CPT® Code 59430 Details

Code Symbols

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

Code Descriptor

Postpartum care only (separate procedure)

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	$143.08	$185.80	$0.00	$0.00	$0.00
Non Facility	$200.74	$250.21	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	Adjusted	26	TC	53
Work RVU:	2.47	3.71	0.00	0.00	0.00
PE RVU:	2.55	2.85	0.00	0.00	0.00
Malpractice RVU:	0.55	0.39	0.00	0.00	0.00
Total RVU:	5.57	6.94	0.00	0.00	0.00

RVU - Facility					
	National	Adjusted	26	TC	53
Work RVU:	2.47	3.71	0.00	0.00	0.00
PE RVU:	0.95	1.06	0.00	0.00	0.00
Malpractice RVU:	0.55	0.39	0.00	0.00	0.00
Total RVU:	3.97	5.16	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 not allowed
80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).		
1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.		
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 not allowed.
81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment not allowed.
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)		
1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.		
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	Code Descriptor / CPT Instruction
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	1	2	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 59430

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 59430

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
0213T	Misuse of column two code with column one code	1
0216T	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
49010	CPT "separate procedure" definition	0
61650	Misuse of column two code with column one code	1
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
64450	Misuse of column two code with column one code	1
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
99201	CPT Manual or CMS manual coding instructions	1
99202	CPT Manual or CMS manual coding instructions	1
99203	CPT Manual or CMS manual coding instructions	1
99204	CPT Manual or CMS manual coding instructions	1
99205	CPT Manual or CMS manual coding instructions	1
99211	CPT Manual or CMS manual coding instructions	1
99212	CPT Manual or CMS manual coding instructions	1
99213	CPT Manual or CMS manual coding instructions	1
99214	CPT Manual or CMS manual coding instructions	1
99215	CPT Manual or CMS manual coding instructions	1
99483	CPT Manual or CMS manual coding instructions	1

99497	CPT Manual or CMS manual coding instructions	1
G0463	CPT Manual or CMS manual coding instructions	1

Medicaid CCI Edits Alert

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
61650	Misuse of column two code with column one code	1
49010	CPT "separate procedure" definition	0
36592	CPT Manual or CMS manual coding instructions	0
36591	CPT Manual or CMS manual coding instructions	0
36410	Standards of medical / surgical practice	1
36000	Standards of medical / surgical practice	1
0218T	Misuse of column two code with column one code	1
0217T	Misuse of column two code with column one code	1
0216T	Misuse of column two code with column one code	1
0215T	Misuse of column two code with column one code	1
0214T	Misuse of column two code with column one code	1
0213T	Misuse of column two code with column one code	1
G0463	CPT Manual or CMS manual coding instructions	1
99497	CPT Manual or CMS manual coding instructions	1
99483	CPT Manual or CMS manual coding instructions	1
99245	CPT Manual or CMS manual coding instructions	1
99244	CPT Manual or CMS manual coding instructions	1
99243	CPT Manual or CMS manual coding instructions	1
99242	CPT Manual or CMS manual coding instructions	1
99241	CPT Manual or CMS manual coding instructions	1
99215	CPT Manual or CMS manual coding instructions	1

99214	CPT Manual or CMS manual coding instructions	1
99213	CPT Manual or CMS manual coding instructions	1
99212	CPT Manual or CMS manual coding instructions	1
99211	CPT Manual or CMS manual coding instructions	1
99205	CPT Manual or CMS manual coding instructions	1
99204	CPT Manual or CMS manual coding instructions	1
99203	CPT Manual or CMS manual coding instructions	1
99202	CPT Manual or CMS manual coding instructions	1
99201	CPT Manual or CMS manual coding instructions	1
96523	CPT Manual or CMS manual coding instructions	0
96377	Standards of medical / surgical practice	1
96376	Standards of medical / surgical practice	1
96375	Standards of medical / surgical practice	1
96374	Standards of medical / surgical practice	1
96372	Standards of medical / surgical practice	1
96365	Standards of medical / surgical practice	1
96360	Standards of medical / surgical practice	1
69990	Misuse of column two code with column one code	0
64495	Misuse of column two code with column one code	1
64494	Misuse of column two code with column one code	1
64493	Misuse of column two code with column one code	1
64492	Misuse of column two code with column one code	1
64491	Misuse of column two code with column one code	1
64490	Misuse of column two code with column one code	1
64489	Misuse of column two code with column one code	1
64488	Misuse of column two code with column one code	1
64487	Misuse of column two code with column one code	1
64486	Misuse of column two code with column one code	1

64450	Misuse of column two code with column one code	1
64417	Misuse of column two code with column one code	1
64416	Misuse of column two code with column one code	1
64415	Misuse of column two code with column one code	1
62327	Misuse of column two code with column one code	1
62326	Misuse of column two code with column one code	1
62325	Misuse of column two code with column one code	1
62324	Misuse of column two code with column one code	1

ICD-10 Crossref

O89.3 : Toxic reaction to local anesthesia during the puerperium
O89.4 : Spinal and epidural anesthesia-induced headache during the puerperium
O89.6 : Failed or difficult intubation for anesthesia during the puerperium
O92.02 : Retracted nipple associated with the puerperium
O92.12 : Cracked nipple associated with the puerperium
Z39.0 : Encounter for care and examination of mother immediately after delivery
Z39.1 : Encounter for care and examination of lactating mother
Z39.2 : Encounter for routine postpartum follow-up

HCPCS Crossref

No data available.

Modifier Crossref

22 : Increased Procedural Services
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
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
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

For this service, the provider or nonphysician healthcare professional provides care to the patient in the outpatient setting following the delivery. Routine postpartum care can involve one or more visits up to six weeks following delivery.

Clinical Responsibility

Typical postpartum care includes ongoing evaluation of the mother’s physical and mental status following birth, a physical examination to ensure that the mother is recovering normally, discussion of lactation, nutrition, and exercise after delivery, review or initiation of birth control options, evaluation of immunizations, and collection of a screening Pap smear specimen if warranted. The first visit can be at four to six weeks following vaginal delivery, but if the patient has a cesarean delivery, the first visit may be seven to fourteen days following delivery and includes minor cesarean wound care. The physical examination should include measuring weight and blood pressure, and an examination of the breasts, abdomen, as well as a pelvic exam. The provider will also incorporate preconceptual counseling into postpartum care, when appropriate, to prepare the patient for a future pregnancy.

Terminology

Cesarean section, C section: A surgical procedure to deliver an infant through an incision rather than vaginally; also called a surgical birth or a cesarean delivery.

Postpartum period: Period from the termination of labor to complete reduction of the uterus to its normal nonpregnant size and state, usually about forty two days.

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

This code is not an ASC approved procedure.

Upcoming and Historical Information

01-01-1990	Code Added