.24	(1.17)
OB/Midwife	Included in group 59400 × 1	17.59	59080 × 1 + 59431 × 1 + 99238 × 1	14.73	(2.86)
Group Total	**59400 × 1**	**37.00**	**99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2 (postpartum) 59080 × 1 + 59431 × 1 + 99238 × 1**	**32.97**	**(4.03)**

Care Model #1a Compensation Implications: APP and OB/Midwife, One TIN

APP — Office

2026 baseline 19.41 → Estimated 2027 18.24 wRVUs

(1.17)

Prenatal and postpartum office care

OB or Midwife — Hospital

2026 baseline 17.59 → Estimated 2027 14.73 wRVUs

(2.86)

Labor, delivery, and in-hospital care

Group Total

2026 baseline 37.00 → Estimated 2027 32.97 wRVUs

(4.03)

Same total, now visible by clinician

Current-state figures are a modeled allocation of the single global value.

Individual Model Impact: Individual compensation may change due to a reduction in wRVUs for identical work.

Group Model Impact: What does the future pool represent? Your pool likely does not include the APP wRVU values.

Proxy Model Impact: How does the proxy compare with the new actual?

Care Model #1b: Multiple OBs/Midwives, One TIN

Multiple OBs/Midwives – one TIN

First OB/Midwife performs prenatal care and postpartum care in the office. Second OB/midwife manages in-hospital care.

PHASE 1 — OFFICE

First OB/Midwife

Performs prenatal care

PHASE 2 — HOSPITAL

Second OB/Midwife

Manages labor

Performs the delivery

Discharge management

PHASE 3 — OFFICE

First OB/Midwife

Performs postpartum care

Operational Impact: Physician work effort is separately identified within the group, enabling resource utilization planning.

Care Model #1b wRVUs: Multiple OBs/Midwives, One TIN

Provider / Billing Unit	2026 Code(s)	2026 wRVUs	2027 Code(s)	2027 Proposed wRVUs	wRVU Change
First OB/Midwife	Included in group 59400 × 1	19.41	99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2 (postpartum)	18.24	(1.17)
Second OB/Midwife	Included in group 59400 × 1	17.59	59080 × 1 + 59431 × 1 + 99238 × 1	14.73	(2.86)
Group Total	**59400 × 1**	**37.00**	**99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2 (postpartum) 59080 × 1 + 59431 × 1 + 99238 × 1**	**32.97**	**(4.03)**

2026 figures are a modeled allocation of the single global value. Straightforward labor, two-day stay, 12 prenatal visits. 2027 values are proposed.

Care Model #1b Compensation Implications: Multiple OBs/Midwives, One TIN



First OB/Midwife — Office

2026 baseline 19.41 → Estimated 2027 18.24 wRVUs

(1.17)

Prenatal and postpartum office care



Second OB/Midwife — Hospital

2026 baseline 17.59 → Estimated 2027 14.73 wRVUs

(2.86)

Labor, delivery, and in-hospital care



Group Total

2026 baseline 37.00 → Estimated 2027 32.97 wRVUs

(4.03)

2026 figures are a modeled allocation of the single global value. All figures are wRVUs.

Individual Model Impact: Individual compensation may change due to a reduction in wRVUs for identical work.

Group Model Impact: What does the future pool represent?

Proxy Model Impact: How does the proxy compare with the new actual?

Care Model #2: Laborist Program, Different TINs

Qualified Healthcare Professional (QHP; i.e., OB, APP, or Midwife) and Laborist – Different TINs
QHP performs prenatal and postpartum care in the office with one TIN.
Laborist manages in-hospital care with a different TIN.

PHASE 1 — OFFICE

QHP – One TIN

Performs prenatal care

PHASE 2 — HOSPITAL

Laborist – Different TIN

Manages labor

Performs the delivery

Discharge management

PHASE 3 — OFFICE

QHP – One TIN

Performs postpartum care

Operational Impact: Hospital services attribution needs focused attention, and because professional collections follow the laborist's TIN, they drive the hospital's support payment.

Care Model #2 wRVUs: Laborist Program, Different TINs

Provider / Billing Unit	2026 Code(s)	2026 wRVUs	2027 Code(s)	2027 Proposed wRVUs	wRVU Change
QHP	59426 × 1 + 59430 × 1	17.52	99212 × 2 + 99213 × 8 + 99214 × 2 99213 × 2 (postpartum)	18.24	0.72
Laborist	59409 × 1 + 99238 × 1	15.87	59080 × 1 + 59431 × 1 + 99238 × 1	14.73	(1.14)
Combined Episode	**59426 + 59430 + 59409 + discharge**	**33.39**	**Combined office and hospital services above**	**32.97**	**(0.42)**

Care Model #2 Compensation Implications: Laborist Program, Different TINs

QHP, Office – First TIN

2026 baseline 17.52 → Estimated 2027 18.24 wRVUs

+0.72

Prenatal plus outpatient postpartum care, billed by the office practice

Laborist, Hospital – Second TIN

2026 baseline 15.87 → Estimated 2027 14.73 wRVUs

(1.14)

Today the laborist bills delivery (59409) plus a separate discharge visit (99238)

Combined Episode

2026 baseline 33.39 → Estimated 2027 32.97 wRVUs

(0.42)

The episode barely moves; the shift is between the two groups

Overarching Impact: The laborist's wRVU target and/or compensation amount in their employment agreement or PSA, and any hospital-funded call coverage stipend priced on delivery volume, were both built on the underlying 2026 coding structure.

Individual Model Impact: Individual compensation may change due to a reduction in wRVUs for identical work.

Group Model Impact: What does the future pool represent?

Proxy Model Impact: How does the proxy compare with the new actual?

Payer variation: Where a payer bundles the discharge into the delivery code, the 2026 baseline is 14.37 (59409 alone, with no separately billed 99238), so 2027 becomes a gain of 0.36 rather than the 1.14 loss shown above, and the combined episode gains 1.08 instead of losing 0.42. The 2027 laborist total is 14.73 wRVUs under either payer — only the 2026 baseline moves.

Laborist Economics: From wRVUs to the Subsidy

Step 1 — The Coding Change

59409 + 99238 → 59080 + 59431 + 99238

(1.14)

Laborist wRVUs fall for identical work, and episode value shifts toward the office TIN.

Step 2 — Professional Collections

More discrete encounters, new rates, new denial and attribution risk

Net ↓

Illustrative: laborist net professional collections decline during adoption, with timing lags at go-live.

Step 3 — The Hospital Subsidy

Support payment = cost − professional collections

Support ↑

Illustrative: every dollar of collections decline flows through to a larger hospital support payment.

Overarching Impact: In a separate TIN the wRVU shift is only step one — the change in professional collections is what re-prices the hospital's support payment.

Re-test the Economics: Refresh the FMV and commercial reasonableness analysis on the updated collections.

Re-price Coverage: Stipends priced on delivery volume need a new basis under the 2027 codes.

Fix Attribution: Hospital-side encounters must register and bill to the correct TIN from day one.

Illustrative only. Direction and magnitude of the collections and subsidy change depend on payer mix, contracted rates, adoption timing, and the terms of the coverage or PSA agreement. Model with your own claims data before amending any agreement. This illustration assumes one labor management code billed. Labor management is inherently continuous. The labor management code account for work performed by the OB/midwife, not clinical nursing staff. Examples: If the OB is monitoring labor overnight, bill labor management once. If the OB leaves and comes back the next day, bill labor management twice. If OB A leaves and OB B comes in the next day, bill it twice.

4. Influencing Factors

Straightforward vs. Complex Labor

Straightforward

- Lower documentation burden
- Lower labor management work effort
- Fewer wRVUs available for the hospital stay

Complex

- Increased documentation demands
- More intensive physician management of labor
- Higher work effort, and higher wRVUs available
- Complexity is not subjective. The proposed guidelines provide clear guidance

The distinction rests on documented work effort, and either path can run a two-day or three-day stay.

Hospital Stay: Labor Complexity and Length of Stay

Hospital Stay	Labor Type	2027 Hospital Codes	Services Included	2027 Proposed wRVUs
Two-day	Straightforward	59080 + 59431 + 99238	Labor management, delivery, discharge	14.73
Two-day	Complex	59081 + 59431 + 99238	Labor management, delivery, discharge	15.88
Two-day	**Change, straightforward to complex**			**1.15**
Three-day	Straightforward	59080 + 59082 + 59431 + 99238	Adds subsequent day labor management	17.73
Three-day	Complex	59081 + 59083 + 59431 + 99238	Adds subsequent complex day management	20.71
Three-day	**Change, straightforward to complex**			**2.98**

Hospital services only; prenatal and postpartum office care are excluded. 2027 values are proposed.

Scenario Summary: wRVU Impact at a Glance

Care Model	TIN	Provider / Billing Unit	2026 wRVUs	2027 Proposed wRVUs	wRVU Change	Compensation Focus
#1 Single OB	**One TIN**	**Complete episode**	**37.00**	**32.97**	**(4.03)**	**Targets, tiers, and guarantees**
#1a APP + OB/Midwife		APP (Office)	19.41	18.24	(1.17)	APP-specific productivity plan
#1a APP + OB/Midwife		OB/Midwife (Hospital)	17.59	14.73	(2.86)	Group pool distribution; proxy comparison
#1a APP + OB/Midwife	**One TIN**	**Group total**	**37.00**	**32.97**	**(4.03)**	
#1b Multiple OBs/Midwives		First OB/Midwife (Office)	19.41	18.24	(1.17)	Individual production; group pool distribution; comparison to proxy
#1b Multiple OBs/Midwives		Second OB/Midwife (Hospital)	17.59	14.73	(2.86)	Individual production; group pool distribution; comparison to proxy
#1b Multiple OBs/Midwives	**One TIN**	**Group total**	**37.00**	**32.97**	**(4.03)**	
#2 Laborist Program		QHP (Office)	17.52	18.24	0.72	Individual production; group pool distribution; comparison to proxy Professional collections and subsidy
#2 Laborist Program		Laborist (Hospital)	15.87	14.73	(1.14)	Individual production; group pool distribution; comparison to proxy Stipend, coverage terms, and subsidy impact
#2 Laborist Program	**Different TINs**	**Combined episode**	**33.39**	**32.97**	**(0.42)**	

Straightforward labor, two-day stay, 12 prenatal visits. #1a and #1b 2026 figures are a modeled allocation of the global value. The 2026 column is the baseline; where a payer bundles the discharge into the delivery code, that baseline is 14.37 laborist / 31.89 combined and both #2 deltas turn positive.

Labor Complexity and Length of Stay May Change the Answer

Episode Variant	2027 Hospital Codes	2027 Proposed Episode wRVUs	Change vs. 2026 37.00 Global Baseline	Change vs. 2026 33.39 Combined Baseline	What It Signals
Straightforward, 2-day	59080 + 59431 + 99238	32.97	(4.03)	(0.42)	Most common scenario — the planning assumption
Straightforward, 3-day	Adds subsequent day management	35.97	(1.03)	2.58	A longer stay recovers most of the loss
Complex, 2-day	59081 + 59431 + 99238	34.12	(2.88)	0.73	Complexity must be documented to earn it
Complex, 3-day	**Adds subsequent complex day**	**38.95**	**1.95**	**5.56**	**Can exceed today's global credit**

All variants assume 12 prenatal visits. The 37.00 global baseline applies to Care Models #1, #1A, and #1B; the 33.39 combined baseline applies to the Care Model #2 combined episode.

The Hidden Variable: Prenatal Visit Volume

12-Visit RUC* Model

15.64

Prenatal wRVUs under the assumed visit mix

8-Visit Risk-Adjusted

10.40

A tailored schedule credits fewer visits

Difference: 12 Prenatal Visits to 8 Risk-Adjusted Prenatal Visits

(5.24)

Invisible under today's bundled payment

In 2027, an eight-visit prenatal episode reduces the 2026 37.00 global wRVU value by 9.27 wRVUs to 27.73.

Model your own visit patterns before go-live — do not assume the RUC mix.

*American Medical Association RVS Update Committee

Benchmarks and Market Data: Expect a Noisy Transition

Trend Line Breaks

Historical OB/GYN wRVU and compensation-per-wRVU trends will break after January 1, 2027

Survey Lag

Benchmarks may need two to three cycles before comparisons are meaningful

Check the Fee Schedule Year

Confirm which MPFS year each survey used before applying a percentile

Read Measures Together

Review compensation, wRVUs, and professional collections as a set

Avoid compensation decisions based solely on raw wRVU comparisons during the transition.

5. What to Do Next

Action Plan: What to Do Before January 1, 2027

1. Analyze

Understand patient population, related acuity, and mix of patients.

Forecast wRVUs under both the bundled and unbundled models.

2. Rewrite Attribution

Credit personally performed work by phase.

3. Separate Coverage Pay

Pay laborist and call coverage outside productivity.

4. Reset Targets

Restate wRVU targets, tiers, and guarantees.

5. Educate and Stabilize

Brief physicians and the compensation committee along the way.

Organizations that anticipate the shift will be better positioned than those that react after the survey data resets.

For additional information see PYA's *OB/GYN Reimbursement Changes and Impact on Physician Compensation* at https://www.pyapc.com/insights/ob-gyn-reimbursement-changes-and-impact-on-physician-compensation/

Stabilization Plan: A Bridge Until Full Compensation Redesign

1. Freeze the Plan for One Year

Hold 2026 targets, tiers, and guarantees in place for a defined bridge period while real 2027 data accumulates.

2. Adjust the Rate, Not the Work

Apply a crosswalk or conversion-factor adjustment so identical work earns identical pay under the new codes.

3. Carve Out Coverage Pay

Move laborist and call stipends outside productivity now — a small, low-risk change that can be done quickly.

4. Build in a Mid-Year True-Up

Add reopener language to revisit targets once actual claims and refreshed survey data are available.

Document the interim approach in writing before January 1 — a defined bridge is defensible; an unaddressed gap is not.

Our Next Healthcare Regulatory Roundup Webinar

Wednesday, October 21, 11 am – 12:00 pm ET

Stark: Referral Source Arrangements Review, Risks in Compensation Arrangements

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