

upstream USA

CODING GUIDELINES FOR CONTRACEPTIVES

Updated for ICD-10 CM (post October 1, 2015)

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Z30.0 Encounter for general counseling and advice on contraception

Z30.01 ENCOUNTER FOR INITIAL PRESCRIPTION OF CONTRACEPTIVES

Z30.011 Contraceptive pills, initial prescription

Z30.012 Emergency contraception, prescription

Z30.013 Injectable contraceptive, initial prescription

Z30.014 Intrauterine contraceptive device, initial prescription

Z30.018 Other contraceptives, initial prescription

Z30.019 Contraceptives unspecified, initial prescription

Z30.02 COUNSELING AND INSTRUCTION IN NATURAL FAMILY PLANNING TO AVOID PREGNANCY

Z30.09 ENCOUNTER FOR OTHER GENERAL COUNSELING AND ADVICE ON CONTRACEPTION

Z30.2 Encounter for sterilization

Z30.4 Encounter for surveillance of contraceptives

Z30.40 ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVES UNSPECIFIED

Z30.41 ENCOUNTER FOR SURVEILLANCE OF CONTRACEPTIVE PILLS

Z30.42 ENCOUNTER FOR SURVEILLANCE OF INJECTABLE CONTRACEPTIVE

Z30.43 ENCOUNTER FOR SURVEILLANCE OF INTRAUTERINE CONTRACEPTIVE DEVICE

Z30.430 Insertion of intrauterine contraceptive device

Z30.431 Routine checking of intrauterine contraceptive device

Z30.432 Removal of intrauterine contraceptive device

Z30.433 Removal and reinsertion of intrauterine contraceptive device

Z30.49 ENCOUNTER FOR SURVEILLANCE OF OTHER CONTRACEPTIVES

Z30.8 Encounter for other contraceptive management

Z30.9 Encounter for contraceptive management, unspecified



LARC: CODING FOR IUD INSERTION AND REMOVAL PROCEDURES

02

CPT code **58300** is coded for IUD insertions while **58301** describes the removal of an IUD. The cost of the IUD is not included in the procedure code and should be reported separately for reimbursement and reporting purposes.

New ICD-10 code **Z30.014 Encounter for initial prescription of IUD** can be used for a prior visit when the patient may decide to have an IUD placed but the insertion is not done.

TYPE	CPT / HCPCS	MODIFIER	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
Insertion and Removal	58300 IUD Insertion		V25.11 Encounter for insertion of an IUD	Z30.430 Encounter for insertion of an IUD
	58301 IUD Removal		V25.12 Encounter for removal of IUD	Z30.432 Encounter for removal of IUD
	58301 IUD Removal and 58300 IUD Insertion	51	V25.13 Encounter for removal and reinsertion of IUD	Z30.433 Encounter for removal and reinsertion of IUD
	E/M (992xx or 993xx) - Report E/M code only if separate and distinct from the insertion procedure	25	As appropriate (Example: V25.09 if main reason for visit is contraceptive options counseling)	As appropriate
Surveillance	E/M (992xx or 993xx)		V25.42 Surveillance of IUD	Z30.431 Encounter for routine checking of IUD
			996.32 Mechanical complication due to IUD	T83.31XA Breakdown (mechanical) of IUD, initial encounter T83.32XA Displacement of IUD, initial encounter (codes for subsequent, sequela)
Device	J7300 IUD Paragard; J7301 IUD Skyla; J7302 IUD Mirena, Liletta			



LARC: CODING FOR IMPLANT (NEXPLANON) INSERTION AND REMOVAL PROCEDURES

03

Unlike IUD coding, there is one **combination code (11983) for removal and reinsertion of Nexplanon**. The cost of the device is typically not included in the procedure codes and should be reported separately for reimbursement.

TYPE	CPT / HCPCS	MODIFIER	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
Insertion and Removal	11981 Insertion, non-biodegradable drug deliver implant		V25.5 Encounter for contraceptive management, insertion of implantable subdermal	Z30.018 Encounter for initial prescription of other contraceptives <i>(Note: Not a specific code)</i>
	11982 Removal, non-biodegradable drug delivery implant		V25.43 Checking, reinsertion, or removal of implantable subdermal contraceptive	Z30.49 Encounter for surveillance of other contraceptives <i>(Note: Not a specific code)</i>
	11983 Removal with reinsertion, non-biodegradable drug delivery implant			
	E/M (992xx or 993xx) <i>- Report E/M code only if separate and distinct from the insertion procedure</i>	25	As appropriate (Example: V25.09 if main reason for E/M is contraceptive options counseling)	As appropriate
Surveillance	E/M (992xx or 993xx)		V25.43 Checking, reinsertion, or removal of implantable subdermal contraceptive	Z30.49 Encounter for surveillance of other contraceptives
Device	J7307 Nexplanon implant			



CODING FOR DEPO PROVERA – INITIAL / FOLLOW-UP WITH E/M

04

TYPE	CPT / HCPCS	MODIFIER	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
Initiate	E/M 992xx or 993xx 96372 Injection	25	V25.9 Unspecified contraceptive management	Z30.013 Encounter for initial prescription of injectable contraceptive
Surveillance	Report E/M if separate and distinct from the 96372 injection		V25.40 Surveillance of other contraceptives	Z30.42 Encounter for surveillance of injectable contraceptive
Drug	J1050 Depo Provera 1 mg (report units per mg dispensed)			



CODING FOR OTHER METHODS

05

Oral contraceptives including emergency contraception (EC), vaginal rings, hormonal patches, barrier methods and other forms of contraception should be documented and coded for each visit in addition to the E/M service. The cost of the contraceptive is typically not included in the medical service and should be reported separately for reimbursement. Check with your payers and contracts for guidelines.

Coding for Oral Contraceptives (OCP)



TYPE	CPT / HCPCS	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
Initial	E/M	V25.01 General counseling on prescription of OCP	Z30.11 Encounter for initial prescription of OCP
Surveillance	E/M	V25.41 Surveillance of OCP - refills	Z30.41 Encounter for surveillance of OCP
Drug	S4993 Oral contraceptive pills		



CODING FOR OTHER METHODS

05

Coding for Emergency Contraception



TYPE	CPT / HCPCS	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
EC	E/M	V25.03 Encounter for emergency contraceptive counseling and prescription	Z30.012 Encounter for prescription of emergency contraception
Drug	Check with Payers on accepted J or S code		

Coding for Vaginal Rings and Hormonal Patches



TYPE	CPT / HCPCS	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
Initial	E/M	V25.9 Unspecified contraceptive management	Z30.018 Encounter for initial prescription of other contraceptives
Surveillance	E/M	V25.40 Contraceptive surveillance unspecified (<i>Depo, Patch, Ring...</i>)	Z30.49 Encounter for surveillance of other contraceptives
Drug	J7303 Vaginal Rings J7304 Hormonal Patches		

Coding for Barrier Methods (Cervical cap, sponge, condoms, spermicide)



TYPE	CPT / HCPCS	ICD-9 CM DIAGNOSIS	ICD-10 CM DIAGNOSIS
Initial	E/M	V25.02 Initiation of other contraceptive measures (barrier method)	Z30.018 Encounter for initial prescription of other contraceptives
Surveillance	E/M	V25.49 Surveillance of other contraceptives	Z30.49 Encounter for surveillance of other contraceptives
Drug	AA261 cervical cap, A4266 diaphragm, A4267 male condom, A4268 female condom, Check with Payer for appropriate codes and if separately reimbursed		



Medical codes describe what happened during the visit and establish medical necessity for why the visit itself and the services provided during the visit were needed. Clinical documentation is needed to support the codes submitted to a Payer for reimbursement. Remember – **if it is not documented – it can't be billed!** Clinical and billing staff must work together as a team to ensure exchange of information is timely, services are promptly billed and paid in full, and any outstanding questions are resolved.

1. Procedures Codes (CPT/HCPCS) – These codes describe **what** services were provided.

- a. **CPT:** The Current Procedural Terminology (CPT) code set is maintained by the American Medical Association. Every service we provide relates to a CPT code including Evaluation and Management (E/M) services, procedures, device implants and removals, lesion removals, pap smears, lab tests, immunizations etc.
- b. **HCPCS** codes are used to describe supplies including contraceptives, LARC devices and drugs

2. ICD Diagnosis Codes – International Classification of Diseases. These codes are used to describe **why** the services were provided. They describe conditions, diseases, injuries, and symptoms. The World Health Organization (WHO) is responsible for updating ICD codes. The US transitioned from using outdated ICD-9 diagnosis codes to the more widely used ICD-10 diagnosis on October 1, 2015. ICD-9 CM codes are no longer accepted for dates of service post October 1.

- a. Although reimbursement is typically based on procedure codes, diagnosis codes also must be included on a claim to establish medical necessity and ensure accurate reimbursement.
- b. It will be essential for clinical and billing staff to learn the new ICD-10 code set and work together to ensure appropriate reimbursement of services is maintained.

3. Modifier Codes – are used to describe **special circumstances** pertaining to the procedure code(s) billed. Some modifiers impact payment.



Coding Tip

Robust documentation practices along with correct coding will support and lead to appropriate payment of services.



ACOG (American College of Obstetricians and Gynecologists) recommends the following practices for coding of LARC (Long acting reversible contraception) services:

E/M Services Code Only

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).

E/M Services Code and Procedure Code

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.

A **modifier 25** (significant, separately identifiable E/M service on the same day as a procedure or other service) is added to the E/M code to indicate that this service was significant and separately identifiable from the insertion. This indicates that two distinct services were provided: an E/M service and a procedure.¹



Coding Tip

An E/M code should not be routinely coded and billed for a scheduled LARC insertion. Documentation is required to support a separate and distinct E/M service.

¹ ACOG LARC Quick Coding Guide 2012; <http://www.acog.org/-/media/Departments/LARC/LARCQuickCodingGuide.pdf>



Time

Clinician counseling is a typically a large part of the visit as the new Quality Family Planning Guidelines (QFP) from the CDC and OPA move towards less exams for contraceptive initiation and surveillance.

To determine the level of the E/M code (992xx codes) using time, the clinician counseling must be greater than 50% of the total face-to-face time with the clinician and patient. Both the total face-to-face time and the amount spent counseling must be documented in the medical record. Note the “typical times” for a face-to-face encounter below:

AVG. MINUTES SPENT (FACE-TO-FACE)	NEW PATIENT	ESTABLISHED PATIENT
5		99211
10	99201	99212
15		99213
20	99202	
25		99214
30	99203	
40		99215
45	99204	
60	99205	



Coding Tip

If a clinician spends more than 50% of a face-to-face visit counseling or coordinating a patient’s care, the clinician can code the E/M on the basis of time. The level of history, physical examination, and medical decision-making do not matter in selecting this code.

Discontinued Insertions

Question: How do you recoup the cost of the device when the IUD insertion was unsuccessful?

Answer: Some payers will pay for the supply of an IUD after a failed attempt. However, contact the payer to be certain. The payer may have specific coding instructions you’ll need to follow so their system can recognize that payment should be made separately for the initial failed attempt and subsequent successful placement. If the payer provides you with such instructions it is appropriate to comply with their request. It’s always best to get this in writing. A copy of the operative note may need to be sent with the claim for the payer to review.

On the other hand, if the payer doesn't cover IUD supplies that failed to be inserted, contact the manufacturer. Various IUD manufacturers will either send your practice a replacement IUD or provide a refund. These manufacturers typically have forms that must be filled out explaining why the device couldn’t be inserted or may request a short letter that explains the circumstance.



Discontinued Insertions (cont'd)

Question2: Can I bill for the discontinued procedure?

Answer: Yes. A **modifier 53** (Discontinued Procedure) is added to code **58300** (Insertion of IUD) or codes **11981** or **11983** for the Nexplanon insertion. This modifier is used when a procedure is started but discontinued and no other procedure is performed during the visit.

Modifier 53 provides a way to receive partial payment for work performed before the procedure is discontinued. It is not necessary to reduce the fee. The payer will determine the fee for the service (typically 50% payment). The payer may require documentation showing how much work was actually performed. This modifier is also useful because it tells the payer that the procedure was unsuccessful for future contraceptive billing.

Ultrasounds Performed to Check IUD Placement

Question: Is an ultrasound performed to check IUD placement included in the IUD insertion?

Answer: An ultrasound to check IUD placement is coded separate from the IUD insertion (code 58300). However, keep in mind it is not common practice to use ultrasound to confirm placement. Therefore, this should not be routinely billed. Ultrasounds may be used to confirm the location of the IUD when the clinician incurs a difficult IUD placement (e.g., severe pain, uterine perforation, etc.). Consider the following possible codes for the placement confirmation:

- **Code 76856** (Ultrasound, pelvic [non-obstetric], real time with image documentation; complete)
- **Code 76857** Ultrasound, pelvic [non-obstetric], real time with image documentation; limited or follow-up
- **Code 76830** Ultrasound, transvaginal

Occasionally, ultrasound is needed to guide IUD insertion. If ultrasound is used, use code 76998 (Ultrasonic guidance, intraoperative)

Difficult Insertions

Question: How do I bill for a difficult LARC insertion that takes additional time and effort?

Answer: The **22 modifier** can be reported if the work required to insert an IUD is substantially greater than usual. The 22 modifier can also be reported in the case of an unsuccessful insertion followed by a successful insertion during the same surgical session. A modifier 22 is added to code. Documentation must support the substantial additional work and the reason for the additional work, such as: increased intensity or time, increased technical difficulty of performing the procedure, severity of patient's condition, increased physical and mental effort required. Check with your payers for guidelines.



Lab Tests

Question: Are in-house lab tests such as a UPT (**CPT 81025**) reimbursed in addition to the contraceptive visit or procedure?

Answer: Depending on the contract with each payer, in-house lab tests are typically reimbursed in addition to the main service. Accurate documentation, coding of the tests and supporting ICD diagnosis codes to support medical necessity are essential.

See Appendix A for QFP Check List²

² http://fpntc.org/sites/default/files/resource-library-files/JobAids_checklists_508.pdf



Coding Tip

The new Quality Family Planning Guidelines (QFP) from the CDC and OPA provides specific recommendations including testing relating to contraceptive services and should be reviewed by clinical staff.

Mission

Upstream has developed a consulting and technical assistance practice for health centers to ensure that all women have access to a full range of contraceptive methods, particularly the most effective ones, IUDs and implants. Upstream's goal is to ensure that every child born in America is a planned for and wanted child, so that they can have very best start on life and improve outcomes for generations.

Additional information: www.upstreamusa.org