Long-Acting Reversible Contraception Quick Coding Guide

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http://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception

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Office Visits Coding			
Site	Diagnosis Code	Procedures/Supplies	Modifier
Office visit	**V23.83** Young Primigravida	Code 99202-57 new patient, typical time of 20 minutes	57
	V25.09 Contraceptive management, general counseling and advice		
Outpatient center	**635.92** Legally induced abortion without mention of complications **V61.7** Other unwanted pregnancy	59840 D&C	51
	V25.5 Insertion of implantable subdermal contraceptive	11981-51 Implant Insertion PCS (Healthcare Procedural Coding System) supply code J7307Etonogestrel contraceptive implant system, including implant	

		and supplies	

Evaluation and Management (E/M) Coding

If a patient comes in to discuss contraception options but no procedure is provided at that visit

If a patient comes in to discuss contraception options but no procedure is provided at that visit	❖ If the discussion takes place during an annual preventive visit (99381–99387 or 99391–99397), it is included in the Preventive Medicine code. The discussion is not reported separately. ❖ If the discussion takes place during an E/M office or outpatient visit (99201–99215), an E/M services code may be reported if an E/M service (including history, physical examination, or medical decision making or time spent counseling) is documented. Link the E/M code to ICD-9-CM diagnosis code V25.09 (General family planning counseling and advice).
If discussion of contraceptive options takes place during the same encounter as a procedure, such as insertion of a contraceptive implant or IUD, it may or may not be appropriate to report both an E/M services code and the procedure code:	❖ If the clinician and patient discuss a number of contraceptive options, decide on a method, and then an implant or IUD is inserted during the visit, an E/M service may be reported, depending on the documentation. ❖ If the patient comes into the office and states, "I want an IUD," followed by a brief discussion of the benefits and risks and the insertion, an E/M service is not reported since the E/M services are minimal. ❖ If the patient comes in for another reason and, during the same visit, a procedure is performed, then both the E/M services code and procedure may be reported. (If reporting both an E/M service and a procedure, the documentation must indicate a significant, separately identifiable E/M service. The documentation must indicate either the key components (history, physical examination, and medical decision making) or time spent counseling. Counseling must be documented as more than 50% of the time spent face-to-face with the patient.)

The following are scenarios to better assist you and your understanding of coding of this section:

Scenario #1

Removal and Reinsertion

Ms. L had a levonorgestrel IUD inserted six years ago. She sees Dr. M for removal of the IUD and insertion of a new one. Ms. L tells Dr. M that she has had no problems with the IUD over the last few years. The nurse takes her vital signs. Dr. M removes the IUD and inserts a new levonorgestrel IUD.

How should Dr. M code for this visit?

Dr. M reports codes 58301 (removal) and 58300-51 (insertion) and J7302 (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) for the IUD. The diagnosis code is V25.13 (removal and reinsertion of IUD). Note that modifier 51 (multiple procedures) is added to the lesser procedure. No E/M services code is reported since the brief discussion and taking of vital signs is not a significant service.

Scenario # 2

Missing String

Ms. R sees Dr. S because she cannot feel the string from an IUD inserted last year. Dr. S completes an examination and locates the string.

How should Dr. S code for this visit?

Coding will depend on the extent of the work involved. If Dr. S performs an examination and finds the missing string fairly easily, she will report a low level E/M services code linked to diagnosis V25.42 (surveillance of previously prescribed IUD).

If, on the other hand, a more extensive examination is needed, she reports a higher level of E/M service linked to diagnosis 996.32 (mechanical complication of IUD).

If the IUD had been removed during this visit, she would report 58301-22 (removal) instead of an E/M service. The modifier 22 indicates that this was more difficult than a simple removal of the IUD. A diagnosis 996.32 (mechanical complication of IUD) would help support the use of the modifier 22, but documentation must also indicate the additional work performed and risk to the patient.

Basic Contraceptive Implant Coding	
Contraceptive implant is a single-rod etonogestrel-releasing contraceptive device inserted under the skin of the upper arm.	
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
The diagnostic coding will vary, but usually will be selected from the V25 (Encounter for contraceptive management) series in ICD-9-CM.	
V25.5	Encounter for contraceptive management, insertion of implantable subdermal contraceptive
V25.43	Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive. This code is reported for checking, reinsertion, or removal of the implant.
CPT **(**Current Procedural Terminology) procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS (Healthcare Procedural Coding System) code.	
J7307	Etonogestrel [contraceptive] implant system, including implant and supplies

The following are scenarios to better assist you and your understanding of coding of this section:

Scenario #1

IUD Removal and Implant Insertion

Ms. P, an established patient, sees Dr. Q. She had an IUD inserted 5 years ago but is now experiencing bleeding and cramping. Dr. Q does an expanded problem-focused examination and takes additional history. They discuss removal of the IUD and other possible contraceptive methods.

Dr. Q suggests an implant. After a brief discussion, Ms. P agrees. Dr. Q removes the IUD without problems and inserts an implant.

How should Dr. Q code for this visit?

Dr. Q reports codes 11981 (implant insertion) and 58301-51 for the IUD removal. Code 11981 is reported first because it has the higher RVU (2.67 vs. 2.54), and the modifier 51 (multiple procedures) is added to the lesser procedure. Dr. Q also reports the diagnosis codes V25.42 (IUD surveillance), V25.12 (IUD removal), and V25.5 (implant insertion) and the J7307 (Etonogestrel [contraceptive] implant system, including implant and supplies) supply code.

Dr. Q might also report an E/M services code for the examination, history, and medical decision making if his documentation is sufficient. If an E/M services code is reported, a modifier 25 (significant, separately identifiable E/M service) is added. This code is linked to diagnoses for pain, cramping, and complications of an IUD, if appropriate.

Scenario #2

Post-Abortion Insertion

Ms. J, a new patient of Dr. K, is 15 years old. Ms. J comes into the office stating she is 12 weeks pregnant and denies pain or cramping. She requests an abortion. Ms. J and Dr. K discuss the procedure and contraceptive options. After a discussion of the benefits and risks of a number of different contraceptive methods and a brief physical examination to confirm the pregnancy, a D&C is scheduled for the next day. An implant will also be inserted at this time. This initial visit lasted 20 minutes, including 15 minutes spent counseling. The content of the counseling is documented in the medical record.

The next day, Ms. J comes to the outpatient center for the abortion. Dr. K takes her temperature and blood pressure and asks if there are any changes in her condition. Dr. K performs the D&C and inserts a contraceptive implant.

How should Dr. K code for the office visit and outpatient procedures?

The table below summarizes codes reported for this scenario. For the initial office visit, Dr. K reports an E/M service. The documentation shows that more than 50% of the time spent face-to-face with the patient was spent counseling Ms. J on contraceptive choices. Therefore, Dr. K reports E/M code 99202-57 (new patient, typical time of 20 minutes). Modifier 57 indicates that a decision for surgery was made during this visit. Note that if the initial visit had been more than 1 day before the surgery, the modifier is not needed. The diagnosis codes are V23.83 (young primigravida) and V25.09 (contraceptive counseling and advice).

For the outpatient center visit, Dr. K reports codes 59840 (D&C), 11981-51 (implant insertion), and HCPCS supply code J7307 for the implant. Note that modifier 51 (multiple procedures) is added to the lesser procedure. The E/M services (taking her temperature, etc.) are part of the preoperative care and not reported separately. The diagnosis codes are 635.92 (legally induced abortion without mention of complications), V61.7 (other, unwanted pregnancy), and V25.5 (insertion of implantable subdermal contraceptive). Code V23.83 (young primigravida) might also be used, but is not required.

Scenario # 3

Pain at Insertion Site

Ms. C had an implant inserted 2 weeks ago. She returns to Dr. D's office with complaints of pain at the insertion site and dizziness. Dr. D examines the insertion site and has a 15 minute discussion with her about whether to keep or remove the implant. Ms. C decides not to remove the implant at this time, and will return to the office in a month if symptoms continue. The total time for the visit was 20 minutes, including the 15 minutes of counseling.

How should Dr. D code for this visit?

More than half of the time spent face-to-face with the patient was spent counseling, therefore Dr. D reports E/M code 99213 (established outpatient) based on time. The diagnosis codes are V25.43 (checking, implantable subdermal contraceptive), 729.5 (pain in limb), and 780.4 (dizziness).

Basic IUD Coding	
The insertion and/or removal of IUDs are reported using one of the following CPT codes:	
58300	Insertion of IUD
58301	Removal of IUD
Most IUD services will be linked to a diagnosis code from the V25 series (Encounter for contraceptive management):	
V25.11	Insertion of intrauterine contraceptive device
V25.12	Removal of intrauterine contraceptive device
V25.13	Removal and reinsertion of intrauterine contraceptive device
V25.42	Surveillance of previously prescribed contraceptive method, intrauterine device
CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS code:	
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg

The following are scenarios to better assist you and your understanding of coding of this section:

Scenario #1

Hysteroscopic Removal

Ms. V had an IUD inserted two years ago and is having severe cramping and menorrhagia. Dr. W does an examination, takes a history, and decides that the IUD is impacted. Dr. W completes a hysteroscopic removal of the IUD.

How should Dr. W code for this visit?

Dr. W reports an E/M services code with a 25 modifier for the examination, and code 58562 (hysteroscopy, surgical; with removal of impacted foreign body). The diagnosis code is 996.32 (mechanical complication of IUD).

The modifier 25 is added to the E/M code to indicate that a significant, separately identifiable E/M service was provided on the same day as a procedure. The E/M service and the procedure should be clearly documented in separate sections of the record.

Scenario # 2

Post-Miscarriage Insertion

Ms. N is 10 weeks pregnant and comes in to see Dr. O because of heavy vaginal bleeding. She had seen Dr. O previously for obstetric care. Dr. O performs an examination, asks some questions, and performs a limited ultrasound. He decides Ms. N is having a miscarriage and counsels her for 15 minutes about the incidence, possible causes, and prognosis of miscarriage, and suggests immediate treatment. Ms. N also requests insertion of a copper IUD. Dr. O completes the miscarriage surgically and inserts an IUD during this visit. The total time for the visit is 25 minutes.

How should Dr. O code for these services?

Dr. O reports codes 76817 (transvaginal ultrasound), 59812 (incomplete abortion completed surgically) and 58300-51 (IUD insertion). HCPCS code J7300 (copper IUD) is reported for the IUD supply. The diagnosis codes are 634.71 (spontaneous abortion with other specified complications, incomplete) and V25.11 (insertion of IUD). More than half of the time spent face-to-face with the patient was spent counseling, therefore Dr. O reports E/M code 99214 (typical time of 25 minutes). The topics discussed must be documented.

If the miscarriage was complete (requiring no surgical intervention), Dr. O would have reported an E/M service with a modifier 25 (significant, separately identifiable E/M service), plus 58300 for the IUD insertion.

Scenario #3

Difficult Insertion

Ms. T sees Dr. U, and requests insertion of a copper IUD. Ms. T weighs 220 lbs and has a BMI of 40.2. Dr. U inserts an IUD with some difficulty due to Ms. T's body habitus.

How should Dr. U code for this visit?

Dr. U reports 58300-22 (insertion) and J7300 (intrauterine copper contraceptive) for the IUD supply. No E/M services code is reported. Dr. U documents the additional work, complexity, and risk to the patient involved in this case to support use of the modifier 22. The diagnosis codes are V25.11 (insertion of IUD), V85.4 (BMI), and 278.01 (morbid obesity).

Coding for Same Day Removal and Reinsertion

Implant

CPT Procedures	Modifier	Diagnosis (ES)
11983 Removal with reinsertion, non-biodegradable drug delivery implant		V25.43 Checking, reinsertion, or removal of implantable subdermal contraceptive
992XX E/M based either on the key components or time spent counseling	25	V25.43 Checking, reinsertion, or removal of implantable subdermal contraceptive

HCPCS Supply Codes

CPT Procedures	Diagnosis (ES)
J7307 Etonogestrel [contraceptive] implant system, including implant and supplies	V25.43 Checking, reinsertion, or removal of implantable subdermal contraceptive

IUD

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
58300 Insertion of IUD	V25.11	V25.11 Insertion of intrauterine contraceptive device
58300 Insertion of IUD	51	
992XX	25	V25.13

E/M based either on the key components or time spend counseling		Removal and reinsertion of intrauterine contraceptive device
HCPCS Supply Codes		
J7300 Intrauterine copper contraceptive		V25.13 Insertion of intrauterine contraceptive device
J7302 Leveonorgestrel-releasing intrauterine contraceptive system, 52mg		V25.13 Insertion of intrauterine contraception device

The following are scenarios to better assist you and your understanding of coding of this section:

Scenario #1

Discontinued Insertion

Ms. X sees Dr. Y, and requests insertion of an IUD. She is a new patient. After a brief discussion of the benefits and risks, Dr. Y attempts to insert a copper IUD. Dr. Y tries several times to insert the device, but Ms. X's cervical os is stenotic, and Ms. X is experiencing a great deal of pain. Dr. Y discontinues the procedure.

Dr. Y discusses other possible methods of contraception with Ms. X and she decides to try oral contraceptives. This conversation lasts 20 minutes. The total time of the office visit was 35 minutes.

How should Dr. Y code for the discontinued procedure and the visit?

Dr. Y reports 58300-53 (insertion) and J7300 (intrauterine copper contraceptive) for the IUD supply. The modifier 53 indicates that the procedure was attempted but unsuccessful. Dr. Y can also report E/M code 99203-25 (new patient office visit) for the counseling, since more than half of the E/M services time with the patient was spent in counseling. The medical record must include the subjects discussed, the time spent counseling, and

Works Cited

America Medical Association (AMA). (2012). Coding for the contraceptive implant and iuds. In *The American College of Obstertricians and Gynecologists* . Washington, DC: Retrieved from http://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception/Coding_and_Reimbursement_for_LARC