CPT® Code 99461 Details

Code Symbols

MIPS : Merit Based Incentive Payment System

Code Descriptor

Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center

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	$64.15	$87.87	$0.00	$0.00	$0.00
Non Facility	$92.98	$120.07	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	1.26	1.89	0.00	0.00	0.00
PE RVU:	1.24	1.39	0.00	0.00	0.00
Malpractice RVU:	0.08	0.06	0.00	0.00	0.00
Total RVU:	2.58	3.33	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	1.26	1.89	0.00	0.00	0.00
PE RVU:	0.44	0.49	0.00	0.00	0.00
Malpractice RVU:	0.08	0.06	0.00	0.00	0.00
Total RVU:	1.78	2.44	0.00	0.00	0.00

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

XXX = The global concept does not apply to the code.

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	No multiple procedure payment adjustment

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

0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

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	1	2	Nature of Service/Procedure
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	1	2	Nature of Service/Procedure

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 99461

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 99461

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
0362T	Misuse of column two code with column one code	1
0373T	Misuse of column two code with column one code	1
0469T	Misuse of column two code with column one code	0
36591	CPT Manual or CMS manual coding instructions	0
36592	CPT Manual or CMS manual coding instructions	0
43752	Misuse of column two code with column one code	1
92531	CPT Manual or CMS manual coding instructions	0
92532	CPT Manual or CMS manual coding instructions	0
93040	Standards of medical / surgical practice	1
93041	Standards of medical / surgical practice	1
93042	Standards of medical / surgical practice	1
93792	CPT Manual or CMS manual coding instructions	1
93793	CPT Manual or CMS manual coding instructions	0
94002	CPT Manual or CMS manual coding instructions	0
94003	CPT Manual or CMS manual coding instructions	0

94004	CPT Manual or CMS manual coding instructions	0
94660	CPT Manual or CMS manual coding instructions	0
94662	CPT Manual or CMS manual coding instructions	0
95831	Standards of medical / surgical practice	0
95832	Standards of medical / surgical practice	0
95833	Standards of medical / surgical practice	0
95834	Standards of medical / surgical practice	0
95851	Standards of medical / surgical practice	0
95852	Standards of medical / surgical practice	0
96020	CPT Manual or CMS manual coding instructions	1
96105	Standards of medical / surgical practice	1
96116	CPT Manual or CMS manual coding instructions	1
96125	Standards of medical / surgical practice	1
96127	Misuse of column two code with column one code	0
96130	Standards of medical / surgical practice	1
96132	Standards of medical / surgical practice	1
96136	Standards of medical / surgical practice	1
96138	Standards of medical / surgical practice	1
96146	Standards of medical / surgical practice	1
96150	CPT Manual or CMS manual coding instructions	0
96151	CPT Manual or CMS manual coding instructions	0
96152	CPT Manual or CMS manual coding instructions	0
96153	CPT Manual or CMS manual coding instructions	0
96154	CPT Manual or CMS manual coding instructions	0
96360	Standards of medical / surgical practice	0
96365	Standards of medical / surgical practice	0
96369	Misuse of column two code with column one code	0
96372	Standards of medical / surgical practice	0

96373	Standards of medical / surgical practice	0
96374	Standards of medical / surgical practice	0
96377	Standards of medical / surgical practice	0
96401	Standards of medical / surgical practice	0
96402	Standards of medical / surgical practice	0
96405	Standards of medical / surgical practice	0
96406	Standards of medical / surgical practice	0
96409	Standards of medical / surgical practice	0
96413	Standards of medical / surgical practice	0
96416	Standards of medical / surgical practice	0
96420	Standards of medical / surgical practice	0
96422	Standards of medical / surgical practice	0
96425	Standards of medical / surgical practice	0
96440	Standards of medical / surgical practice	0
96446	Standards of medical / surgical practice	0
96450	Standards of medical / surgical practice	0
96523	CPT Manual or CMS manual coding instructions	0
97151	Misuse of column two code with column one code	1
97153	Misuse of column two code with column one code	1
97154	Misuse of column two code with column one code	1
97155	Misuse of column two code with column one code	1
97156	Misuse of column two code with column one code	1
97157	Misuse of column two code with column one code	1
97158	Misuse of column two code with column one code	1
97802	Misuse of column two code with column one code	0
97803	Misuse of column two code with column one code	0
97804	Misuse of column two code with column one code	0
99091	CPT Manual or CMS manual coding instructions	0

99172	CPT Manual or CMS manual coding instructions	0
99173	CPT Manual or CMS manual coding instructions	1
99174	Misuse of column two code with column one code	1
99177	Misuse of column two code with column one code	1
99221	CPT Manual or CMS manual coding instructions	0
99222	CPT Manual or CMS manual coding instructions	0
99231	CPT Manual or CMS manual coding instructions	0
99232	CPT Manual or CMS manual coding instructions	0
99233	CPT Manual or CMS manual coding instructions	0
99408	Standards of medical / surgical practice	0
99409	Standards of medical / surgical practice	0
99446	CPT Manual or CMS manual coding instructions	0
99447	CPT Manual or CMS manual coding instructions	0
99448	CPT Manual or CMS manual coding instructions	0
99449	CPT Manual or CMS manual coding instructions	0
99451	CPT Manual or CMS manual coding instructions	0
99452	CPT Manual or CMS manual coding instructions	0
99460	Mutually exclusive procedures	0
99462	Mutually exclusive procedures	0
99463	HCPCS/CPT procedure code definition	0
99464	CPT Manual or CMS manual coding instructions	1
99479	CPT Manual or CMS manual coding instructions	0
99480	CPT Manual or CMS manual coding instructions	0
99605	Misuse of column two code with column one code	1
99606	Misuse of column two code with column one code	1
G0102	Standards of medical / surgical practice	0
G0270	Misuse of column two code with column one code	0
G0271	Misuse of column two code with column one code	0

G0396	Standards of medical / surgical practice	1
G0397	Standards of medical / surgical practice	1
G0406	Mutually exclusive procedures	0
G0407	Mutually exclusive procedures	0
G0408	Mutually exclusive procedures	0
G0425	Mutually exclusive procedures	0
G0426	Mutually exclusive procedures	0
G0427	Mutually exclusive procedures	0
G0442	Standards of medical / surgical practice	1
G0443	Standards of medical / surgical practice	1
G0498	Standards of medical / surgical practice	0
G0508	Mutually exclusive procedures	0
G0509	Mutually exclusive procedures	0
G2011	Standards of medical / surgical practice	1

ICD-10 Crossref

P04.11 : Newborn affected by maternal antineoplastic chemotherapy
P04.12 : Newborn affected by maternal cytotoxic drugs
P04.13 : Newborn affected by maternal use of anticonvulsants
P04.14 : Newborn affected by maternal use of opiates
P04.15 : Newborn affected by maternal use of antidepressants
P04.16 : Newborn affected by maternal use of amphetamines
P04.17 : Newborn affected by maternal use of sedative-hypnotics
P04.18 : Newborn affected by other maternal medication
P04.19 : Newborn affected by maternal use of unspecified medication
P04.1A : Newborn affected by maternal use of anxiolytics
P04.40 : Newborn affected by maternal use of unspecified drugs of addiction
P04.42 : Newborn affected by maternal use of hallucinogens
P04.81 : Newborn affected by maternal use of cannabis
P04.89 : Newborn affected by other maternal noxious substances
P96.82 : Delayed separation of umbilical cord
P96.89 : Other specified conditions originating in the perinatal period
P96.9 : Condition originating in the perinatal period, unspecified
Z00.110 : Health examination for newborn under 8 days old
Z00.111 : Health examination for newborn 8 to 28 days old
Z00.129 : Encounter for routine child health examination without abnormal findings
Z38.00 : Single liveborn infant, delivered vaginally
Z38.01 : Single liveborn infant, delivered by cesarean
Z38.1 : Single liveborn infant, born outside hospital

Z38.2 : Single liveborn infant, unspecified as to place of birth
Z38.30 : Twin liveborn infant, delivered vaginally
Z38.31 : Twin liveborn infant, delivered by cesarean
Z38.4 : Twin liveborn infant, born outside hospital
Z38.5 : Twin liveborn infant, unspecified as to place of birth
Z38.61 : Triplet liveborn infant, delivered vaginally
Z38.62 : Triplet liveborn infant, delivered by cesarean
Z38.63 : Quadruplet liveborn infant, delivered vaginally
Z38.64 : Quadruplet liveborn infant, delivered by cesarean
Z38.65 : Quintuplet liveborn infant, delivered vaginally
Z38.66 : Quintuplet liveborn infant, delivered by cesarean
Z38.68 : Other multiple liveborn infant, delivered vaginally
Z38.69 : Other multiple liveborn infant, delivered by cesarean
Z38.7 : Other multiple liveborn infant, born outside hospital
Z38.8 : Other multiple liveborn infant, unspecified as to place of birth
Z76.2 : Encounter for health supervision and care of other healthy infant and child

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HCPCS Crossref

No data available.

Modifier Crossref

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
33 : Preventive Services
57 : Decision for Surgery
80 : Assistant Surgeon
81 : Minimum Assistant Surgeon
82 : Assistant Surgeon (when qualified resident surgeon not available)
AS : Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
GC : This service has been performed in part by a resident under the direction of a teaching physician
GV : Attending physician not employed or paid under arrangement by the patient's hospice provider
GW : Service not related to the hospice patient's terminal condition
KX : Requirements specified in the medical policy have been met
PD : Diagnostic or related non diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days
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

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CPT® Lay Terms

The provider evaluates and manages the care of a normal newborn infant, typically immediately after birth, at a location other than a hospital or birthing center.

Clinical Responsibility

The provider may perform the initial care of a newborn immediately after birth in a location other than a hospital or

birthing center, in which he clears mucus from the mouth, nose and throat of the infant using a suction bulb and ligates the umbilicus. Subsequently, or at the point where he assumes care, he reviews the medical history and prenatal care of the mother, reviews the newborn's history to date, conducts a physical examination, orders any necessary diagnostic tests or treatments, and meets with the family to discuss his findings. He documents his services and findings in the medical record.

Terminology

Umbilicus: The navel.

Tips

A normal newborn has no medical conditions or need for special care.

CPT® Guidelines

Range Specific Guideline

The following codes are used to report the services provided to newborns (birth through the first 28 days) in several different settings. Use of the normal newborn codes is limited to the initial care of the newborn in the first days after birth prior to home discharge.

Evaluation and Management (E/M) services for the newborn include maternal and/or fetal and newborn history, newborn physical examination(s), ordering of diagnostic tests and treatments, meetings with the family, and documentation in the medical record.

When delivery room attendance services (99464) or delivery room resuscitation services (99465) are required, report these in addition to normal newborn services Evaluation and Management codes.

For E/M services provided to newborns who are other than normal, see codes for hospital inpatient services (99221-99233) and neonatal intensive and critical care services (99466-99469, 99477-99480). When normal newborn services are provided by the same individual on the same date that the newborn later becomes ill and receives additional intensive or critical care services, report the appropriate E/M code with modifier 25 for these services in addition to the normal newborn code.

Procedures (eg, 54150, newborn circumcision) are not included with the normal newborn codes, and when performed, should be reported in addition to the newborn services.

When newborns are seen in follow-up after the date of discharge in the office or outpatient setting, see 99201-99215, 99381, 99391 as appropriate.

Upcoming and Historical Information

01-01-2009	Code Added