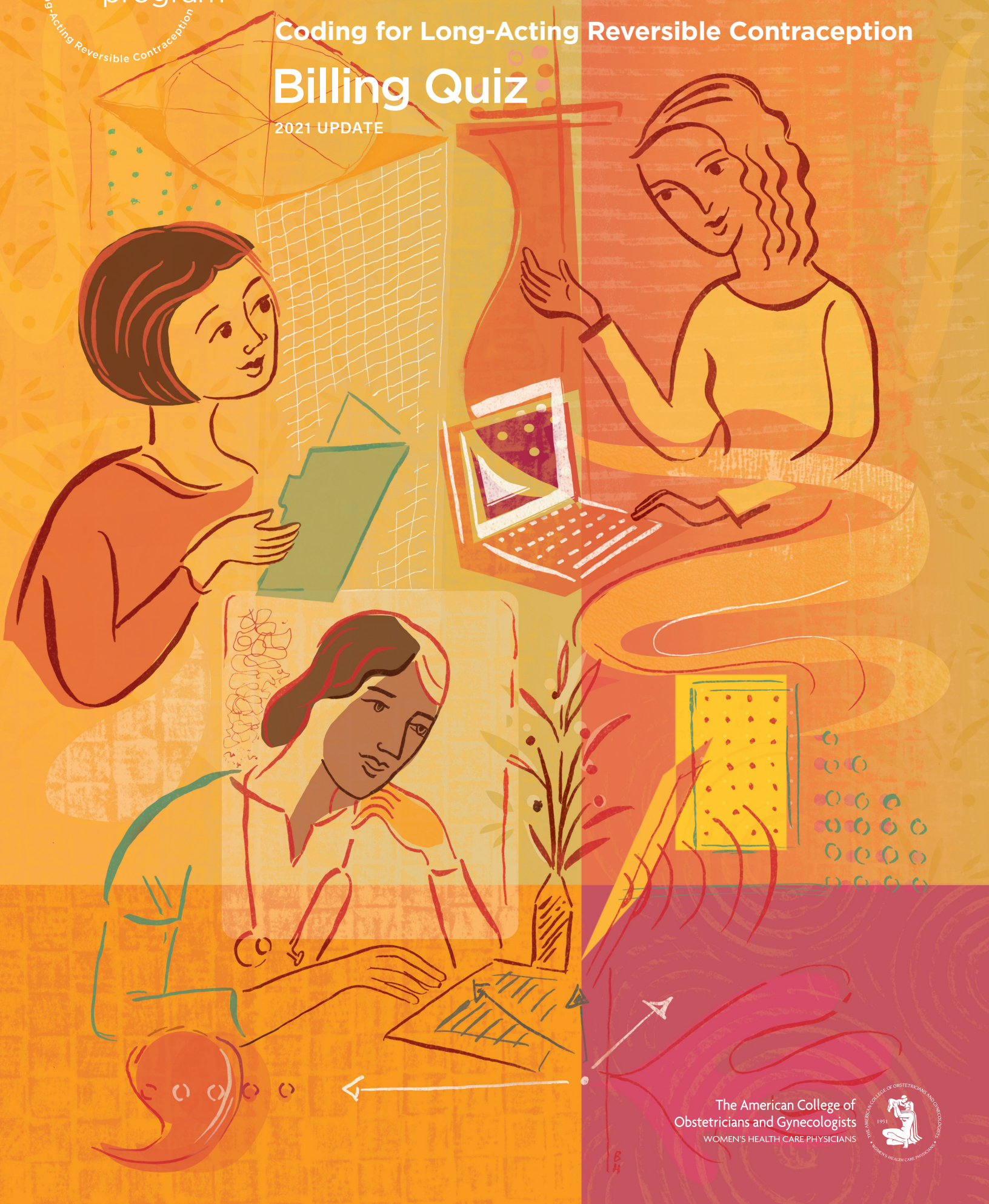
the LARC program
Long-Acting Reversible Contraception

Coding for Long-Acting Reversible Contraception

Billing Quiz

2021 UPDATE



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care.
It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center.

While ACOG makes every effort to present accurate and reliable information, this publication is provided "as is" without any warranty of accuracy, reliability, or otherwise, either express or implied. ACOG does not guarantee, warrant, or endorse the products or services of any firm, organization, or person. Neither ACOG nor its officers, directors, members, employees, or agents will be liable for any loss, damage, or claim with respect to any liabilities, including direct, special, indirect, or consequential damages, incurred in connection with this publication or reliance on the information presented.

Billing Quiz

2021 UPDATE

CORRECT CODING can result in more appropriate compensation for services. To help practices master coding for the contraceptive implant and intrauterine devices (IUDs), the American College of Obstetricians and Gynecologists' Long-Acting Reversible Contraception (LARC) Program, in collaboration with the ACOG Practice Management Department, has developed this updated billing quiz for LARC methods. The scenarios and answers offer examples of possible appropriate coding in a variety of situations, and their inclusion is not meant to imply that they are the only clinical solutions or correct coding for a particular scenario. Quiz yourself and test your coding knowledge by first reviewing and trying to code each scenario. Answers, developed by coding experts, are provided after each scenario.

The information included in this guide is current as of March 9, 2021.

For more information about the LARC Program and additional LARC coding and clinical resources, go to **www.acog.org/larc**.

ACOG FELLOWS AND THEIR STAFF can submit specific coding questions to the ACOG Payment Advocacy and Policy Portal at acogcoding.freshdesk.com. Questions are answered in the order received, usually within 1 week. There is no charge for this service.

Contraceptive Implant

SCENARIO 1

Removal

Ms. A had an implant inserted 2 years ago, and has now decided she would like to become pregnant. Dr. B provides 15 minutes of prepregnancy counseling and then removes the implant.

How should Dr. B code for this visit?

Dr. B reports an E/M service 99401-25 (preventive medicine counseling, 15 minutes) and 11982 (implant removal). The modifier 25 indicates that a significant and separately identifiable E/M service was provided on the same day as a procedure. The diagnoses are Z31.69 (procreative counseling and advice) and Z30.46 (surveillance of implantable subdermal contraceptive [includes removal]).

SCENARIO 2

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?

If Dr. D chooses to report E/M office visit level based on time, CPT code 99213 (established outpatient visit, 20-29 minutes total time) is most appropriate. The diagnosis codes are Z30.46 (surveillance of implantable subdermal contraceptive), M79.603 (pain in arm, unspecified), and R42 (dizziness).

SCENARIO 3

Consultation

Ms. E is sent to Dr. G by Dr. F. Dr. F asks Dr. G to evaluate whether Ms. E is a good candidate for the contraceptive implant. Dr. G performs a detailed history and physical examination with low medical decision making, and has a brief discussion with the patient concerning the benefits and risks of this contraceptive method. He writes a report on his findings and sends it back to Dr. F.

How should Dr. G code for this visit?

Dr. G reports an office consultation code 99243. The diagnosis is Z01.818 (pre-procedural examination).

A consultation requires that doctor #1 asks doctor #2 for his or her opinion about how a patient should be managed. Both the request and need for the consultation must be documented in the patient's medical record. Doctor #2 then sends back his or her opinion on how doctor #1 should manage the patient.

Note that Medicaid and some private payers do not reimburse for consultation codes. To avoid claim denials, providers should check with payers to determine if they reimburse for consultation codes.

SCENARIO 4

Removal with Reinsertion

Ms. H has had an implant for 3 years. She is not planning on having children for 3–5 years, and would like another implant. Dr. I asks a few questions about any problems she has had with the implant and has Ms. H sign a consent form. No other issues are discussed, and Dr. I removes the old implant and inserts a new one all during this one visit.

How should Dr. I code for this visit?

Dr. I reports CPT code 11983 (implant removal with reinsertion) and a supply code of J7307 for the implant. The diagnosis is Z30.46 (surveillance of implantable subdermal contraceptive [includes reinsertion]). No E/M services are reported for the brief discussion with the patient prior to the removal and reinsertion procedures.

SCENARIO 5

Post-Abortion Insertion

Ms. J, a new patient of Dr. K, is 18 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 into Ms. J's arm.

(continued on next page)

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 the total time on the date-of-service was 20 minutes. Therefore, Dr. K reports E/M code 99202-57 (new outpatient visit, 15-29 minutes of total time). 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 code is Z30.017 (initial prescription of implantable subdermal contraceptive). Code Z3A.12 (12 weeks gestation of pregnancy) might also be used, but is not required.

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 Z33.2 (elective termination of pregnancy), Z64.0 (problems related to unwanted pregnancy), and Z30.017 (initial prescription of implantable subdermal contraceptive [includes insertion]).

SITE	DIAGNOSIS CODE	PROCEDURES/SUPPLIES	MODIFIER
Office visit	Z30.017 Encounter for initial prescription of implantable subdermal contraceptive	99202 New outpatient visit, 15-29 minutes of total time	57
Outpatient center	Z33.2 Encounter for elective termination of pregnancy Z64.0 Problems related to unwanted pregnancy	59840 Induced abortion by D&C	
	Z30.017 Encounter for initial prescription of implantable subdermal contraceptive (includes insertion)	11981 Insertion, non-biodegradable drug delivery implant J7307 Etonogestrel (contraceptive) implant system, including implant and supplies	51

SCENARIO 6

Immediate Postpartum Insertion

Ms. L is a 28 year old G4P3 patient of Dr. M. She delivered all previous pregnancies vaginally. During antepartum care, counseling was provided about the benefits and risks of all contraceptive methods, and Ms. L expressed desire to use a contraceptive implant postpartum. The decision was made to have the implant inserted immediately after delivery.

At 39 weeks 0 days following an uncomplicated antepartum course, Ms. L presents to the hospital. Dr. M delivers Ms. L's fourth child vaginally and immediately inserts a contraceptive implant. She is scheduled for her routine six week postpartum visit.

How should Dr. M code for the global obstetric care and postpartum implant insertion?

The table below summarizes the codes reported for this scenario. For obstetric services, Dr. M reports global CPT code 59400 (routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy, and/or forceps] and postpartum care) with outcome of delivery diagnosis codes O80 (full-term uncomplicated delivery), Z37.0 (single live birth), and Z3A.39 (39 weeks gestation of pregnancy).

For the implant, Dr. M reports 11981-51 (insertion) and J7307 (etonogestrel [contraceptive] implant system, including implant and supplies) supply code. Since the implant was inserted immediately after delivery, the modifier 51 (multiple procedures) is added to the lesser procedure. No E/M services code is reported since counseling on contraception was provided during antepartum care visit and included into the global code. The diagnosis code is Z30.017 (initial prescription of implantable subdermal contraceptive [includes insertion]).

Note that coverage of immediate postpartum LARC varies by payer and state. A list of states with published guidance on Medicaid reimbursement for postpartum LARC can be found at **www.acog.org/IPPLARCmedicaid**. To avoid claim denials, providers should check with payers to determine if they reimburse for immediate postpartum LARC and how to bill appropriately to ensure reimbursement.

DIAGNOSIS CODE		PROCEDURES/SUPPLIES		MODIFIER
O80	Encounter for full-term uncomplicated delivery	59400	Routine obstetric care including antepartum vaginal delivery and postpartum care	
Z37.0	Single live birth			
Z3A.39	39 weeks gestation of pregnancy			
Z30.017	Encounter for initial prescription of implantable subdermal contraceptive (includes insertion)	11981	Insertion, non-biodegradable drug delivery implant	51
		J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	

Intrauterine Device

SCENARIO 1

Removal and Reinsertion

Ms. N had a 52 mg, 6 year duration levonorgestrel IUD inserted seven years ago. She sees Dr. O for removal of the IUD and insertion of a new one. Ms. N tells Dr. O that she has had no problems with the IUD over the last few years. The nurse takes her vital signs. Dr. O removes the IUD and inserts a new 52 mg, 6 year duration levonorgestrel IUD.

How should Dr. O code for this visit?

Dr. O reports codes 58301 (removal) and 58300-51 (insertion) and J7298 (levonorgestrel-releasing intrauterine contraceptive system [Mirena®], 52 mg [6 year duration]) for the IUD. The diagnosis code is Z30.433 (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. To avoid claim denials, providers should check with payers to determine if they reimburse for both removal and reinsertion and how to bill appropriately to ensure reimbursement.

SCENARIO 2

Post-Miscarriage Insertion

Ms. P is 10 weeks pregnant and comes in to see Dr. Q because of heavy vaginal bleeding. She had seen Dr. Q previously for obstetric care. Dr. Q performs an examination, asks some questions, and performs a limited ultrasound. He decides Ms. P is having a miscarriage and counsels her for 25 minutes about the incidence, possible causes, and prognosis of miscarriage, and suggests immediate treatment. Ms. P also requests insertion of a copper IUD. Dr. Q completes the miscarriage surgically and inserts a copper IUD during this visit. The total time for the visit is 35 minutes.

How should Dr. Q code for these services?

Dr. Q reports codes 76817 (transvaginal ultrasound), 59812 (incomplete abortion completed surgically) and 58300-51 (IUD insertion). HCPCS code J7300 (intrauterine copper contraceptive [Paragard®] [10 year duration]) is reported for the IUD supply. The diagnosis codes are O03.39 (spontaneous abortion with other specified complications, incomplete) and Z30.430 (insertion of IUD). More than half of the time spent face-to-face with the patient was spent counseling, therefore Dr. Q reports E/M code 99214 (established outpatient visit, 30-39 minutes of total time) with a modifier 25 (significant, separately identifiable E/M service). The topics discussed must be documented.

If the miscarriage was complete (requiring no surgical intervention), Dr. Q 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

IUD Removal and Implant Insertion

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

After a brief discussion, Ms. R selects the implant. Dr. S removes the IUD without problems and inserts an implant.

How should Dr. S code for this visit?

Dr. S reports codes 11981 (implant insertion) and 58301-51 for the IUD removal. Code 11981 is reported first because it has the higher RVU, and the modifier 51 (multiple procedures) is added to the lesser procedure. Dr. S also reports the diagnosis codes Z30.431 (routine checking of IUD), Z30.432 (removal of IUD), and Z30.017 (initial prescription of implantable subdermal contraceptive [includes insertion]) and the J7307 (etonogestrel [contraceptive] implant system, including implant and supplies) supply code.

Dr. S might also report an E/M services code for the examination, history, medical decision making and/ or time 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 4

Missing Strings

Ms. T sees Dr. U because she cannot feel the strings from an IUD inserted last year. Dr. U completes an examination and locates the strings.

How should Dr. U code for this visit?

Coding will depend on the extent of the work involved and documented.

If Dr. U performs an examination and finds the missing strings fairly easily, she will report a low level E/M services code linked to diagnosis Z30.431 (routine checking of IUD).

If, on the other hand, a more extensive examination is needed, she reports a higher level of E/M service linked to diagnosis T83.32XA (displacement of IUD, initial encounter).

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 T83.32XA (displacement of IUD, initial encounter) would help support the use of the modifier 22, but documentation must also indicate the additional work performed and risk to the patient.

SCENARIO 5

Difficult Insertion

Ms. V sees Dr. W, and requests insertion of a copper IUD. Ms. V weighs 220 lbs and has a BMI of 40.2. Dr. W inserts an IUD with some difficulty due to Ms. V's body habitus.

How should Dr. W code for this visit?

Dr. W reports 58300-22 (insertion) and J7300 (Intrauterine copper contraceptive [Paragard®] [10 year duration]) for the IUD supply. No E/M services code is reported. Dr. W 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 Z30.430 (insertion of IUD), Z68.41 (body mass index [40.0-44.9] adult), and E66.01 (morbid obesity due to excess calories).

SCENARIO 6

Hysteroscopic Removal

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

How should Dr. Y code for this visit?

Dr. Y 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 T83.39XA (mechanical complication of IUD, initial encounter).

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 7

Discontinued Insertion

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

Dr. A discusses other possible methods of contraception with Ms. Z 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. A code for the discontinued procedure and the visit?

Dr. A reports 58300-53 (insertion) and J7300 (intrauterine copper contraceptive [Paragard®] [10 year duration]) for the IUD supply. The modifier 53 indicates that the procedure was attempted but unsuccessful. Dr. A can also report E/M code 99203-25 (new outpatient visit, 30-44 minutes of total time) 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 the total time for the visit.

SCENARIO 8

Immediate Postpartum Insertion

Ms. B is a 33 year old G3P2 patient of Dr. C. She delivered both previous pregnancies by cesarean. During antepartum care, Ms. B expressed desire for an IUD postpartum, and the benefits and risks of an IUD were discussed. The decision was made to have the IUD inserted immediately after delivery.

At 40 weeks 1 day following an uncomplicated antepartum course, Ms. B presents to the hospital. Ms. B delivers her third child by cesarean followed immediately by a copper IUD insertion. She is scheduled for her routine six week postpartum visit.

How should Dr. C code for the global obstetric care and immediate postpartum IUD insertion?

The table below summarizes the codes reported for this scenario. For obstetric services, Dr. C reports global CPT code 59510 (routine obstetric care including antepartum care, cesarean delivery, and postpartum care) with outcome of delivery diagnosis codes O34.21- (maternal care for scar from previous cesarean delivery), Z37.0 (single live birth), and Z3A.40 (40 weeks gestation of pregnancy).

For the IUD insertion, Dr. C reports 58300-51 (insertion). HCPCS code J7300 (intrauterine copper contraceptive [Paragard®] [10 year duration]) is reported for the IUD supply. The modifier 51 (multiple procedures) is added to CPT code 58300 to indicate the additional procedure (IUD insertion) performed at the same session as the primary procedure (delivery). The diagnosis code is Z30.430 (insertion of intrauterine contraceptive device).

Note that coverage of immediate postpartum LARC varies by payer and state. A list of states with published guidance on Medicaid reimbursement for postpartum LARC can be found at **www.acog.org/IPPLARCmedicaid.** To avoid claim denials, providers should check with payers to determine if they reimburse for immediate postpartum LARC and how to bill appropriately to ensure reimbursement.

DIAGNOSIS CODE	PROCEDURES/SUPPLIES	MODIFIER
O34.21- Maternal care for scar from previous cesarean delivery Z37.0 Single live birth Z3A.40 40 weeks gestation of pregnancy	59510 Routine obstetric care including antepartum, cesarean delivery, and postpartum care	
Z30.430 Encounter for insertion of intrauterine contraceptive device	58300 Insertion of IUD J7300 Intrauterine copper contraceptive (Paragard®) (10 year duration)	51

The LARC Program
American College of Obstetricians and Gynecologists
409 12th Street SW
Washington DC 20024-2188

www.acog.org/larc

The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS