Correct coding can result in more appropriate compensation for services. To help practices receive appropriate payment for providing LARC methods, the following information can be helpful. Please see the online version of this Quick Coding Guide [1] for updates, as well as the Billing Quiz [2] that delves into further detail.

### Basic contraceptive implant coding

The insertion and/or removal of the implant are reported using one of the following CPT® codes:

- **11981** Insertion, non-biodegradable drug delivery implant
- **11982** Removal, non-biodegradable drug delivery implant
- **11983** Removal with reinsertion, non-biodegradable drug delivery implant

The diagnostic coding will vary, but usually will be selected from the Encounter for Contraceptive Management code series - V25 in ICD-9-CM or Z30 in ICD-10-CM. These codes are:

- **V25.5** Encounter for contraceptive management, insertion of implantable subdermal contraceptive or
- **Z30.018** Encounter for initial prescription of other contraceptives in ICD-10-CM.
- **V25.43** Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive or
- **Z30.49** For checking, reinsertion, or removal of the implant in ICD-10-CM.

**Note:** ICD-10 codes are scheduled to go into effect October 1, 2015. They may not be reported prior to effective date.

The 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

The insertion and/or removal of IUDs are reported using one of the following CPT codes:

58300 Insertion of IUD
58301 Removal of IUD

Most IUD services will be linked to a diagnosis code from the V25 series (Encounter for Contraceptive Management) or the Z30 series in ICD-10-CM:

V25.11 Insertion of intrauterine contraceptive device or
Z30.430 Encounter for insertion of intrauterine contraceptive device in ICD-10-CM.

V25.12 Removal of intrauterine contraceptive device or
Z30.432 Encounter for removal of intrauterine contraceptive device in ICD-10-CM.

V25.13 Removal and reinsertion of intrauterine contraceptive device or
Z30.433 Encounter for removal and reinsertion of intrauterine contraceptive device in ICD-10-CM.

V25.42 Surveillance of previously prescribed contraceptive method, intrauterine device or
Z30.431 Encounter for routine checking of intrauterine contraceptive device in ICD-10-CM.

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

J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
(Begin use of J7297 on January 1, 2015)

J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
(Begin use of J7298 on January 1, 2015)

J7300 Intrauterine copper contraceptive

J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg

J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Discontinue use of J7302 on December 31, 2015)

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. Documentation must support each billing code.

**E/M Services Code**

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

- If the discussion takes place during a 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) or ICD-10-CM diagnosis code Z30.09 (Encounter for other general counseling and advice on contraception).

**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 not significant and separate.
- If the patient comes in for another reason, such as an annual exam, 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. In order to report an evaluation and management visit based on time, more than 50% of the visit must be spent counseling the patient. When time is the determining factor for the selection of the level of service, documentation should include the following:

- The total length of time spent by the physician with the patient,
- The time spent in counseling and/or coordination of care activities, and
- A description of the content of the counseling and/or coordination of care activities.

Note the “typical times” listed in outpatient E/M services codes 99201?99215. For example, if an established patient is seen for 25 minutes, including 15 minutes spent counseling, report code 99214?this code lists a “typical time” of 25 minutes. The level of history, physical examination, and medical decision making do not matter in selecting this code. Not all payers recognize time spent counseling. Providers should consult 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.

Additional coding guidance

Coding guidance for specific LARC clinical scenarios can also be found on the ACOG LARC Program website [3] and the ACOG Department of Coding and Nomenclature website [4].

ACOG Fellows and their staff can submit specific coding questions to the ACOG Department of Health Economics and Coding at the coding ticket database [5]. Questions are answered in the order received, usually within 3?5 weeks. There is no charge for this service.

*CPT copyright 2014 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Source URL: https://larcprogram.ucsf.edu/coding

Links