CPT® Code 59899 Details

Code Symbols

♀ : Female
M : Maternity

Code Descriptor

Unlisted procedure, maternity care and delivery

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 C
C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

Medicare Fees					
	National	**Adjusted**	**26**	**TC**	**53**
Facility	$0.00	$0.00	$0.00	$0.00	$0.00

CPT® 2018 American Medical Association. All rights reserved.

Non Facility	$0.00	$0.00	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.00	0.00	0.00	0.00	0.00
PE RVU:	0.00	0.00	0.00	0.00	0.00
Malpractice RVU:	0.00	0.00	0.00	0.00	0.00
Total RVU:	0.00	0.00	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.00	0.00	0.00	0.00	0.00
PE RVU:	0.00	0.00	0.00	0.00	0.00
Malpractice RVU:	0.00	0.00	0.00	0.00	0.00
Total RVU:	0.00	0.00	0.00	0.00	0.00

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

YYY = The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

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)**

CPT® 2018 American Medical Association. All rights reserved.

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

80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

CO-SURG	62	Co-surgeon payment allowed when supported

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.

1 = Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.

TEAM SURG	66	Team payment allowed when supported

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.

CPT® 2018 American Medical Association. All rights reserved.

1 = Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report.		
MINIMUM ASST SURG	81	Assistant payment allowed.
81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment 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)		
2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may 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	3	Clinical: CMS Workgroup
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	1	3	Clinical: CMS Workgroup

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

CPT® 2018 American Medical Association. All rights reserved.

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 59899

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 59899

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
96523	CPT Manual or CMS manual coding instructions	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
96523	CPT Manual or CMS manual coding instructions	0

ICD-10 Crossref

O09.00 : Supervision of pregnancy with history of infertility, unspecified trimester
O09.211 : Supervision of pregnancy with history of pre-term labor, first trimester
O09.291 : Supervision of pregnancy with other poor reproductive or obstetric history, first trimester
O09.891 : Supervision of other high risk pregnancies, first trimester
O09.892 : Supervision of other high risk pregnancies, second trimester
O09.893 : Supervision of other high risk pregnancies, third trimester
O09.899 : Supervision of other high risk pregnancies, unspecified trimester

CPT® 2018 American Medical Association. All rights reserved.

O33.7XX0 : Maternal care for disproportion due to other fetal deformities, not applicable or unspecified
O33.7XX1 : Maternal care for disproportion due to other fetal deformities, fetus 1
O33.7XX2 : Maternal care for disproportion due to other fetal deformities, fetus 2
O33.7XX3 : Maternal care for disproportion due to other fetal deformities, fetus 3
O33.7XX4 : Maternal care for disproportion due to other fetal deformities, fetus 4
O33.7XX5 : Maternal care for disproportion due to other fetal deformities, fetus 5
O33.7XX9 : Maternal care for disproportion due to other fetal deformities, other fetus
O34.211 : Maternal care for low transverse scar from previous cesarean delivery
O34.212 : Maternal care for vertical scar from previous cesarean delivery
O34.219 : Maternal care for unspecified type scar from previous cesarean delivery
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
O70.20 : Third degree perineal laceration during delivery, unspecified
O70.21 : Third degree perineal laceration during delivery, IIIa
O70.22 : Third degree perineal laceration during delivery, IIIb
O70.23 : Third degree perineal laceration during delivery, IIIc
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

HCPCS Crossref

No data available.

Anesthesia Crossref

-00006
Base Unit Value: N/A : *** UNLISTED CODES ARE NON-SPECIFIC. SELECT THE ANESTHESIA CODE THAT BEST CORRESPONDS TO THE SPECIFIC PROCEDURE PERFORMED ***

Anesthesia Tips: N/A

CPT® 2018 American Medical Association. All rights reserved.

Modifier Crossref

51 : Multiple Procedures
52 : Reduced Services
53 : Discontinued Procedure
59 : Distinct Procedural Service
62 : Two Surgeons
78 : Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
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)
AR : Physician provider services in a physician scarcity area
AS : Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
GY : Item or service statutorily excluded, does not meet the definition of any medicare benefit or, for non-medicare insurers, is not a contract benefit
GZ : Item or service expected to be denied as not reasonable and necessary
KX : Requirements specified in the medical policy have been met
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

---

CPT® Lay Terms

Use 59899 to report procedures in maternity care and delivery that do not have a specific code.

Clinical Responsibility

The provider performs a procedure while the patient is pregnant or at the time of delivery that is not represented by any of the standard and active CPT® codes available.

Tips

CPT® guidelines instruct that you should not choose a code that merely approximates the service provided. You should report the service using only the appropriate unlisted procedure code if no such specific procedure or service code exists.

You must report a Category III code when available in place of an unlisted procedure code.

When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined, active code. Include one or more similar codes, and compare your service to those codes to justify the claim amount you are billing. Also include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payers will consider claims with unlisted procedure codes on a case by case basis, and they will determine payment based on the documentation you provide.

CPT® 2018 American Medical Association. All rights reserved.

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: 5411
APC descriptor: Level 1 Gynecologic Procedures
Status indicator: T

CPT® 2018 American Medical Association. All rights reserved.

Status Definition: Procedure or Service, Multiple Procedure Reduction Applies
OPPS Payment Status: Paid under OPPS; separate APC payment.
Changed since last quarter: N
Medicare payment rate: $165.93
Nat'l unadjusted copay: $0.00
Min unadjusted copay: $33.19

Upcoming and Historical Information

01-01-1990	Code Added

CPT® 2018 American Medical Association. All rights reserved.