LARC Quick Coding Guide

2021 UPDATE

the LARC program
Long-Acting Reversible Contraception

Coding for the Contraceptive Implant and IUDs

CORRECT CODING can result in more appropriate compensation for services and devices. To help practices receive appropriate payment for providing 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 Coding Department, has prepared this updated quick reference guide to coding for LARC methods. The information included in this guide is current as of March 9, 2021. For more information about the LARC Program and coding for LARC methods, go to **http://www.acog.org/larc**.

Basic Contraceptive Implant Coding

The diagnostic coding will vary, but usually will be selected from the Z30.01- (encounter for initial prescription of contraceptives) and Z30.4- (encounter for surveillance of contraceptives) series in ICD-10-CM. These codes are:

Z30.017 Encounter for initial prescription of implantable subdermal contraceptive

This code is reported for the initial prescription, counseling, advice, and insertion of the implant, even when the insertion is performed at a separate encounter

Z30.46 Encounter for surveillance of implantable subdermal contraceptive

This code is reported for checking, reinsertion, or removal of the implant

The contraceptive implant is a single-rod etonogestrel-releasing contraceptive device inserted under the skin of the upper arm. The insertion and/or removal of the implant are reported using one of the following CPT (Current Procedural Terminology) codes:

11981 Insertion, non-biodegradable drug delivery implant

11982 Removal, non-biodegradable drug delivery implant

11983 Removal with reinsertion, non-biodegradable drug delivery implant

CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS (Healthcare Procedural Coding System) code:

J7307 Etonogestrel (contraceptive) implant system, including implant and supplies

Basic IUD Coding

Most IUD services will be linked to a diagnosis code from the Z30.01- (encounter for initial prescription of contraceptives) and Z30.43- (encounter for surveillance of intrauterine contraceptive device) series.

Z30.014 Encounter for initial prescription of intrauterine contraceptive device

This code includes the initial prescription of the IUD, counseling, and advice, but excludes the IUD insertion

Z30.430 Encounter for insertion of intrauterine contraceptive device

Z30.431 Encounter for routine checking of intrauterine contraceptive device

Z30.432 Encounter for removal of intrauterine contraceptive device

Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device

Intrauterine devices include the copper IUD and the hormonal IUDs. The insertion and/or removal of IUDs are reported using one of the following CPT codes:

58300 Insertion of IUD

58301 Removal of IUD

CPT procedure codes do not include the cost of the supply. Report the supply separately using a HCPCS code:

J7296 Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg (5 year duration)

J7297 Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg (6 year duration)

J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg (6 year duration)

J7300 Intrauterine copper contraceptive (Paragard®) (10 year duration)

J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg (3 year duration)

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WOMEN'S HEALTH CARE PHYSICIANS

Reporting Contraceptive Services with Other Services

Under some circumstances, an Evaluation and Management (E/M) services code, a procedure code, and a HCPCS code may all be reported.

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.

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 (99202–99215), an E/M services code may be reported if an E/M service (including medically appropriate history and/or physical examination, or medical decision making or time spent counseling) is documented. Link the E/M code to ICD-10-CM diagnosis code Z30.014 (encounter for initial prescription of intrauterine contraceptive device) or Z30.017 (encounter for initial prescription of implantable subdermal contraceptive) when applicable.

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. Physicians may choose outpatient E/M visit level based on either medical decision making (MDM) or time. For code selection based on time, the time reported is total physician/qualified health care professional (QHP) time (face-to-face and non face-to-face) on the date-of-service. Time may be used to select a code level whether or not counseling or care coordination is the primary office or other outpatient service (codes 99202-99215). Note the "typical times" listed in outpatient E/M services codes of the AMA-CPT code set have been revised to depict a range of time. Providers should be sure to refer to the 2021 E/M changes to outpatient visits and consult with their third-party payers before instituting this coding practice to ensure compliance with specific plan guidelines.

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.

Contraceptive Implant Coding: Specific Clinical Scenarios

E/M Service and Implant Insertion

The following table illustrates coding when an implant insertion and an office visit occur at the same encounter. Under certain circumstances and when supported by documentation, it may be appropriate to report a CPT procedure code, an E/M code, and a HCPCS supply code for the one visit. Diagnostic codes are reported based on services provided, such as outpatient or preventive services, as appropriate.

Coding for Implant Insertion and E/M Service

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
11981 Insertion, non-biodegradable drug delivery implant		Z30.017 Encounter for initial prescription of implantable subdermal contraceptive
992XX E/M based either on medical decision making or time	25	Z30.017 Encounter for initial prescription of implantable subdermal contraceptive
HCPCS SUPPLY CODES		
J7307 Etonogestrel (contraceptive) implant system, including implant and supplies		Z30.017 Encounter for initial prescription of implantable subdermal contraceptive

OR

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
11981 Insertion, non-biodegradable drug delivery implant		Z30.017 Encounter for initial prescription of implantable subdermal contraceptive
9939X or 9938X Preventive E/M service based on age and whether a new or established patient	25	Z01.41- Routine gynecological examination (series) Z01.411 with abnormal findings Z01.419 without abnormal findings Z30.017 Encounter for initial prescription of implantable subdermal contraceptive
HCPCS SUPPLY CODES		
J7307 Etonogestrel (contraceptive) implant system, including implant and supplies		Z30.017 Encounter for initial prescription of implantable subdermal contraceptive

Implant Reassessment

ICD-10-CM code Z30.46 (encounter for surveillance of implantable subdermal contraceptive) is assigned for a follow-up visit in the office to check, reinsert, or remove the implant. If the patient has symptoms, report these as secondary diagnoses. For example, code S40.021 (contusion of right upper arm) or other physical symptoms such as code R11.0 (nausea)

Same Day Implant Removal and Reinsertion

The following chart shows coding when an implant is removed and a new one inserted during an office visit. When appropriate and supported by documentation, a CPT procedure code, an E/M code, and a HCPCS supply code are reported for the one visit.

Coding for Same Day Removal and Reinsertion of Implant with an E/M Service

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
11983 Removal with reinsertion, non-biodegradable drug delivery implant		Z30.46 Encounter for surveillance of implantable subdermal contraceptive
992XX E/M based either on medical decision making or time	25	Z30.46 Encounter for surveillance of implantable subdermal contraceptive
HCPCS SUPPLY CODES		
J7307 Etonogestrel (contraceptive) implant system, including implant and supplies		Z30.46 Encounter for surveillance of implantable subdermal contraceptive

IUD Coding: Specific Clinical Scenarios

E/M Service and IUD Insertion

The following table illustrates coding when an IUD insertion and an office visit occur at the same encounter. Under certain circumstances and when supported by documentation, it may be appropriate to report a CPT procedure code, an E/M code, and a HCPCS supply code for the one visit. Diagnostic codes are reported based on services provided, such as outpatient or preventive services, as appropriate.

Coding for IUD Insertion and E/M Service

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
58300 Insertion of IUD		Z30.430 Encounter for insertion of intrauterine contraceptive device
992XX E/M based either on medical decision making or time	25	Z30.014 Encounter for initial prescription of intrauterine contraceptive device
HCPCS SUPPLY CODES		
J7296 Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg (5 year duration) J7297 Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg (6 year duration) J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg (6 year duration) J7300 Intrauterine copper contraceptive (Paragard®) (10 year duration) J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg (3 year duration)		Z30.430 Encounter for insertion of intrauterine contraceptive device

OR (continued next page)

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
58300 Insertion of IUD		Z30.430 Encounter for insertion of intrauterine contraceptive device
9939X or 9938X Preventive E/M service based on age and whether a new or established patient	25	Z01.41- Routine gynecological examination (series) Z01.411 with abnormal findings Z01.419 without abnormal findings Z30.014 Encounter for initial prescription of intrauterine contraceptive device
HCPCS SUPPLY CODES		
J7296 Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg (5 year duration) J7297 Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg (6 year duration) J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg (6 year duration) J7300 Intrauterine copper contraceptive (Paragard®) (10 year duration) J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg (3 year duration)		Z30.430 Encounter for insertion of intrauterine contraceptive device

Use of Ultrasound

The performance of an ultrasound to check IUD placement is not bundled into the IUD insertion (code 58300), and it is not common practice to use ultrasound to confirm placement. Therefore, this should not be routinely billed. However, ultrasonography may be used to confirm the location of the IUD when the qualified clinicician incurs a difficult IUD placement (e.g., severe pain, uterine perforation, etc.). If ultrasound is used, one of the following codes is added:

- Code 76857 Ultrasound, pelvic [nonobstetric], real time with image documentation; limited or follow-up, or
- Code 76830 Ultrasound, transvaginal

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

IUD Reassessment

ICD-10-CM code Z30.431 (encounter for routine checking of intrauterine contraceptive device) is assigned for a follow-up visit in the office to check the proper placement of the IUD.

Difficult Insertions

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 58300 (insertion of IUD) (i.e., 58300-22).

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. The qualified clinician should specifically document the total time of the procedure and how it compares with the typical duration of the procedure.

Discontinued IUD Insertion

On occasion, a clinician may elect to discontinue the IUD insertion due to extenuating circumstances or a threat to the patient's well-being. A modifier 53 (discontinued procedure) is added to code 58300 (insertion of IUD) (i.e., 58300-53). 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. 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. If the procedure is performed successfully at a later date, the payer will be more likely to recognize that the first claim (reported with a modifier 53) and the second one are not duplicates.

Same Day IUD Removal and Reinsertion

The following chart shows coding when an IUD is removed and a new one inserted during an office visit. When appropriate and supported by documentation, two CPT procedure codes, an E/M code, and a HCPCS supply code are reported for the one visit. A modifier 51 (multiple procedures) is added to code 58300.

Coding for Same Day Removal and Reinsertion of IUD with an E/M Service

CPT PROCEDURES AND SERVICES	MODIFIER	DIAGNOSIS(ES)
58301 Removal of IUD		Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device
58300 Insertion of IUD	51	
992XX E/M based either on medical decision making or time	25	
HCPCS SUPPLY CODES		
J7296 Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg (5 year duration) J7297 Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg (6 year duration) J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg (6 year duration) J7300 Intrauterine copper contraceptive (Paragard®) (10 year duration) J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg (3 year duration)		Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device

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