CPT® Code 59414 Details

Code Symbols

♀ : Female
M : Maternity

Code Descriptor

Delivery of placenta (separate procedure)
Notes:
(For antepartum care only, see 59425, 59426 or appropriate E/M code[s])

(For 1-3 antepartum care visits, see appropriate E/M code[s])

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	$95.50	$122.71	$0.00	$0.00	$0.00
Non Facility	$95.50	$122.71	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	1.61	2.42	0.00	0.00	0.00
PE RVU:	0.62	0.69	0.00	0.00	0.00
Malpractice RVU:	0.42	0.30	0.00	0.00	0.00
Total RVU:	2.65	3.40	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	1.61	2.42	0.00	0.00	0.00
PE RVU:	0.62	0.69	0.00	0.00	0.00
Malpractice RVU:	0.42	0.30	0.00	0.00	0.00
Total RVU:	2.65	3.40	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	1	3	Nature of Service/Procedure
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	1	3	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 59414

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 59414

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
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
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
59430	CPT "separate procedure" definition	0
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
G0471	Standards of medical / surgical practice	0

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
G0471	Standards of medical / surgical practice	0
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
64484	Anesthesia service included in surgical procedure	0
64483	Anesthesia service included in surgical procedure	0
64450	Misuse of column two code with column one code	1
64435	Anesthesia service included in surgical procedure	0
64430	Anesthesia service included in surgical procedure	0
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
62323	Anesthesia service included in surgical procedure	0
62322	Anesthesia service included in surgical procedure	0
61650	Misuse of column two code with column one code	1
59430	CPT "separate procedure" definition	0
51702	Standards of medical / surgical practice	0
51701	Standards of medical / surgical practice	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
0231T	Anesthesia service included in surgical procedure	0
0230T	Anesthesia service included in surgical procedure	0
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
01967	Anesthesia service included in surgical procedure	0
01960	Anesthesia service included in surgical procedure	0

ICD-10 Crossref

O44.20 : Partial placenta previa NOS or without hemorrhage, unspecified trimester
O44.21 : Partial placenta previa NOS or without hemorrhage, first trimester
O44.22 : Partial placenta previa NOS or without hemorrhage, second trimester
O44.23 : Partial placenta previa NOS or without hemorrhage, third trimester
O44.30 : Partial placenta previa with hemorrhage, unspecified trimester
O44.31 : Partial placenta previa with hemorrhage, first trimester
O44.32 : Partial placenta previa with hemorrhage, second trimester
O44.33 : Partial placenta previa with hemorrhage, third trimester
O44.40 : Low lying placenta NOS or without hemorrhage, unspecified trimester
O44.41 : Low lying placenta NOS or without hemorrhage, first trimester
O44.42 : Low lying placenta NOS or without hemorrhage, second trimester
O44.43 : Low lying placenta NOS or without hemorrhage, third trimester
O44.50 : Low lying placenta with hemorrhage, unspecified trimester
O44.51 : Low lying placenta with hemorrhage, first trimester
O44.52 : Low lying placenta with hemorrhage, second trimester
O44.53 : Low lying placenta with hemorrhage, third trimester
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
O60.22X1 : 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
O60.23X1 : 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
O73.0 : Retained placenta without hemorrhage

O73.1 : Retained portions of placenta and membranes, without hemorrhage
O89.3 : Toxic reaction to local anesthesia during the puerperium

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HCPCS Crossref

No data available.

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
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
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, a provider who did not perform the delivery manually removes the afterbirth.

Clinical Responsibility

The patient is in lithotomy position after delivery. The physician examines her for a retained placenta. He is given IV sedation for this procedure if she has not already been given an anesthetic for the birth. The physician inserts his or her hand into the uterus to try to evacuate the placenta and uses the other hand to exert pressure on the top of the uterus from outside. This may take several attempts, but the physician ensures that the patient's uterus is contracting during this procedure to ease the placenta out. Once the placenta is released, the physician examines it for completeness of all tissue.

Terminology

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

Lithotomy position: The patient rests on her back with knees bent, positioned above the hips, and spread apart through the use of stirrups

Placenta: An organ that forms during pregnancy to provide oxygen and nutrients to the fetus and which removes waste products from the fetal blood supply; it attaches to the wall of the uterus, and the umbilical cord arises from it; the placenta usually attaches at the top of side of the uterus.

Umbilical cord: The connecting stalk between the fetus and the placenta, normally containing two umbilical arteries and one umbilical vein; the umbilical vein supplies the fetus with oxygenated, nutrient rich blood from the placenta and the umbilical arteries transport deoxygenated, nutrient depleted blood from the fetal heart back to the placenta.

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.

Tips

The delivering provider may not report this code.

All deliveries require removal of the placenta whether it occurs immediately after birth or much later, even if the provider uses forceps or does a manual extraction of the placenta.

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

OPPS Non-Facility Payment Amount: $58.02
OPPS Facility Payment Amount: $58.02
Subject to Multiple Procedure Discounting: Y
ASC Payment Amount: $1,157.19
Payment Indicator: G2
Status Indicator: J1
Payment Indicator Definition: Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
Changed since Last Quarter: N

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

01-01-1990	Code Added