Questions and Answers – Expert to Expert Webinar Annual Updates PC-02 and PC-07 for 2026 RY

Broadcast February 26, 2026

Topic	Question	Answer
Benchmarks	For PC-07, will the national and state average observed rates continue to be available in the Hospital-Specific Reports (HSRs)?	Yes, the national and state average observed severe obstetric complication rates will be available in the HSRs.
Benchmarks	Where can we find the benchmarks / targets or national rates for ePC-02 and ePC-07?	There are no benchmarks for the measures.
Denominator	Is a patient in the denominator for PC-07 if fetal demise at week 17 or needs to be >= 20 weeks?	No, a patient at 17 weeks' gestation would not be in the denominator since they do not meet the specification requiring that a patient be at greater than or equal to 20 weeks gestation. The measure looks for gestational age greater than or equal to 20 weeks for patients delivering stillborn or live birth.
Denominator	For ePC-02, why does the logic not stop at gravida 2. We have patients in our denominator only that are Gravida 2 or more.	The denominator would include all deliveries for nulliparous patients. If someone is a gravida 2 or more, but para 0, they are still nulliparous, and they would be included in the denominator.
Denominator	For ePC-02, should patients with history of HSV but no active outbreak be included in denominator?	Yes, with no active outbreak of HSV, patients should be included in the denominator. Per the rationale for PC-02: In accordance with the American College of Obstetricians and Gynecologists (ACOG) recommendations (2020), cesarean delivery is indicated for patients with active genital lesions of genital herpes or prodromal symptoms (i.e., vulvar pain or burning at delivery) that may indicate viral shedding. Therefore, the measure will exclude encounters with a diagnosis of active genital herpes.
Exclusions	PC02: Should only active HSV be excluded or does history of HSV also get excluded?	Yes, only active HSV cases, not merely the history of having HSV, should be excluded from this population. Per the rationale for PC-02: In accordance with the American College of Obstetricians and Gynecologists (ACOG) recommendations (2020), cesarean delivery is indicated for patients with active genital lesions of genital herpes or prodromal symptoms (i.e., vulvar pain or burning at delivery) that may indicate viral shedding. Therefore, the measure will exclude encounters with a diagnosis of active genital herpes.
Exclusions	For PC-02, why is cord prolapse not an exclusion?	The Technical Advisory Panel (TAP) reviewed multiple presentations and determined that cord prolapse (for which the code includes both funic presentation and prolapse) is usually a mismanagement of labor while in the hospital that makes it necessary for an emergent cesarean. This is why it is not an exclusion for PC-02.

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Mapping	When CMS says that diagnosis data may come from the problem list, encounter diagnosis list, claims data, or other EHR sources, does that mean that all of these MUST be used or that hospitals have flexibility in how they map what data ends up included?	Hospitals have the flexibility in how and from where they map data according to their Electronic Health Record (EHR) system's capability. We recommend that you work with your organization's leadership, IT department, and EHR vendor for the best approach for mapping within your organization. We recommend maintaining mapping documentation in case of a CMS audit.
Myomectomy	Why is prior myomectomy not an exclusion from the ePC-02 measure? The diagnosis code used for a prior myomectomy (O34.29) is not on the list of allowed exclusions. But medical guidelines, like those from ACOG, say that women who had a myomectomy where the uterus was entered may need a planned C-section. So why isn't a history of myomectomy considered an exclusion for PC-02?	While extensive or complicated myomectomy can be an indication for a cesarean section, these cases are rare in nulliparous patients. The code to identify prior myomectomy is too broad to only exclude extensive or complicated cases, which is why it is not listed for the exclusions for this measure. In addition, neurosurgery, spine, Inflammatory Bowel Disease (IBD) complications, and severe fetal anomalies are less common and should not significantly increase a hospital's rate. We will continue to monitor feedback and consult with the TAP for potential updates. As always, we recommend that appropriate care should be provided based upon the provider's assessment of patient's needs, regardless of the impact on the performance calculation.
Nulliparous Patients	Can you confirm for ePC02 is it just Gravida 1 or (Gravida equals number of pregnancies, current and past regardless of outcome). If it is just Gravida 1 would all cases where Gravida is greater than one be excluded?	No, not all cases where Gravida is greater than one would be excluded. The logic looks for ONE of the following three (3) conditions: Gravidity = 1 **or** Parity = 0, **or** Preterm & Term Births both = 0. With that said, if Gravidity is more than 1, then Parity and Preterm & Term Births should be evaluated.
Nulliparous Patients	Is this measure specific for G1P0? So previous miscarriages are exclusionary - for example G5P0 but have 4 miscarriages prior to 20 weeks.	Previous miscarriages are not exclusionary. The measure evaluates nulliparous patients, so the logic looks for one of the following three (3) conditions: Gravidity = 1, Parity = 0, or Preterm & Term Births both = 0. If Gravidity is more than 1, then Parity and Preterm & Term Births should be considered.
Numerator	For PC-07, is blood transfusion an SMM anytime during the delivery stay? If the blood transfusion was before delivery, is it in numerator?	Yes, blood transfusions are specified as severe obstetric complication numerator events captured at any time during the inpatient delivery encounter, which includes any emergency, observation, or OB Triage visit that ends 1 hour or less before the admission to inpatient for the delivery encounter to discharge from the hospital.
Numerator	For PC-07, is being on CPAP enough to place the patient in the numerator?	Yes, CPAP during the delivery hospitalization, as indicated by one of three SNOMED codes in the Ventilation value set, regardless of preexisting illness, is enough to qualify a patient for the numerator.

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Numerator	For PC-07, does the QRDA file determine SMM presence based on coding alone? Or do the files look at other clinical factors in the EHR to determine if a SMM is present?	Yes, the PC-07 numerator is defined with diagnosis and procedure codes as specified in the value sets, and mortality as identified by a discharge disposition of expired. No other unspecified clinical factors determine the occurrence of a severe obstetric complication.
PC-02 Rationale	Can you please elaborate on Physician factors?	Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al.,1989; Goyert et al., 1989; Luthy et al., 2003, Symum et al., 2021). Although a proportion of variations in cesarean rates can be explained by the differences in risk factors, the remaining unexplained variations suggest differences in practice patterns and imply potential quality concerns Symum, H., & Zayas-Castro, J. L. (2021).
Placenta Accreta	For PC-07, placenta Increta and Percreta are numerator exclusions for blood transfusions and hysterectomies. Why did the Technical Advisory Panel not include Placenta Accreta as an exclusion as well?	You are correct that placenta accreta is not included in the numerator exclusions for PC-07. The Technical Advisory Panel (TAP) felt that not all cases of placenta accreta require a hysterectomy and reproductive justice or preservation should be considered.
Placenta Accreta	PC-07 if placenta accreta is diagnosed will that be excluded or is it only percreta/increta?	No, placenta accreta is not included in the numerator exclusions for PC-07. The Technical Advisory Panel (TAP) felt that not all cases of placenta accreta require a hysterectomy, and reproductive justice or preservation should be considered.
Placenta Accreta	Why not accreta, should be the entire spectrum, accreta, increta, percreta…	Placenta accreta spectrum disorders are an exclusion for PC-02. This includes accreta. However, placenta accreta is not a numerator exclusion for PC-07 in cases where a hysterectomy or blood transfusion is the only complication. The Technical Advisory Panel (TAP) felt that not all cases of placenta accreta require a hysterectomy and reproductive justice or preservation should be considered.
POA	For PC-07, if a risk factor is coded, but does not have the POA status, will it still be included in the risk adjustment calculation?	No, that is why it is important to submit POA indicators. It is recommended that a quality review of all measure results outside of expected outcomes (outliers) be reviewed by hospital quality leadership to ensure accurate data entry and complete submission of all data required by the measure.
POA	For PC-07, if a patient is admitted with a diagnosis of anemia, and this is listed as POA - "yes", why does the case still fail the PC07 measure?	Anemia is a risk factor included in the risk adjustment model, and its value including POA status, does not impact whether a patient is identified with a numerator event.
POA	For PC-07, if a patient has a POA dx of anemia and gets a blood transfusion will this be excluded from the PCO7 numerator?	No, Anemia is a risk factor included in the risk adjustment model, and identification of anemia as a risk factor does not exclude blood transfusion as a numerator event.

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POA	Is it correct to code pre-term birth POA for a delivery encounter where the GA =<36 weeks?	For the preterm birth risk variable, Z codes from the Preterm Birth value set will only be used if it is not possible to determine calculated gestational age from the due date or estimated gestational age from a field in the EHR. If a Z code is submitted to indicate preterm birth, POA exempt should be coded.
POA	For PC-07, how can POA be defined for a diagnosis code in problem list during the hospitalization? Our problem list does not currently indicate POA status.	Yes, submitting POA indicators is mandatory for this measure. We recommend that you work with your EHR vendor to see if POA can be mapped and reported from the problem list in your system. It is highly recommended that the hospital leadership and quality department review this concern. The submitted POA codes are used for risk adjustment in the measure calculation and incomplete submission of POA codes could potentially result in a higher SOC measure score for the hospital. Hospital QAPI (Quality Assurance Performance Improvement) leadership should review any measure outcomes if results are outside expected parameters.
POA	We submitted our eCQM for CY 2025 about 6 weeks ago. Just got an email from TJC that we need to resubmit files with POA status which was missing. Is this mandatory?	Yes, POA indicators are required for reporting PC-07. It is highly recommended that the hospital leadership and quality department review this concern. The submitted POA codes are used in the measure calculation and incomplete submission of POA codes could potentially result in higher SOC rates. Hospital QAPI leadership should review any measure outcomes if results are outside expected parameters.
Reporting	Do you have an idea of when CMS will begin reporting the measure results for this measure on Care Compare?	CMS will likely report the measure results for Calendar Year (CY) 2025 data on Care Compare in Fall 2026. CMS highly recommends that hospital leadership and QAPI leadership should review any measure outcomes if results are outside expected parameters.
Risk Adjustment	How does a hospital that has no cases (0%) with severe complications excluding blood transfusions only have a risk adjusted rate greater than 0%?	Even if there are zero observed complications, a hospital can still have a non-zero risk-standardized obstetric complications rate (RSOCR) since the RSOCR represents the hospital's relative performance compared to other hospitals with the same case mix, and not a raw complication rate. The measure score is a risk-standardized rate, anchored by the national rate, and not a risk-adjusted rate.

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Risk Adjustment	Will a hospital with high acuity high risk patient population have a higher PC-07 score than a hospital that doesn't?	A benefit of the risk model in the PC-07 measure is that hospitals with higher risk patients will not necessarily have worse measure scores than hospitals with lower risk patients. While the answer to your question will depend on the exact case mix of each hospital (risk factors among patients) and the observed complication rate at the hospital, the opposite could be true. For example, if Hospital A and Hospital B have the same observed complication rate, but Hospital A has a higher acuity high risk population than Hospital B as captured by risk variables identified in the PC-07 risk model, Hospital A is anticipated to have a lower risk-standardized measure score than Hospital B, reflecting that Hospital A is performing better than Hospital B in relation to expected complications given their patient acuity.
Risk Adjustment	Also, why would an observed rate be 400 and then with risk adjustment its 900?	While a hospital's observed rate contributes to the calculation of their measure score, it should not be mathematically compared to the risk-standardized measure score. The measure score represents the hospital's relative performance compared to other hospitals adjusting for case mix, and is anchored by the national rate, and not the hospital's observed rate. A risk-standardized score could be higher than the observed rate if the national rate is higher than the observed rate or if the hospital has more complications than would be expected given their patient case mix. We encourage you to review Section 2.8 of the Severe Obstetric Complications Methodology Report available on the eCQI Resource Center (https://ecqi.healthit.gov) to learn more about the calculation of the measure score.
Risk Adjustment	Do we compare raw rates to national rate?	Yes, you may compare your hospital's raw rates to the national observed rate to assess measure outcomes without risk standardization.
Risk Adjustment	Is the national rate risk adjusted?	No, the national observed rate is simply the numerator divided by the denominator for all encounters submitted in the country, without considering hospital.