Cigna Healthcare to recognize 2027 AMA Current Procedural Terminology codes

- *August 24, 2026*
- *Updated on: November 17, 2026*

2027 Maternity billing guidance update

Effective January 1, 2027, Cigna Healthcare® will begin recognizing the American Medical Association's (AMA's) new maternity coding and reporting framework. The new framework establishes a standardized approach to reporting maternity care based on the specific services provided throughout a patient's pregnancy.

This transition will align maternity billing more closely with the services provided during each phase of care, creating greater consistency and transparency in how maternity services are reported. By adopting the new framework, Cigna Healthcare is supporting a more precise approach that recognizes the individual services delivered throughout a patient's pregnancy.

What providers need to know

Through December 31, 2026:

- Continue to follow Cigna Healthcare's existing global maternity billing and coding requirements, except as noted below for maternity care spanning 2026 and 2027.
- Continue to bill and report maternity services for patients with Cigna Healthcare benefit plans in accordance with applicable contractual requirements, reimbursement policies, and maternity billing practices.

Beginning January 1, 2027:

- Cigna Healthcare will transition from its existing global maternity billing approach to the new AMA maternity coding and reporting framework, which includes 12 new and six revised Current Procedural Terminology (CPT®) codes. As part of this transition, 17 existing global maternity CPT codes will be retired.
- Maternity care will be reported based on the specific services provided during the antepartum, labor management, delivery and postpartum phases of care rather than through a single global maternity code submission.

- Routine antepartum and postpartum services will be reported using the appropriate Evaluation and Management (E/M) codes and applicable diagnosis codes, modifiers, and reporting requirements.
- Labor management and delivery services will be reported using the applicable 2027 maternity care CPT codes and AMA coding guidance.
- There are no changes to covered services or customer eligibility for covered maternity care as a result of this coding transition.

Maternity care spanning 2026 and 2027

For maternity care that begins in 2026 and is expected to continue into 2027, qualifying 2026 antepartum (i.e., prenatal) care can be billed separately from maternity services provided in 2027.

Beginning December 14, 2026, Cigna Healthcare will reimburse eligible antepartum services provided during 2026 when the patient's maternity care is expected to continue into 2027.

For these qualifying "split-year pregnancies," Cigna Healthcare will reimburse 2026 antepartum services based on the total number of antepartum visits completed during 2026.

- ***Fewer than four antepartum visits****:* Appropriate E/M codes with the TH modifier, Weeks of Gestation of Pregnancy diagnosis codes, and applicable obstetric diagnosis codes
- ***Four to six antepartum visits****:* CPT code 59425
- ***Seven or more antepartum visits****:* CPT code 59426

Beginning December 14, 2026, providers should bill qualifying 2026 antepartum services once there is certainty regarding the total number of routine antepartum visits completed during 2026. Providers do not need to wait until the patient's maternity care ends in 2027.

Cigna Healthcare reimbursement policy updates

Cigna Healthcare's updated reimbursement policies address the AMA's 2027 maternity coding and reporting structure and provide reimbursement information for the 2026 transition period.

- **For maternity care spanning 2026 and 2027:** Log in to the Cigna for Health Care Professionals portal (CignaforHCP.com > Resources > Reimbursement and Payment Policies > *Interim Maternity Billing Guidelines*).
- **For maternity care provided beginning January 1, 2027:** Log in to CignaforHCP.com (Resources > Reimbursement and Payment Policies > *R55 Maternity Services Reimbursement Policy*).
- Cigna Healthcare will retire its current *R11, Global Maternity/Obstetric Package* and *R03 Multiple Births* reimbursement policies, effective January 1, 2027.

Additional resources

- For additional reference, a full list of maternity codes and additional billing guidelines are available in the AMA's CPT® Maternity Care Services Codes and Guidelines.
- The AMA also provides frequently asked questions addressing specific transition scenarios, labor management, antepartum, delivery, and postpartum care.

Questions?

To help providers prepare for implementation, Cigna Healthcare will continue to update this article with additional coding, billing, and claim submission guidance as needed. If you have any questions, please contact us at AMAMaternityCodes@CignaHealthcare.com.

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

Reimbursement Policy Commercial

Effective Date 01/01/2027
Last Updated Date 11/17/2026
Annual Review Date 01/01/2028
Reimbursement Policy Number R55

Maternity Services

Table of Contents

Overview 1
Reimbursement Policy 2
General Background 3
Coding/Billing Information 5
References 12
Policy History/Update 13

Related Policy Resources

A004 Preventive Care Services
R54 Maternity Services: Interim Billing Guidelines

Instructions for Use

*Cigna's Reimbursement policies are intended to supplement certain **standard** benefit plans issued or administered by Cigna or a Cigna affiliate. As such, these policies are to be administered only by operating subsidiaries of The Cigna Group or their authorized representative(s) and any use or distribution outside of this scope is prohibited unless explicitly authorized in writing by Cigna.*

Please note, the terms of a particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. In the event of a conflict, Cigna or its authorized representative will apply the terms of the applicable plan benefit document. Further, reimbursement terms in agreements with Cigna's participating health care providers may also supersede the information in a reimbursement policy.

Confidential, unpublished property of Cigna Healthcare. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel. © 2026 Cigna Healthcare

Overview

These reimbursement policies do not constitute medical advice, clinical protocols, or treatment recommendations and should not influence or replace the independent clinical judgement of healthcare professionals in the care of individual patients.

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

This reimbursement policy outlines the billing requirements for maternity services in support of the American Medical Association (AMA) 2027 Maternity code changes, for maternity care that begins in 2027. Providers should submit services for reimbursement based on the AMA 2027 Current Procedural Terminology (CPT®) maternity coding guidelines.

The policy applies to Centers for Medicare and Medicaid Services (CMS) 1500 claim forms or electronic equivalent.

Reimbursement Policy

Cigna reimburses maternity services when services are billed using the AMA CPT® codes as defined in the 2027 Current Procedural Terminology (CPT®) maternity coding guidelines. Maternity care should be reported based on the specific services provided during the antepartum, labor management, delivery and postpartum phases of care rather than through a single global maternity code submission.

As recommended by the Americal College of Obstetrician and Gynecologists (ACOG), the Healthcare Common Procedure Coding System (HCPCS) TH modifier should only be appended to services reported by the rendering provider for obstetrical services.

Services Reimbursable

- Antepartum services reported with the appropriate evaluation and management (E/M) CPT® code, TH modifier and appropriate obstetric diagnosis code(s).
- Antepartum procedures / services:
    - Amniocentesis; diagnostic
    - Amniocentesis; therapeutic amniotic fluid reduction
    - Cordocentesis
    - Chorionic villus sampling
    - Fetal contraction stress test
    - Fetal non-stress test
    - Transabdominal amnioinfusion
    - Fetal umbilical cord occlusion
    - Fetal fluid drainage
    - Fetal shunt placement
    - Cerclage of cervix, during pregnancy; vaginal
    - Cerclage of cervix, during pregnancy; abdominal
    - External cephalic version
    - Multifetal pregnancy reduction(s) (MPR)
    - Removal of cerclage suture under anesthesia (other than local)
- Postpartum services reported with the appropriate E/M CPT® code, TH modifier and appropriate diagnosis code(s).

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

- One labor management code, straightforward or complex, can be reimbursed on a calendar day. Labor management is only reimbursed once even when there are multiple gestations. Both straightforward and complex labor management will not be reimbursed when reported on the same calendar day.

- Delivery services, vaginal and cesarean. If multiple gestational include both vaginal and cesarean deliveries, each may be reimbursed with appropriate documentation, including the diagnosis to support the multiple gestation.

- One inpatient or observation E/M code billed with a scheduled primary cesarean delivery with no labor management.

Services Not Reimbursable

Cigna will not provide reimbursement for the following:

- E/M codes that are used to report antepartum services billed between dates of service 01/01/2027 – 02/28/2027 when CPT® code 59426 (antepartum care only, 7 or more visits) was previously reported and reimbursed.

- Hospital evaluation and management (E/M) CPT® codes 99221- 99223 and 99231-99233 on the same day as a cesarean delivery when reported together by the same provider.

- E/M codes submitted for postpartum services when a previous global maternity code was submitted by the same provider and reimbursed. Prior to 01/01/2027, postpartum care was included in the global maternity code.

- Labor management services reported on the same day as a planned cesarean delivery.

- Straightforward and complex labor management codes billed on the same calendar day.

- Delivery of the placenta only by the same provider reporting the delivery.

- First and second-degree episiotomy or laceration performed by the delivering provider, as reimbursement is included in the delivery charge.

General Background

Beginning January 1, 2027, the AMA redesigned the maternity section of the CPT® codebook and guidelines, restructuring from global maternity billing to individual code reporting for all stages of maternity. The stages of maternity now include antepartum, labor, delivery and postpartum care.

Antepartum Care

Based on the AMA maternity coding guidelines, antepartum care is the management of pregnancy prior to when labor begins. The antepartum services may be reimbursed when reported with evaluation and management (E/M) and HCPCS modifier TH. Modifier TH identifies prenatal and/or postpartum obstetrical treatment/services.

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

Labor

Labor management codes were created to report services provided while an individual is in active labor. These codes cover both initial and subsequent visits per calendar day and include, but are not limited to, the following requirements:

- Face to face visit
- Codes reported once per calendar day
- A continuous visit that spans two calendar days is only reported as a single service

Labor management complexity is defined as either straightforward or complex. The duration of labor does not determine the level of complexity without documented support of prolonged labor within the medical record. To report labor management, report the highest level of complexity based on medical decision making (MDM) and associated services.

Labor management services may be reimbursed in conjunction with an unplanned cesarean delivery, consistent with the AMA 2027 maternity coding guidelines.

The labor management codes are not effective until 01/01/2027. If a labor begins in late December and continues on or after January 01, 2027, labor codes should only be reported on the days on or after the code effective date of the labor management CPT® codes.

Delivery

Per the guidelines set forth by the AMA, delivery begins when labor is complete and includes both the parturient and the baby. Immediate postpartum care is considered part of the delivery care and will not be separately reimbursed.

In accordance with the AMA 2027 CPT® maternity coding guidelines, delivery services are classified into two primary categories:

- **Vaginal Delivery:** Includes delivery services performed vaginally, with the applicable CPT® code selected based on the circumstances of the delivery.
- **Cesarean Delivery:** Includes delivery services performed surgically, with the applicable CPT® code selected based on whether the cesarean delivery is primary or repeat.

    - Primary cesarean delivery: The first cesarean delivery.
    - Repeat cesarean delivery: A cesarean delivery performed on a patient who has previously undergone a cesarean delivery.
    - Unplanned cesarean delivery: A cesarean deliver that was not scheduled or anticipated. It may be either a primary or a repeat cesarean.

Delivery codes represent the delivery service and do not include separately reportable antepartum care, labor management, or subsequent postpartum services, except as otherwise specified in the CPT guidelines.
If a vaginal delivery is attempted and later becomes an unplanned cesarean delivery, only the cesarean delivery CPT® code may be reimbursed.

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

Postpartum Care

Postpartum care defined by the AMA within the 2027 maternity guidelines begins after delivery. Immediate postpartum care will not be reimbursed when reported on the same day as delivery, as reimbursement is included in the delivery charge. Postpartum care following the day after delivery may be reimbursed when reported with the appropriate E/M CPT® code.

Coding/Billing Information

Antepartum and Postpartum Codes

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

CPT® Code	Description
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded
99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded
99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded
99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

Labor Management Codes

CPT® Code	**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

Vaginal and Cesarean Delivery Codes

Notification: Effective 01/01/2027 R55 Maternity Services policy is for care beginning on or after January 1, 2027

CPT® Codes	Description
59431	Vaginal delivery, with or without episiotomy
59432	Vaginal delivery, with or without episiotomy; after previous cesarean delivery
59414	Delivery of placenta only (separate procedure)
59300	Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)
59433	Repair of episiotomy or laceration; third-degree laceration
59434	Repair of episiotomy or laceration; fourth-degree laceration
59502	Cesarean delivery; primary
59503	Cesarean delivery; repeat
59504	Subtotal or total hysterectomy after cesarean delivery

Modifiers

Modifier	Description
TH	Obstetrical treatment/services, prenatal or postpartum
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
22	Increased Procedural Services
59	Distinct Procedural Service

References

1. American College of Obstetricians and Gynecologists (ACOG)**.** *Payment for Obstetric Services*. 2026. https://www.acog.org/practice/coding-and-billing/payment-for-obstetric-services/

2. American Medical Association (AMA). *CPT® 2027 Maternity Care Services Code Changes*. Updated September 17, 2026. https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes.

3. American Medical Association (AMA). *CPT® 2027 Professional Edition*. Chicago, IL: American Medical Association; 2026.

4. Centers for Medicare & Medicaid Services (CMS). *Healthcare Common Procedure Coding System (HCPCS) Level II, 2027 Edition.*

Policy History/Update

Date	Change/Update
11/17/2026	Notification: Effective January 1, 2027, a new Maternity Services Reimbursement Policy has been developed to recognize the American Medical Association (AMA) 2027 Current Procedural Terminology (CPT®) maternity coding guidelines.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2026 Cigna Healthcare.