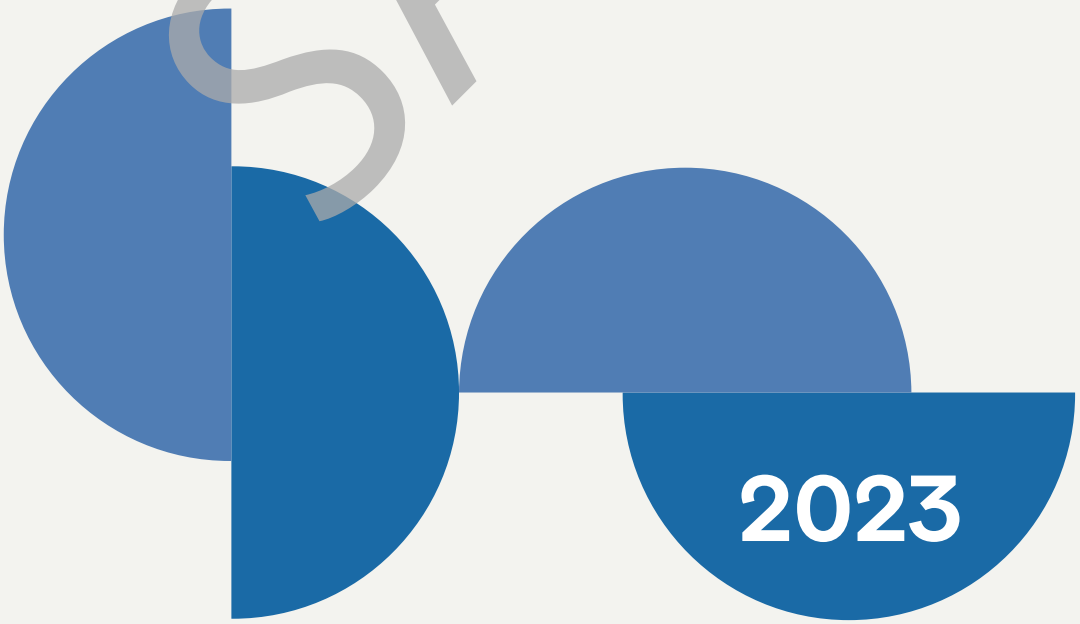
Optum

Coding Companion

OB/GYN

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

Coding Companion for OB/GYN is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and management codes related to OB/GYN are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edit and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

could be found in the index under the following main terms:

Abdominohysterectomy
Total, 58150, 58200
OR
Hysterectomy
Abdominal
Total, 58150, 58200
OR
TAH, 58150-58152

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

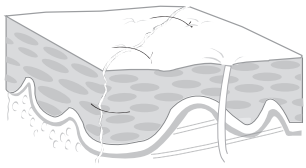
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

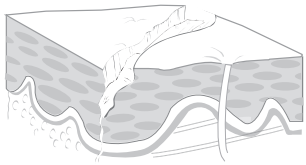
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

12020-12021

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The physician cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips

For extensive or complicated secondary wound closure, see 13160. Medicare and some other payers may require G0168 be reported for wound closure by tissue adhesives only. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

O90.0	Disruption of cesarean delivery wound ♂ ♀
O90.1	Disruption of perineal obstetric wound ♂ ♀
T81.31XA	Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter
T81.32XA	Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter
T81.33XA	Disruption of traumatic injury wound repair, initial encounter

Associated HCPCS Codes

G0168	Wound closure utilizing tissue adhesive(s) only

AMA: **12020** 2019,Nov,3; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,
12021 2019,Nov,3; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.82	0.43	8.92
12021	1.89	2.97	0.3	5.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.43	0.43	5.53
12021	1.89	1.91	0.3	4.1

	FUD	Status	MUE	Modifiers				IOM Reference
12020	10	A	2(3)	51	N/A	N/A	N/A	None
12021	10	A	3(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

perineal. Pertaining to the pelvic floor area between the thighs; the diamond-shaped area bordered by the pubic symphysis in front, the ischial tuberosities on the sides, and the coccyx in back.

subcutaneous. Below the skin.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

wound repair. Surgical closure of a wound is divided into three categories: simple, intermediate, and complex. ***simple repair:*** Surgical closure of a superficial wound, requiring single layer suturing of the skin epidermis, dermis, or subcutaneous tissue. ***intermediate repair:*** Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin; contaminated wounds with single layer closure that need extensive cleaning or foreign body removal. ***complex repair:*** Repair of wounds requiring more than layered closure (debridement, scar revision, stents, retention sutures).

1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number/complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

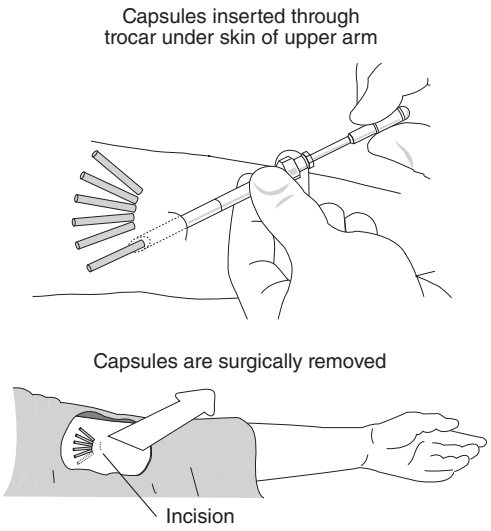
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

11976

11976 Removal, implantable contraceptive capsules



Explanation

The physician makes a small incision in the skin on the inside of the upper arm of a female patient and removes contraceptive capsules previously implanted subdermally. The incision is closed.

Coding Tips

Because this procedure is usually not done out of medical necessity, the patient may be responsible for charges. Verify with the insurance carrier for coverage. Local anesthesia is included in this service. For removal of contraceptive capsules with subsequent reinsertion, report 11976 in conjunction with 11981. The cost of the contraceptive is not included and should be reported separately using the appropriate HCPCS Level II code. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. Supplies used when providing this service may be reported with 99070 or the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

Z30.46 Encounter for surveillance of implantable subdermal contraceptive ♀

AMA: **11976** 1992,Win,1

Relative Value Units/Medicare Edits

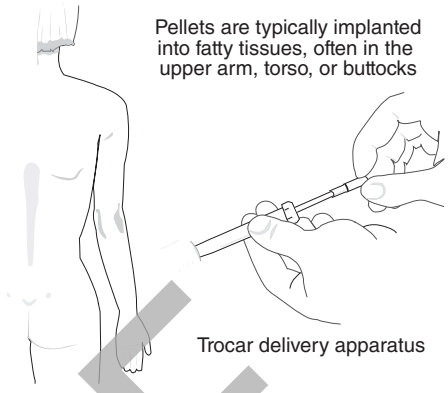
Non-Facility RVU	Work	PE	MP	Total
11976	1.78	2.22	0.27	4.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
11976	1.78	0.68	0.27	2.73

	FUD	Status	MUE	Modifiers				IOM Reference
11976	0	R	1(2)	51	N/A	N/A	80*	None

* with documentation

11980

11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)



Explanation

Biodegradable time-release medication pellets are implanted subcutaneously for the slow delivery of hormones. The physician makes a small incision in the skin with a scalpel. A trocar and cannula are inserted into the incised area. Hormone pellets are inserted through the cannula and the cannula is withdrawn. Pressure is applied to the incised area until any bleeding is stopped, and the incision is closed with Steri-strips. The time-release medication is typically used for women who require hormone replacement therapy during menopause. One method is to implant pellets of testosterone and/or estradiol (taken in conjunction with progesterone) into the fatty tissue of the buttocks. New pellets may be inserted whenever symptoms recur, usually in six to nine months.

Coding Tips

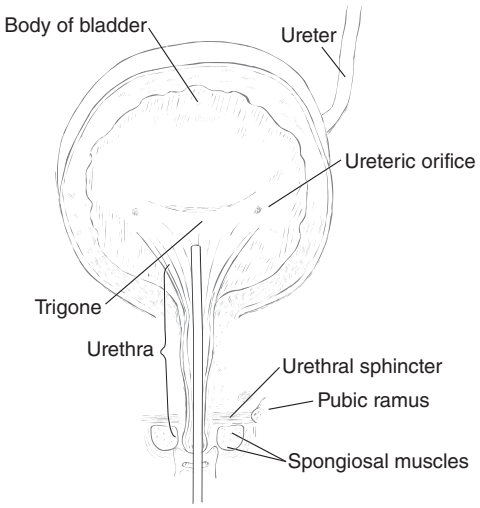
When 11980 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Report supplies and materials separately using 99070 or the appropriate HCPCS Level II code for the cost of the capsule. Local anesthesia is included in this service. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For insertion of implantable contraceptive capsules, see 11981.

ICD-10-CM Diagnostic Codes

E28.310 Symptomatic premature menopause 🅰 ♀
E28.319 Asymptomatic premature menopause 🅰 ♀
E28.39 Other primary ovarian failure ♀
E28.8 Other ovarian dysfunction ♀
E30.0 Delayed puberty
E89.40 Asymptomatic postprocedural ovarian failure ♀
E89.41 Symptomatic postprocedural ovarian failure ♀
N92.4 Excessive bleeding in the premenopausal period ♀
N95.0 Postmenopausal bleeding ♀
N95.1 Menopausal and female climacteric states ♀
N95.2 Postmenopausal atrophic vaginitis ♀
N95.8 Other specified menopausal and perimenopausal disorders ♀
R53.81 Other malaise
R53.83 Other fatigue
R68.82 Decreased libido 🅰

51701-51703

51701 Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)
51702 Insertion of temporary indwelling bladder catheter; simple (eg, Foley)
51703 complicated (eg, altered anatomy, fractured catheter/balloon)



Explanation

The patient is catheterized with a non-indwelling bladder catheter (e.g., for residual urine) in 51701; simple catheterization with a temporary indwelling bladder catheter (Foley) is performed in 51702. The area is properly cleaned and sterilized. A water-soluble lubricant may be injected into the urethra before catheterization begins. The distal part of the catheter is coated with lubricant. The catheter is gently inserted until urine is noted. With an indwelling catheter, insertion continues into the bladder until the retention balloon can be inflated. The catheter is gently pulled until the retention balloon is snuggled against the neck of the bladder. The catheter is secured to the abdomen or thigh and the drainage bag is secured below bladder level. Report 51703 if a circumstance (i.e., change in anatomy or fractured catheter/balloon) occurs to complicate the catheterization process.

Coding Tips

Codes 51701 and 51702 should not be reported in addition to any other procedure that includes catheter insertion as a component. Report 51701 and 51702 only when performed independently. Do not report 51702 with CPT Category III code 0071T or 0072T. Supplies used when providing these procedures may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

C67.5 Malignant neoplasm of bladder neck
C68.0 Malignant neoplasm of urethra
N32.89 Other specified disorders of bladder
N35.021 Urethral stricture due to childbirth ♀
N35.028 Other post-traumatic urethral stricture, female ♀
N35.82 Other urethral stricture, female ♀
N39.3 Stress incontinence (female) (male)
N39.45 Continuous leakage
N39.490 Overflow incontinence
N99.12 Postprocedural urethral stricture, female ♀
R30.0 Dysuria
R30.1 Vesical tenesmus
R31.0 Gross hematuria
R31.1 Benign essential microscopic hematuria
R31.21 Asymptomatic microscopic hematuria
R31.29 Other microscopic hematuria
R33.8 Other retention of urine
R35.0 Frequency of micturition
R35.81 Nocturnal polyuria
R39.14 Feeling of incomplete bladder emptying
R39.81 Functional urinary incontinence

AMA: **51701** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **51702** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **51703** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
51701	0.5	0.78	0.06	1.34
51702	0.5	1.32	0.05	1.87
51703	1.47	2.73	0.17	4.37
Facility RVU	**Work**	**PE**	**MP**	**Total**
51701	0.5	0.18	0.06	0.74
51702	0.5	0.18	0.05	0.73
51703	1.47	0.58	0.17	2.22

	FUD	Status	MUE	Modifiers				IOM Reference
51701	0	A	2(3)	51	N/A	N/A	N/A	None
51702	0	A	2(3)	51	N/A	N/A	N/A	
51703	0	A	2(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

catheterization. Use or insertion of a tubular device into a duct, blood vessel, hollow organ, or body cavity for injecting or withdrawing fluids for diagnostic or therapeutic purposes.

distal. Located farther away from a specified reference point or the trunk.

dysuria. Pain upon urination.

Foley catheter. Temporary indwelling urethral catheter held in place in the bladder by an inflated balloon containing fluid or air.

hematuria. Blood in urine, which may present as gross visible blood or as the presence of red blood cells visible only under a microscope.

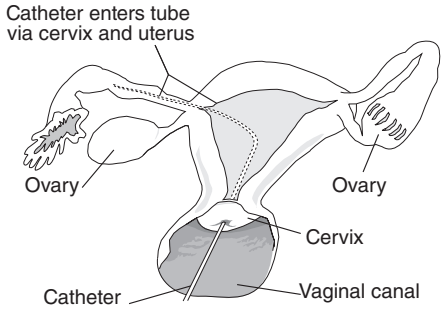
polyuria. Excessive urination.

stress incontinence. Involuntary escape of urine at times of minor stress against the bladder, such as coughing, sneezing, or laughing.

 N Newborn: 0 **P Pediatric: 0-17** **M Maternity: 9-64** **A Adult: 15-124** ♂ **Male Only** ♀ **Female Only**

58345

58345 Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography



Explanation

The physician introduces a catheter into the cervix, and takes it into the uterus and through the fallopian tube. The catheter must be made of a material that will show on x-ray film so that any blockages or abnormalities in the tube can be seen. The physician may inject radiographic contrast material into the endometrial cavity with mild pressure to force the material into the tubes. The shadow of this material on separately reported x-ray film permits examination of the uterus and tubes for any abnormalities or blockages.

Coding Tips

This procedure can be accomplished in a physician's office when radiology equipment is present or in a radiology facility. This code includes any method of re-establishing patency of the tube and a hysterosalpingography performed by the physician. For radiological supervision and interpretation of transcervical catheterization of a fallopian tube, see 74742. Because this procedure is usually performed for the treatment of infertility, the patient may be responsible for charges. Verify with the insurance carrier for coverage. For surgical treatment of an ectopic pregnancy, see 59120–59140. For laparoscopic treatment of an ectopic pregnancy, see 59150–59151.

ICD-10-CM Diagnostic Codes

E28.2 Polycystic ovarian syndrome ♀
E28.8 Other ovarian dysfunction ♀
N70.01 Acute salpingitis ♀
N70.02 Acute oophoritis ♀
N70.03 Acute salpingitis and oophoritis ♀
N70.11 Chronic salpingitis ♀
N70.12 Chronic oophoritis ♀
N70.13 Chronic salpingitis and oophoritis ♀
N73.6 Female pelvic peritoneal adhesions (postinfective) ♀
N80.2 Endometriosis of fallopian tube ♀
N83.321 Acquired atrophy of right fallopian tube ♀ ☑
N83.322 Acquired atrophy of left fallopian tube ♀ ☑
N83.331 Acquired atrophy of right ovary and fallopian tube ♀ ☑
N83.332 Acquired atrophy of left ovary and fallopian tube ♀ ☑
N83.41 Prolapse and hernia of right ovary and fallopian tube ♀ ☑
N83.42 Prolapse and hernia of left ovary and fallopian tube ♀ ☑
N83.521 Torsion of right fallopian tube ♀ ☑
N83.522 Torsion of left fallopian tube ♀ ☑
N83.53 Torsion of ovary, ovarian pedicle and fallopian tube ♀
N83.6 Hematosalpinx ♀
N83.8 Other noninflammatory disorders of ovary, fallopian tube and broad ligament ♀
N85.01 Benign endometrial hyperplasia ♀
N85.02 Endometrial intraepithelial neoplasia [EIN] ♀
N85.2 Hypertrophy of uterus ♀
N85.3 Subinvolution of uterus ♀
N85.5 Inversion of uterus ♀
N88.2 Stricture and stenosis of cervix uteri ♀
N88.8 Other specified noninflammatory disorders of cervix uteri ♀
N97.1 Female infertility of tubal origin ♀
N97.8 Female infertility of other origin ♀
N99.83 Residual ovary syndrome ♀
Q50.4 Embryonic cyst of fallopian tube ♀
Q50.6 Other congenital malformations of fallopian tube and broad ligament ♀
Z31.41 Encounter for fertility testing
Z31.42 Aftercare following sterilization reversal
Z31.49 Encounter for other procreative investigation and testing

AMA: **58345** 2019,Jul,6; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
58345	4.7	3.06	0.74	8.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
58345	4.7	3.06	0.74	8.5

	FUD	Status	MUE	Modifiers				IOM Reference
58345	10	A	1(3)	51	50	62	80	None

* with documentation

Terms To Know

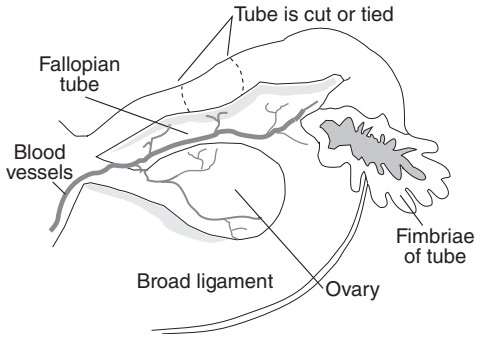
hysterosalpingography. Radiographic pictures taken of the uterus and the fallopian tubes after the injection of a radiopaque dye.

patency. State of a tube-like structure or conduit being open and unobstructed.

58600-58605

58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)



Explanation

The physician ties off the fallopian tube or removes a portion of it on one side or both. The procedure may be done through the vagina or through a small incision just above the pubic hairline. In 58605, the procedure is done during the same hospital stay as the delivery of a baby.

Coding Tips

Report 58605 only when a tubal ligation is completed while the patient is hospitalized following a delivery. Note that 58605, a separate procedure by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. When 58600 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For tubal ligation performed via laparoscopy, see 58670 and 58671.

ICD-10-CM Diagnostic Codes

Z30.2 Encounter for sterilization

AMA: **58600** 2019,Jul,6; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
58605 2019,Jul,6; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

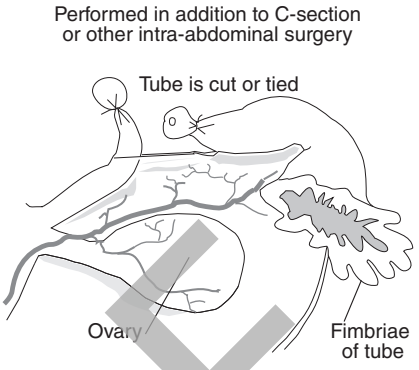
Non-Facility RVU	Work	PE	MP	Total
58600	5.91	4.09	0.94	10.94
58605	5.28	3.81	0.82	9.91
Facility RVU	**Work**	**PE**	**MP**	**Total**
58600	5.91	4.09	0.94	10.94
58605	5.28	3.81	0.82	9.91

	FUD	Status	MUE	Modifiers				IOM Reference
58600	90	A	1(2)	51	N/A	62*	80	100-03,230.3
58605	90	A	1(2)	51	N/A	N/A	80	

* with documentation

58611

+ 58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)



Explanation

The physician ties off the fallopian tube or removes a portion of it on one side or both. This procedure is done at the time of a cesarean section or during intra-abdominal surgery.

Coding Tips

This code should only be used for a tubal ligation completed during a cesarean section or during intra-abdominal surgery. Unlike other minor procedures, 58611 is reported in conjunction with the primary procedure. No reimbursement reduction or modifier 51 is applied. To report a tubal ligation performed via laparoscopy, see 58670 and 58671.

ICD-10-CM Diagnostic Codes

Z30.2 Encounter for sterilization

AMA: **58611** 2019,Jul,6

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
58611	1.45	0.56	0.23	2.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
58611	1.45	0.56	0.23	2.24

	FUD	Status	MUE	Modifiers				IOM Reference
58611	N/A	A	1(2)	N/A	N/A	N/A	80	None

* with documentation

Terms To Know

fallopian tubes. Bilateral, paired tubes that extend from the uterus to the ovaries, through which an ovum released from the follicle travels to the uterus during ovulation.

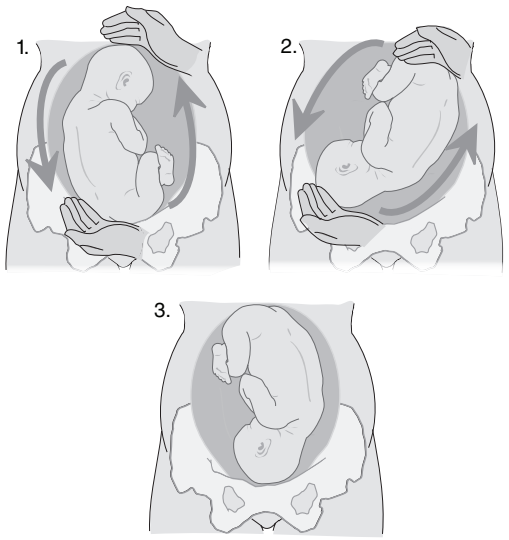
intra. Within.

ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.

transection. Transverse dissection; to cut across a long axis; cross section.

59412

59412 External cephalic version, with or without tocolysis



The baby is in breech presentation (1), the physician feels for the baby's head and bottom externally. By applying pressure the baby is turned (2) to a cephalic presentation for delivery (3)

Explanation

The physician turns the fetus from a breech presenting position to a cephalic presenting position. External cephalic version is performed by manipulating the fetus from the outside of the abdominal wall. The physician places both hands on the patient's abdomen and locates each pole of the fetus by palpation. The fetus is shifted so that the breech or rear end of the fetus is moved upward and the head downward. The physician may elect to use tocolytic drug therapy to suppress uterine contractions during the manipulation.

Coding Tips

This code may be used for manipulation prior to or during delivery. It may be reported in addition to any of the delivery codes (59400–59622). Procedure 59412 has not been designated in CPT as an "add-on" code or exempt from modifier 51. However, this procedure is not billed as a stand-alone service and it is recommended that it be reported using "add-on" reporting guidelines when the same physician performs the service/procedure on the same date of service as other related services/procedures.

ICD-10-CM Diagnostic Codes

O32.1XX0 Maternal care for breech presentation, not applicable or unspecified M ♀
O32.1XX1 Maternal care for breech presentation, fetus 1 M ♀
O32.1XX2 Maternal care for breech presentation, fetus 2 M ♀
O32.1XX3 Maternal care for breech presentation, fetus 3 M ♀
O32.1XX4 Maternal care for breech presentation, fetus 4 M ♀
O32.1XX5 Maternal care for breech presentation, fetus 5 M ♀
O32.1XX9 Maternal care for breech presentation, other fetus M ♀
O64.1XX0 Obstructed labor due to breech presentation, not applicable or unspecified M ♀
O64.1XX1 Obstructed labor due to breech presentation, fetus 1 M ♀
O64.1XX2 Obstructed labor due to breech presentation, fetus 2 M ♀
O64.1XX3 Obstructed labor due to breech presentation, fetus 3 M ♀
O64.1XX4 Obstructed labor due to breech presentation, fetus 4 M ♀
O64.1XX5 Obstructed labor due to breech presentation, fetus 5 M ♀
O64.1XX9 Obstructed labor due to breech presentation, other fetus M ♀

AMA: **59412** 2019,Jul,6

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
59412	1.71	0.83	0.47	3.01
Facility RVU	**Work**	**PE**	**MP**	**Total**
59412	1.71	0.83	0.47	3.01

	FUD	Status	MUE	Modifiers				IOM Reference
59412	N/A	A	1(3)	N/A	N/A	N/A	80*	100-02,15,20.1; 100-02,15,180

* with documentation

Terms To Know

breech presentation. Abnormal condition in which the fetal buttocks present first. In frank breech, the legs of the fetus extend over the abdomen and thorax so that the feet lie beside the face. In complete breech, the legs are flexed and crossed, while incomplete breech presents with one or both lower legs and feet prolapsed into the vagina.

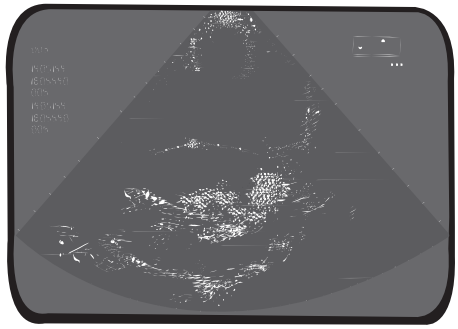
cephalad. Toward the head.

tocolytic. Drug administered during pregnancy in order to relax the uterus and reduce or halt contractions, administered primarily to stop premature labor.

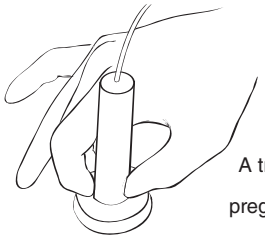
76813-76814

76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation

\+ **76814** Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)



A real time ultrasound is taken of a pregnant uterus to examine nuchal translucency measurement of transabdominal or transvaginal approach



A transducer is passed over the patient's pregnant abdominal area

Explanation

Fetal nuchal translucency provides a noninvasive method to screen for chromosomal abnormalities or heart defects in the first trimester. Nuchal pertains to the back of the neck. Until the lymphatic system of the fetus develops, the back of the neck is a good predictor of fetal health, because the fetus will lie on its back and edema will form in the neck if circulatory problems are present. In a fetal nuchal translucency test, ultrasound transducers on the maternal abdomen or vagina focus on the fetal neck, and the depth of tissue there is measured. The examination includes a calculation of fetal length, and the two measurements are correlated. Fetal nuchal edema does not provide a definitive diagnosis, but would warrant further testing (e.g., chorionic villus sampling). Report 76813 for fetal nuchal translucency testing of one fetus and 76814 for each additional fetus.

Coding Tips

Report 76814 in addition to 76813. For fetal and maternal evaluation performed with detailed fetal anatomic examination, see 76811–76812.

ICD-10-CM Diagnostic Codes

O09.511 Supervision of elderly primigravida, first trimester M ♀

O35.1XX0 Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified M ♀

O35.1XX1 Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1 M ♀

O35.1XX2 Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2 M ♀

O35.1XX3 Maternal care for (suspected) chromosomal abnormality in fetus, fetus 3 M ♀

O35.1XX4 Maternal care for (suspected) chromosomal abnormality in fetus, fetus 4 M ♀

O35.1XX5 Maternal care for (suspected) chromosomal abnormality in fetus, fetus 5 M ♀

O35.1XX9 Maternal care for (suspected) chromosomal abnormality in fetus, other fetus M ♀

Z03.73 Encounter for suspected fetal anomaly ruled out M ♀

Z36.82 Encounter for antenatal screening for nuchal translucency M ♀

AMA: **76813** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **76814** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
76813	1.18	2.34	0.05	3.57
76814	0.99	1.25	0.05	2.29
Facility RVU	**Work**	**PE**	**MP**	**Total**
76813	1.18	2.34	0.05	3.57
76814	0.99	1.25	0.05	2.29

	FUD	Status	MUE	Modifiers				IOM Reference
76813	N/A	A	1(2)	N/A	N/A	N/A	80*	None
76814	N/A	A	2(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures.

fetal nuchal translucency. Fluid collection residing behind the neck of the fetus that occurs, in part, due to the fetus position, primarily on its' back, as well as the laxity of the neck skin. Fluid collection in the nuchal or neck area in the fetus, like fluid collection in the ankle (edema), can point to a number of pathological processes, such as heart failure. The process of fluid collecting behind the fetal neck may be identified and measured on ultrasound as nuchal translucency with more fluid present representing a higher risk for abnormalities.

fetus. Unborn offspring past the embryonic stage that has developed major structures. It is the period defined from nine weeks after fertilization until birth.

gestation. Carrying of offspring in the womb throughout the period of development of the fetus(es) during pregnancy.

real-time. Immediate imaging, with movement as it happens.

trimester. Normal pregnancy has a duration of approximately 40 weeks and is grouped into three-month periods consisting of three trimesters. ICD-10-CM counts trimesters from the first day of the last menstrual period as follows: 1st trimester less than 14 weeks and 0 days; 2nd trimester 14 weeks, 0 days to less than 28 weeks and 0 days; and 3rd trimester 28 weeks and 0 days until delivery.

ultrasound. Imaging using ultra-high sound frequency bounced off body structures.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0071T 0213T, 0216T, 36000, 36410, 36591-36592, 51701-51702, 57180, 57400-57410, 57452, 57500, 57530, 57800, 58100, 61650, 62324-62327, 64415-64417, 64435, 64450, 64454, 64486-64490, 64493, 69990, 72195-72197, 74712, 76376-76380, 76940, 76998, 77013, 77021-77022, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452, G0471

0072T 0071T, 0213T, 0216T, 36000, 36410, 36591-36592, 51701-51702, 57180, 57400-57410, 57452, 57500, 57530, 57800, 58100, 61650, 62324-62327, 64415-64417, 64435, 64450, 64454, 64486-64490, 64493, 69990, 72195-72197, 74712, 76376-76380, 76940, 76998, 77013, 77021-77022, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452, G0471

0404T 0213T, 0216T, 0567T, 0596T-0597T, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 43752, 51701-51703, 57100, 57410, 57800, 58100, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 76830-76831, 76856-76857, 76940, 76942, 76998, 92012-92014, 93000-93010, 93040-93042, 93318, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378

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0476T 36591-36592, 96523, 99453-99454, 99473

0477T 36591-36592, 96523, 99453-99454, 99473

0478T 36591-36592, 96523, 99453-99454, 99473

0487T 36591-36592, 51701-51702, 96523

0500T 80500-80502, 81400-81408, 87624-87625, 96523

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