

A UPA Billing Office Newsletter
November 2026

Revenue Cycle MANAGEMENT

DISCLAIMER NOTICE: This information is intended as generalized coding guidance and should not be misinterpreted as medical, health, legal or financial advice. Furthermore, it is the responsibility of the provider to code services as they are documented in the permanent medical record following federal and state regulations, as well as carrier specific guidelines. Any information given should not be modified in any way, sold for profit or shared without the express permission of UPA. While all information given is thoroughly researched and believed to be correct, recipients of this email accept responsibility for their own coding and documentation.

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2027 Medicare Physician Fee Schedule-Final Rule Highlights

CMS released the final Medicare Physician Fee Schedule (MPFS) updates on November 4, with policies and rates effective January 1, 2027. A summary of impactful highlights is below.

Conversion factors: $33.17 for qualifying Advanced APM participants (–1.19%) and $32.84 for non-qualifying clinicians (–1.68%). The temporary 2026 2.5% increase expires. Actual practice impact also depends on code mix and RVUs.

Same-day services: For separately identifiable office/outpatient E/M reported on the same day as a 0-day global procedure by the same physician/practice, CMS proposes 100% payment for the highest-priced service and 80% for other affected services. This is less severe than the originally proposed 50% reduction.

G2211: G2211 add-on code, is replaced with two new modifiers adding 16% to the E/M payment (reported with modifier B1); and an eligible ACO modifier B2 would add 32%.

New HCPCS for Advanced Care Planning:
CMS is finalizing two new G-codes (HCPCS G0572 and G0573) for advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing physician or other practitioner, as well as finalizing a revision to the existing CPT codes describing ACP services (CPT codes 99497 and 99498) to only be used to report time personally spent by the billing practitioner.

Remote monitoring proposal:
CMS finalized an established-patient requirement for RTM, an initiating visit for RPM/RTM, and payment only for monitoring furnished by practice-employed clinical staff rather than contractors.

Recommended financial preparation:
Model proposed rates separately from approved budgets. Inventory visits with modifier 25 and G2211 and identify monitoring contracts affected by staffing rules. Update estimates and patient scripts only after final rates and payer adoption are confirmed. The same-day payment proposal changes reimbursement; it is distinct from a payer reducing an E/M code level. Continue coding the documented service accurately.
Resource: AMA Summary — CLICK HERE

University Physicians' Association, Inc.
upasolutions.com

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2027 ICD-10-CM Updates Effective 10/1/2026

The annual updates for the ICD-10-CM diagnosis codes for 2027 are now released, effective on October 1, 2026. There are 190 new codes, 30 deleted codes, and 4 revised codes.

Highlights of these changes include:

- Expanded specificity for cardiomyopathy coding (I42.0 will expand to I42.00, I42.01, I42.09)
- Detailed descriptions for ectopic pregnancies
- Updated secondary malignant neoplasm codes (Categories C78.- & C79.-)
- Changes to breast carcinoma in situ; Beginning Oct. 1, you no longer report two codes from category D05 & C50 together if a patient is diagnosed with both conditions
- New codes for post procedural hypoglycemia (E89.83, E89.830, E89.838)
- Osteomyelitis now requires a 7th digit for M86.8X category
- Genetic disorders in category QA1 are expanded to include lifelong conditions

Please ensure that your office staff is aware of pertinent updates impacting the practice specialty and that all EHR and/or charge capture, coding software are up to date with these changes. For Intergy and MedAptus users, these changes have already been made.

Upcoming 2027 CPT & HCPCS Code Changes

While CMS is still working to finalize HCPCS coding update for 2027, CPT updates are final which includes 299 new codes, 74 revisions and 80 deletions. While the major changes to the maternity coding framework are the biggest overhaul for 2027, there are other notable changes providers will need to be aware of.

Unattended Sleep Studies will be updated to reflect modernized current technology with 6 new codes that define complexity of channels will replace the existing unattended sleep study codes. New interpretation and reporting codes by complexity will also be included in these changes.

New and revised guidelines, including three new codes involving left ventricular assist devices, are implemented to improve reporting for these procedures. As well as 9 new codes to expand reporting for hernia repair, providing options for more specificity.

For the full release from the AMA Click HERE:

2027 Maternity Coding Updates

CPT Maternity Care Services Codes and Guidelines
(Effective Jan. 1, 2027)
The AMA has announced revisions to maternity care coding in the CPT 2027 code set, replacing the traditional "global obstetric package" with separate reporting for antepartum care, labor management, delivery, and postpartum care. This change will significantly affect OB documentation, charge capture, coding workflows, and provider education beginning January 1, 2027, and UPA recommends practices prepare with educating providers and coding staff now.

Key Recommendations for the Transition to Obstetric Coding Changes
ACOG recommends that health plans begin transitioning from the global obstetric payment model by allowing antepartum visits to be reported using E/M codes (CPT 99202-99499) without prior authorization requirements or visit limits. The TH modifier should be appended to identify services related to maternity care.

Delivery-only CPT codes (59409, 59514, 59612, and 59620) will continue to cover labor management through delivery, completion of postpartum orders, and birth certificate documentation. Services provided at or near delivery, such as long-acting reversible contraception (LARC), should be billed separately when appropriate. These changes are expected to support a more flexible and accurate approach to obstetric reimbursement, enabling providers to bill for individualized prenatal care, social needs screening and management, telehealth services, and remote patient monitoring. Additional guidance and educational resources are expected as implementation moves forward.

Key Changes:
Antepartum Care

- Routine prenatal care is no longer reported with bundled OB package codes.
- Antepartum services are reported using the appropriate E/M codes based on the setting (office, telehealth, hospital, home, etc.).
- Diagnostic tests and fetal procedures (ultrasounds, amniocentesis, chorionic villus sampling, fetal monitoring, etc.) may be billed separately from antepartum visits.

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Continued 2027 Maternity Coding Updates

New Labor Management Coding

- Labor management is recognized as a distinct service and has new daily codes:
  - 59080 Initial day labor management, straightforward
  - 59081 Initial day labor management, complex
  - 59082 Subsequent day labor management, straightforward
  - 59083 Subsequent day labor management, complex
- Services are reported once per calendar day.
- Labor complexity is based on maternal/fetal condition and medical decision-making, not labor duration alone.

Examples of Complex Labor

- Multiple gestation
- Prior cesarean delivery
- Abnormal fetal heart tracings requiring intervention
- Preeclampsia
- Diabetes or hypertension requiring active management
- Severe maternal complications

Major Deletions of Global Maternity Codes Several long-standing global OB codes are deleted, including:

- 59400, 59409, 59410
- 59425, 59426
- 59430
- 59510, 59514, 59515
- 59610, 59612, 59614, 59618, 59620, 59622

Delivery Care

Vaginal Delivery

- 59431 Vaginal delivery
- 59432 Vaginal delivery after previous cesarean (VBAC)
- Delivery care is now reported separately from labor management and postpartum care.

Cesarean Delivery

- 59502 Primary cesarean delivery
- 59503 Repeat cesarean delivery
- 59504 Cesarean delivery with hysterectomy during the same operative session

Postpartum Care

- Postpartum care is reported using appropriate E/M codes rather than dedicated postpartum package codes.
- Same-day postpartum care is included in the delivery service.
- Postpartum visits occurring after the delivery date can be reported separately using inpatient, outpatient, telehealth, or home E/M codes, depending on the setting.

Additional Important Points

- Pregnancy confirmation is reported with the appropriate E/M service.
- Labor management is reported only once per day regardless of the number of fetuses.
- For scheduled cesarean deliveries without labor, labor-management codes are not reported.
- Multiple gestation deliveries may require separate delivery coding depending on delivery route.

Bottom Line

The 2027 CPT revision fundamentally shifts maternity coding from a single bundled maternity package to a component-based model, requiring separate reporting for:

1. Antepartum care (E/M codes)
2. Labor management (new 59080-59083 codes)
3. Delivery services (59431-59504)
4. Postpartum care (E/M codes)

Provider resources can be found at the links below for additional education materials:
CPT® 2027 Maternity Care Services code changes | American Medical Association
CPT Maternity Care Services Codes and Guidelines | AMA
CPT Maternity Care Services Education Brief: Antepartum Transition Reporting | AMA

Seasonal Viral Infection Reminders:

Flu A & B Testing: Commonly reported with CPT 87804, separately documented A and B results may support two units of 87804 (or 87400 for the appropriate assay). Follow payer guidelines for reporting on two lines with modifier 59 on the subsequent line. Do not double units for a single combined result.

COVID Testing: Commonly reported with CPT 87811
Combination Testing COVID + Flu A/B: Commonly reported with CPT 87812

RSV Testing: Commonly reported with CPT 87807
Strep A Testing: Commonly reported with CPT 87880
Please note: QW modifier should be applied to all CLIA Waived lab tests

ICD-10-CM Diagnosis Coding:

COVID: U07.1 for confirmed disease; Z20.822 for documented contact/suspected exposure. Z11.52 is for true screening, not symptomatic testing.

Flu: J10.1 for diagnosed seasonal influenza with respiratory manifestations other than pneumonia and an identified virus; J11.1 when influenza is diagnosed but the virus is unidentified. Pneumonia or other complications require a different appropriate code.

Strep: J02.0 for diagnosed streptococcal pharyngitis. If undiagnosed, pending or negative, report the documented reason or symptom warranting testing: e.g., J02.9 (unspecified acute pharyngitis), R05.1 (acute cough) or R50.9 (unspecified fever), as applicable.

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