CPT® Code 59409 Details

Code Symbols

MIPS : Merit Based Incentive Payment System
: Female
M : Maternity

Code Descriptor

Vaginal delivery only (with or without episiotomy and/or forceps)

CPT® Advice

No data Available

Illustration

No data Available.

Fee Schedule

Medicare Physician Fee Schedules (MPFS)	
Sources:	2019 National Physician Fee Schedule Relative Value File, GPCI19, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2019, MCR-MUE-PractitionerServices
Publisher:	CMS
Effective:	July 01, 2019
Medicare Carrier/Locality:	ALASKA** 01-02102
Conversion Factor:	36.0391

Note: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

Code Status A
A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

Medicare Fees

	National	Adjusted	26	TC	53
Facility	$842.23	$1,089.01	$0.00	$0.00	$0.00
Non Facility	$842.23	$1,089.01	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	Adjusted	26	TC	53
Work RVU:	14.37	21.56	0.00	0.00	0.00
PE RVU:	5.60	6.26	0.00	0.00	0.00
Malpractice RVU:	3.40	2.41	0.00	0.00	0.00
Total RVU:	23.37	30.22	0.00	0.00	0.00

RVU - Facility					
	National	Adjusted	26	TC	53
Work RVU:	14.37	21.56	0.00	0.00	0.00
PE RVU:	5.60	6.26	0.00	0.00	0.00
Malpractice RVU:	3.40	2.41	0.00	0.00	0.00
Total RVU:	23.37	30.22	0.00	0.00	0.00

Global & Other Info	
	Global Split
Preoperative %:	0
Intraoperative %:	0
Postoperative %:	0
Total RVU:	0
Global Period (days):	MMM

MMM = Maternity codes; usual global period does not apply.

Radiology Diagnostic Tests : 99

99 = Concept does not apply

PC/TC Indicator : 0

0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

Endoscopic Base Code : None

Modifier Guidelines

	Modifier	Rules(Click on rules for Details)
MULT PROC	51	Multiple procedure reduction applies
51 = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes		
2 = Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage.		
BILAT SURG	50	No 150% bilateral payment boost
50 = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.		
0 = 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.		
ASST SURG	80	Assistant payment allowed when supported
80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
CO-SURG	62	Co-surgeons not permitted
62 = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.		
0 = Co-surgeons not permitted for this procedure.		
TEAM SURG	66	Team surgeons not permitted
66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.		
0 = Team surgeons not permitted for this procedure.		

MINIMUM ASST SURG	81	Assistant payment allowed when supported.
81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment allowed when supported.
82 = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
PHYSICIAN SUPERVISION	*PS	Concept does not apply.
PS = This field is for use in post payment review.		
9 = Concept does not apply		

Medically Unlikely Edits

Source: 2019 Medically Unlikely Edits (MUE)

Publisher: CMS

Date: July 01, 2019

Services	MUE	MAI	MUE Rationale
Practitioner Services	2	3	Clinical: Data
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	2	3	Clinical: Data

MAI 1: Line Edit
MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy
MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

LCD Details

LCD Details for 59409

The chosen state has no LCD for this code/title. Please search All States to see if another state has an LCD for this code/title.

Article Details for 59409

The chosen state has no Article for this code/title. Please search All States to see if another state has an Article for this code/title.

NCD

No data available.

MEDICARE CCI

0 - Can NOT be billed under any circumstances
1 - A CCI-associated modifier on the Col. 2 code will override the edit.

Col B Code	Reason Edit	Modifier Indicator
01958	Anesthesia service included in surgical procedure	0
01960	Anesthesia service included in surgical procedure	0
01967	Anesthesia service included in surgical procedure	0
0213T	Misuse of column two code with column one code	1
0216T	Misuse of column two code with column one code	1
0230T	Anesthesia service included in surgical procedure	0
11000	Misuse of column two code with column one code	1
11001	Misuse of column two code with column one code	1
11004	Misuse of column two code with column one code	1
11005	Misuse of column two code with column one code	1
11006	Misuse of column two code with column one code	1
11042	Misuse of column two code with column one code	1
11043	Misuse of column two code with column one code	1
11044	Misuse of column two code with column one code	1

11045	Misuse of column two code with column one code	1
11046	Misuse of column two code with column one code	1
11047	Misuse of column two code with column one code	1
12001	Misuse of column two code with column one code	1
12002	Misuse of column two code with column one code	1
12004	Misuse of column two code with column one code	1
12005	Misuse of column two code with column one code	1
12006	Misuse of column two code with column one code	1
12007	Misuse of column two code with column one code	1
12011	Misuse of column two code with column one code	1
12013	Misuse of column two code with column one code	1
12014	Misuse of column two code with column one code	1
12015	Misuse of column two code with column one code	1
12016	Misuse of column two code with column one code	1
12017	Misuse of column two code with column one code	1
12018	Misuse of column two code with column one code	1
12020	Misuse of column two code with column one code	1
12021	Misuse of column two code with column one code	1
12031	Misuse of column two code with column one code	1
12032	Misuse of column two code with column one code	1
12034	Misuse of column two code with column one code	1
12035	Misuse of column two code with column one code	1
12036	Misuse of column two code with column one code	1
12037	Misuse of column two code with column one code	1
12041	Misuse of column two code with column one code	1
12042	Misuse of column two code with column one code	1
12044	Misuse of column two code with column one code	1
12045	Misuse of column two code with column one code	1

12046	Misuse of column two code with column one code	1
12047	Misuse of column two code with column one code	1
12051	Misuse of column two code with column one code	1
12052	Misuse of column two code with column one code	1
12053	Misuse of column two code with column one code	1
12054	Misuse of column two code with column one code	1
12055	Misuse of column two code with column one code	1
12056	Misuse of column two code with column one code	1
12057	Misuse of column two code with column one code	1
13100	Misuse of column two code with column one code	1
13101	Misuse of column two code with column one code	1
13102	Misuse of column two code with column one code	1
13120	Misuse of column two code with column one code	1
13121	Misuse of column two code with column one code	1
13122	Misuse of column two code with column one code	1
13131	Misuse of column two code with column one code	1
13132	Misuse of column two code with column one code	1
13133	Misuse of column two code with column one code	1
13151	Misuse of column two code with column one code	1
13152	Misuse of column two code with column one code	1
13153	Misuse of column two code with column one code	1
36000	Standards of medical / surgical practice	1
36410	Standards of medical / surgical practice	1
36591	CPT Manual or CMS manual coding instructions	0
36592	CPT Manual or CMS manual coding instructions	0
51701	Standards of medical / surgical practice	0
51702	Standards of medical / surgical practice	0
59050	Standards of medical / surgical practice	0

59051	Standards of medical / surgical practice	0
59200	CPT "separate procedure" definition	0
59300	HCPCS/CPT procedure code definition	0
59414	CPT "separate procedure" definition	0
59430	CPT "separate procedure" definition	0
59610	Mutually exclusive procedures	1
61650	Misuse of column two code with column one code	1
62322	Anesthesia service included in surgical procedure	0
62323	Anesthesia service included in surgical procedure	0
62324	Misuse of column two code with column one code	1
62325	Misuse of column two code with column one code	1
62326	Misuse of column two code with column one code	1
62327	Misuse of column two code with column one code	1
64415	Misuse of column two code with column one code	1
64416	Misuse of column two code with column one code	1
64417	Misuse of column two code with column one code	1
64430	Anesthesia service included in surgical procedure	0
64435	Anesthesia service included in surgical procedure	0
64450	Misuse of column two code with column one code	1
64483	Anesthesia service included in surgical procedure	0
64486	Misuse of column two code with column one code	1
64487	Misuse of column two code with column one code	1
64488	Misuse of column two code with column one code	1
64489	Misuse of column two code with column one code	1
64490	Misuse of column two code with column one code	1
64493	Misuse of column two code with column one code	1
69990	Misuse of column two code with column one code	0
96360	Standards of medical / surgical practice	1

96365	Standards of medical / surgical practice	1
96372	Standards of medical / surgical practice	1
96374	Standards of medical / surgical practice	1
96375	Standards of medical / surgical practice	1
96376	Standards of medical / surgical practice	1
96377	Standards of medical / surgical practice	1
96523	CPT Manual or CMS manual coding instructions	0
97597	Misuse of column two code with column one code	1
97598	Misuse of column two code with column one code	1
97602	Misuse of column two code with column one code	1
G0471	Standards of medical / surgical practice	0

Medicaid CCI Edits Alert

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0215T	Misuse of column two code with column one code	1
0216T	Misuse of column two code with column one code	1
0217T	Misuse of column two code with column one code	1
0218T	Misuse of column two code with column one code	1
0230T	Anesthesia service included in surgical procedure	0
0231T	Anesthesia service included in surgical procedure	0
11000	Misuse of column two code with column one code	1

11001	Misuse of column two code with column one code	1
11004	Misuse of column two code with column one code	1
11005	Misuse of column two code with column one code	1
11006	Misuse of column two code with column one code	1
11042	Misuse of column two code with column one code	1
11043	Misuse of column two code with column one code	1
11044	Misuse of column two code with column one code	1
11045	Misuse of column two code with column one code	1
11046	Misuse of column two code with column one code	1
11047	Misuse of column two code with column one code	1
12001	Misuse of column two code with column one code	1
12002	Misuse of column two code with column one code	1
12004	Misuse of column two code with column one code	1
12005	Misuse of column two code with column one code	1
12006	Misuse of column two code with column one code	1
12007	Misuse of column two code with column one code	1
12011	Misuse of column two code with column one code	1
12013	Misuse of column two code with column one code	1
12014	Misuse of column two code with column one code	1
12015	Misuse of column two code with column one code	1
12016	Misuse of column two code with column one code	1
12017	Misuse of column two code with column one code	1
12018	Misuse of column two code with column one code	1
12020	Misuse of column two code with column one code	1
12021	Misuse of column two code with column one code	1
12031	Misuse of column two code with column one code	1
12032	Misuse of column two code with column one code	1
12034	Misuse of column two code with column one code	1

12035	Misuse of column two code with column one code	1
12036	Misuse of column two code with column one code	1
12037	Misuse of column two code with column one code	1
12041	Misuse of column two code with column one code	1
12042	Misuse of column two code with column one code	1
12044	Misuse of column two code with column one code	1
12045	Misuse of column two code with column one code	1
12046	Misuse of column two code with column one code	1
12047	Misuse of column two code with column one code	1
12051	Misuse of column two code with column one code	1
12052	Misuse of column two code with column one code	1
12053	Misuse of column two code with column one code	1
12054	Misuse of column two code with column one code	1
12055	Misuse of column two code with column one code	1
12056	Misuse of column two code with column one code	1
12057	Misuse of column two code with column one code	1
13100	Misuse of column two code with column one code	1
13101	Misuse of column two code with column one code	1
13102	Misuse of column two code with column one code	1
13120	Misuse of column two code with column one code	1
13121	Misuse of column two code with column one code	1
13122	Misuse of column two code with column one code	1
13131	Misuse of column two code with column one code	1
13132	Misuse of column two code with column one code	1
13133	Misuse of column two code with column one code	1
13151	Misuse of column two code with column one code	1
13152	Misuse of column two code with column one code	1
13153	Misuse of column two code with column one code	1

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36410	Standards of medical / surgical practice	1
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36592	CPT Manual or CMS manual coding instructions	0
51701	Standards of medical / surgical practice	0
51702	Standards of medical / surgical practice	0
59050	Standards of medical / surgical practice	0
59051	Standards of medical / surgical practice	0
59200	CPT "separate procedure" definition	0
59300	HCPCS/CPT procedure code definition	0
59414	CPT "separate procedure" definition	0
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62325	Misuse of column two code with column one code	1
62326	Misuse of column two code with column one code	1
62327	Misuse of column two code with column one code	1
64415	Misuse of column two code with column one code	1
64416	Misuse of column two code with column one code	1
64417	Misuse of column two code with column one code	1
64430	Anesthesia service included in surgical procedure	0
64435	Anesthesia service included in surgical procedure	0
64450	Misuse of column two code with column one code	1
64483	Anesthesia service included in surgical procedure	0
64484	Anesthesia service included in surgical procedure	0

64486	Misuse of column two code with column one code	1
64487	Misuse of column two code with column one code	1
64488	Misuse of column two code with column one code	1
64489	Misuse of column two code with column one code	1
64490	Misuse of column two code with column one code	1
64491	Misuse of column two code with column one code	1
64492	Misuse of column two code with column one code	1
64493	Misuse of column two code with column one code	1
64494	Misuse of column two code with column one code	1
64495	Misuse of column two code with column one code	1
69990	Misuse of column two code with column one code	0
96360	Standards of medical / surgical practice	1
96365	Standards of medical / surgical practice	1
96372	Standards of medical / surgical practice	1
96374	Standards of medical / surgical practice	1
96375	Standards of medical / surgical practice	1
96376	Standards of medical / surgical practice	1
96377	Standards of medical / surgical practice	1
96523	CPT Manual or CMS manual coding instructions	0
97597	Misuse of column two code with column one code	1
97598	Misuse of column two code with column one code	1
97602	Misuse of column two code with column one code	1
G0471	Standards of medical / surgical practice	0

ICD-10 Crossref

O09.00 : Supervision of pregnancy with history of infertility, unspecified trimester
O09.522 : Supervision of elderly multigravida, second trimester
O09.523 : Supervision of elderly multigravida, third trimester
O10.112 : Pre-existing hypertensive heart disease complicating pregnancy, second trimester
O10.113 : Pre-existing hypertensive heart disease complicating pregnancy, third trimester
O10.12 : Pre-existing hypertensive heart disease complicating childbirth

O10.212 : Pre-existing hypertensive chronic kidney disease complicating pregnancy, second trimester
O10.213 : Pre-existing hypertensive chronic kidney disease complicating pregnancy, third trimester
O10.22 : Pre-existing hypertensive chronic kidney disease complicating childbirth
O10.312 : Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, second trimester
O10.313 : Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, third trimester
O10.32 : Pre-existing hypertensive heart and chronic kidney disease complicating childbirth
O11.2 : Pre-existing hypertension with pre-eclampsia, second trimester
O11.3 : Pre-existing hypertension with pre-eclampsia, third trimester
O11.4 : Pre-existing hypertension with pre-eclampsia, complicating childbirth
O11.5 : Pre-existing hypertension with pre-eclampsia, complicating the puerperium
O24.415 : Gestational diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs
O24.419 : Gestational diabetes mellitus in pregnancy, unspecified control
O24.425 : Gestational diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs
O24.429 : Gestational diabetes mellitus in childbirth, unspecified control
O24.435 : Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs
O24.912 : Unspecified diabetes mellitus in pregnancy, second trimester
O24.913 : Unspecified diabetes mellitus in pregnancy, third trimester
O30.002 : Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.003 : Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.013 : Twin pregnancy, monochorionic/monoamniotic, third trimester
O30.033 : Twin pregnancy, monochorionic/diamniotic, third trimester
O30.043 : Twin pregnancy, dichorionic/diamniotic, third trimester
O30.093 : Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30.102 : Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.103 : Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.202 : Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.203 : Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O31.32X0 : Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, not applicable or unspecified
O31.33X0 : Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, not applicable or unspecified
O31.8X30 : Other complications specific to multiple gestation, third trimester, not applicable or unspecified
O36.0930 : Maternal care for other rhesus isoimmunization, third trimester, not applicable or unspecified
O36.1130 : Maternal care for Anti-A sensitization, third trimester, not applicable or unspecified
O36.1930 : Maternal care for other isoimmunization, third trimester, not applicable or unspecified
O36.4XX0 : Maternal care for intrauterine death, not applicable or unspecified
O36.5130 : Maternal care for known or suspected placental insufficiency, third trimester, not applicable or unspecified
O36.5930 : Maternal care for other known or suspected poor fetal growth, third trimester, not applicable or unspecified
O36.63X0 : Maternal care for excessive fetal growth, third trimester, not applicable or unspecified
O36.8130 : Decreased fetal movements, third trimester, not applicable or unspecified
O36.8230 : Fetal anemia and thrombocytopenia, third trimester, not applicable or unspecified
O36.8930 : Maternal care for other specified fetal problems, third trimester, not applicable or unspecified
O36.92X0 : Maternal care for fetal problem, unspecified, second trimester, not applicable or unspecified
O40.3XX0 : Polyhydramnios, third trimester, not applicable or unspecified

O41.03X0 : Oligohydramnios, third trimester, not applicable or unspecified
O41.1020 : Infection of amniotic sac and membranes, unspecified, second trimester, not applicable or unspecified
O41.1030 : Infection of amniotic sac and membranes, unspecified, third trimester, not applicable or unspecified
O41.1220 : Chorioamnionitis, second trimester, not applicable or unspecified
O41.1230 : Chorioamnionitis, third trimester, not applicable or unspecified
O41.1420 : Placentitis, second trimester, not applicable or unspecified
O41.1430 : Placentitis, third trimester, not applicable or unspecified
O41.8X30 : Other specified disorders of amniotic fluid and membranes, third trimester, not applicable or unspecified
O41.93X0 : Disorder of amniotic fluid and membranes, unspecified, third trimester, not applicable or unspecified
O42.013 : Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, third trimester
O60.02 : Preterm labor without delivery, second trimester
O60.03 : Preterm labor without delivery, third trimester
O60.12X0 : Preterm labor second trimester with preterm delivery second trimester, not applicable or unspecified
O60.13X0 : Preterm labor second trimester with preterm delivery third trimester, not applicable or unspecified
O60.14X0 : Preterm labor third trimester with preterm delivery third trimester, not applicable or unspecified
O60.20X0 : Term delivery with preterm labor, unspecified trimester, not applicable or unspecified
O60.20X1 : Term delivery with preterm labor, unspecified trimester, fetus 1
O60.20X2 : Term delivery with preterm labor, unspecified trimester, fetus 2
O60.20X3 : Term delivery with preterm labor, unspecified trimester, fetus 3
O60.20X4 : Term delivery with preterm labor, unspecified trimester, fetus 4
O60.20X5 : Term delivery with preterm labor, unspecified trimester, fetus 5
O60.20X9 : Term delivery with preterm labor, unspecified trimester, other fetus
O60.22X0 : Term delivery with preterm labor, second trimester, not applicable or unspecified
O60.22X1 : Term delivery with preterm labor, second trimester, fetus 1
O60.22X2 : Term delivery with preterm labor, second trimester, fetus 2
O60.22X3 : Term delivery with preterm labor, second trimester, fetus 3
O60.22X4 : Term delivery with preterm labor, second trimester, fetus 4
O60.22X5 : Term delivery with preterm labor, second trimester, fetus 5
O60.22X9 : Term delivery with preterm labor, second trimester, other fetus
O60.23X0 : Term delivery with preterm labor, third trimester, not applicable or unspecified
O60.23X1 : Term delivery with preterm labor, third trimester, fetus 1
O60.23X2 : Term delivery with preterm labor, third trimester, fetus 2
O60.23X3 : Term delivery with preterm labor, third trimester, fetus 3
O60.23X4 : Term delivery with preterm labor, third trimester, fetus 4
O60.23X5 : Term delivery with preterm labor, third trimester, fetus 5
O60.23X9 : Term delivery with preterm labor, third trimester, other fetus
O66.5 : Attempted application of vacuum extractor and forceps
O69.0XX0 : Labor and delivery complicated by prolapse of cord, not applicable or unspecified
O69.1XX0 : Labor and delivery complicated by cord around neck, with compression, not applicable or unspecified
O69.2XX0 : Labor and delivery complicated by other cord entanglement, with compression, not applicable or unspecified
O69.3XX0 : Labor and delivery complicated by short cord, not applicable or unspecified
O69.5XX0 : Labor and delivery complicated by vascular lesion of cord, not applicable or unspecified
O69.81X0 : Labor and delivery complicated by cord around neck, without compression, not applicable or unspecified
O69.82X0 : Labor and delivery complicated by other cord entanglement, without compression, not applicable or unspecified
O69.89X0 : Labor and delivery complicated by other cord complications, not applicable or unspecified
O70.0 : First degree perineal laceration during delivery
O70.1 : Second degree perineal laceration during delivery
O70.3 : Fourth degree perineal laceration during delivery

O80 : Encounter for full-term uncomplicated delivery
O99.810 : Abnormal glucose complicating pregnancy
O99.814 : Abnormal glucose complicating childbirth
Z33.3 : Pregnant state, gestational carrier
Z34.80 : Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.90 : Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z37.0 : Single live birth
Z37.1 : Single stillbirth
Z37.2 : Twins, both liveborn
Z37.3 : Twins, one liveborn and one stillborn
Z37.4 : Twins, both stillborn
Z37.59 : Other multiple births, all liveborn
Z37.69 : Other multiple births, some liveborn
Z37.7 : Other multiple births, all stillborn
Z37.9 : Outcome of delivery, unspecified

HCPCS Crossref

No data available.

Anesthesia Crossref

01967
Base Unit Value: 5 : Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

Alternate Codes

01960
Base Unit Value: 5 : Anesthesia for vaginal delivery only

Anesthesia Tips: N/A

Modifier Crossref

22 : Increased Procedural Services
47 : Anesthesia by Surgeon
51 : Multiple Procedures
52 : Reduced Services
53 : Discontinued Procedure
58 : Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59 : Distinct Procedural Service
63 : Procedure Performed on Infants less than 4 kg
76 : Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77 : Repeat Procedure by Another Physician or Other Qualified Health Care Professional
79 : Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80 : Assistant Surgeon
81 : Minimum Assistant Surgeon

82 : Assistant Surgeon (when qualified resident surgeon not available)
99 : Multiple Modifiers
AQ : Physician providing a service in an unlisted health professional shortage area (hpsa)
AR : Physician provider services in a physician scarcity area
AS : Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
CR : Catastrophe/disaster related
ET : Emergency services
GA : Waiver of liability statement issued as required by payer policy, individual case
GB : Claim being re-submitted for payment because it is no longer covered under a global payment demonstration
GC : This service has been performed in part by a resident under the direction of a teaching physician
GJ : "opt out" physician or practitioner emergency or urgent service
GR : This service was performed in whole or in part by a resident in a department of veterans affairs medical center or clinic, supervised in accordance with va policy
HD : Pregnant/parenting women's program
KX : Requirements specified in the medical policy have been met
Q5 : Service furnished under a reciprocal billing arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
Q6 : Service furnished under a fee-for-time compensation arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
QJ : Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 cfr 411.4 (b)
SB : Nurse midwife
TH : Obstetrical treatment/services, prenatal or postpartum
XE : Separate encounter, a service that is distinct because it occurred during a separate encounter
XP : Separate practitioner, a service that is distinct because it was performed by a different practitioner
XS : Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU : Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

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CPT® Lay Terms

In this procedure, the provider provides admission to the hospital for delivery, labor management, including induction of labor, fetal monitoring, use of low forceps, and episiotomy, vaginal delivery of the fetus and placenta on the same date of service.

Clinical Responsibility

Intrapartum Care: Management of labor usually begins when the patient informs the provider that she thinks she is in labor or presents to the hospital in apparent labor. If the patient calls the provider about labor, he advises the patient when to come to hospital, alerts hospital personnel of the patient’s arrival, and provides initial instructions for the patient's care. The provider then performs an initial history and physical examination at the time of admission to determine that labor has indeed begun. He then assesses the condition of mother and fetus, develops a treatment plan, and communicates with nursing staff, anesthesia, and pediatric staff as necessary. When his initial evaluation is complete, the provider periodically reevaluates the condition of his patient and her fetus throughout the course of labor and alters the treatment plan as necessary. The provider may induce or augment labor, but this is inclusive of labor management no matter if he performs this service using, IV drugs, or rupture of membranes. During the first stage of labor, which starts with contractions and ends with complete dilation of the cervix, the provider evaluates the

patient usually every thirty minutes. During the second stage of labor, which lasts from complete dilation of the cervix through the birth of the baby, the provider usually evaluates the patient at 5 to 15–minute intervals.

During labor, the provider may administer regional or local anesthesia to ease labor pains. He then continually monitors uterine contractions and the fetal heart rate using external monitors he places on the mother's abdomen. The provider may instruct the patient on breathing technique, check the uterine contractions for regularity, and perform a vaginal examination to determine position of the fetal head. When he sees the dilation of the cervix is fully or nearly fully complete, he moves the patient to the delivery room, and the patient is prepped and draped. The provider instructs the patient to begin pushing the baby at this stage, and when the baby's head begins to show through the vaginal opening, called crowning, the provider may perform a few maneuvers with the baby's emerging body to facilitate a smooth and better delivery. He may use low forceps to assist in the delivery of the head and shoulders, or apply a vacuum extractor in some cases. He may also perform an episiotomy when the perineum does not stretch adequately, and it obstructs delivery. Once the head comes out, the provider gently supports the whole body with his hand so the body can rotate and come out through the birth canal. After the delivery is complete, the provider removes the placenta and incises the umbilical cord. The provider inspects the cervix and vagina for lacerations, repairs the episiotomy incision, and repairs any minor vaginal or cervical lacerations as well.

Terminology

Cervix: Fleshy end of the uterus that juts into the vaginal canal, which consists of an outer opening, called the exocervix or ectocervix, middle section, called the transformation zone, where the squamous and columnar cells meet, and inner portion that opens into the body of the uterus, called the endocervix; menstrual blood passes from the uterine lining into the cervix and out into the vaginal canal.

Episiotomy: An incision made in the perineum to allow passage of the baby's head and to prevent ragged tearing of the perineal tissues.

Forceps: A two bladed instrument used to compress or grasp.

Forceps delivery: One of three types of delivery with forceps may occur, but they are still part of intrapartum care; a provider uses outlet forceps when the baby's scalp is visible at the vaginal opening; low forceps when the baby's head is at +2 station or lower; and midforceps when the baby's head is above +2 station, but the head is engaged.

Intrapartum period: Period from the onset of labor to the complete expulsion of the placenta.

Perineum: The short stretch of skin that starts at the bottom of the vulva, the external female genital organs, and continues to the anal opening.

Placenta: A special layer developed during pregnancy to protect and nourish the fetus.Uterus: A hollow, muscular, pear shaped organ located between the base of the bladder and the rectum; it bends forward at its narrowest part, called the isthmus, and rests on the bladder; the body of the uterus is the widest part, and it lies above the isthmus; the cervix forms the lower part of the uterus and is below the isthmus and juts into the vaginal canal.

Vacuum extraction: Placement of a bell shaped cup on the baby's head and application of vacuum pressure to create suction on the baby's head; the provider then pulls on the device he attaches to the cup at the same time as the mother indicates a contraction is beginning, and he continues throughout the full contraction; at the end of the contraction the provider stops pulling and waits for the next contraction, continuing until the baby's head begins to exit the vaginal opening.

Vagina: A canal made up of muscle lined with a mucous membrane that can stretch due to folds in the membrane; it extends from the vestibule area to where the cervix butts up against the vaginal vault; it is longer on the posterior wall, the side located above the rectum, than the anterior wall, the side located below the bladder.

Tips

Add a modifier 22, Unusual procedural service, to 59409 when the provider performs work greater than normal. This may occur because the labor management, or delivery was significantly more work than for routine care. The provider must provide detailed documentation to get additional reimbursement.

If the provider who delivers the baby also provides inpatient postpartum care, he may bill for this in addition. However, if the provider will perform the outpatient postpartum care as well, report 59410, Vaginal delivery only, with or without episiotomy and or forceps; including postpartum care.

CPT® Guidelines

Section Specific Guideline

The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. Pregnancy confirmation during a problem oriented or preventive visit is not considered a part of antepartum care and should be reported using the appropriate E/M service codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99384, 99385, 99386, 99394, 99395, 99396 for that visit.

Antepartum care includes the initial prenatal history and physical examination; subsequent prenatal history and physical examinations; recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation; biweekly visits to 36 weeks gestation; and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient postdelivery management and discharge services using Evaluation and Management Services codes (99217-99239). Delivery and postpartum services (59410, 59515, 59614, 59622) include delivery services and all inpatient and outpatient postpartum services. Medical complications of pregnancy (eg, cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery management may require additional resources and may be reported separately.

Postpartum care only services (59430) include office or other outpatient visits following vaginal or cesarean section delivery.

For surgical complications of pregnancy (eg, appendectomy, hernia, ovarian cyst, Bartholin cyst), see services in the Surgery section.

If all or part of the antepartum and/or postpartum patient care is provided except delivery due to termination of pregnancy by abortion or referral to another physician or other qualified health care professional for delivery, see the antepartum and postpartum care codes 59425, 59426, and 59430.

(For circumcision of newborn, see 54150, 54160)

OPPS

Carrier/Locality : National
Conversion Factor : 36.0391

OPPS Freestanding

Not a Qualified ASC service

OPPS Hospital Based

APC: 5414
APC descriptor: Level 4 Gynecologic Procedures
Status indicator: J1
Status Definition: Hospital Part B services paid through a comprehensive APC
OPPS Payment Status: Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
Changed since last quarter: N
Medicare payment rate: $2,361.27
Nat'l unadjusted copay: $0.00
Min unadjusted copay: $472.26

Upcoming and Historical Information

01-01-2010	Code Changed

Previous Descriptor

Vaginal delivery only (with or without episiotomy and/or forceps);

01-01-1994	Code Added