Optum

Coding Companion

OB/GYN

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

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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/HCPCS 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/HCPCS 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 Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. 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.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

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 Edits, RVUs, HCPCS, 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 28.3, 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 website address is http://www.optumcoding.com/ProductUpdates/. The 2024 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

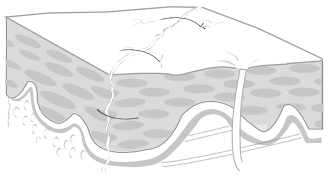
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

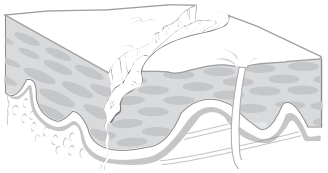
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

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** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov **12021** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.9	0.41	8.98
12021	1.89	3.08	0.31	5.28
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.44	0.41	5.52
12021	1.89	1.95	0.31	4.15 ♀

	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/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ 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 audio-visual 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 93 or 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.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

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 Optum 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.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2024 edition password is **23SPECIALTY**.

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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 codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶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 evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

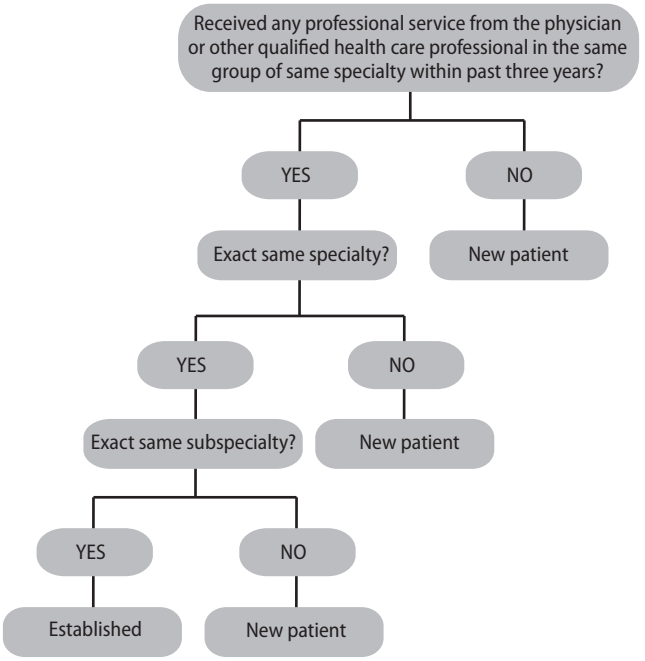
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other 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 subspecialty** 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

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 and 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 not considered 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 patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. 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** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	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*	

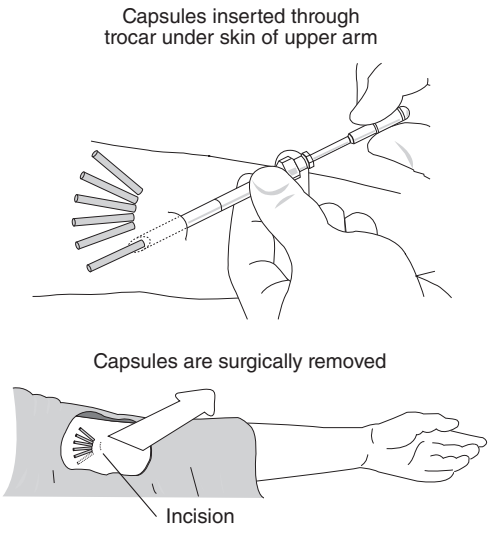
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a physician or other 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** 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

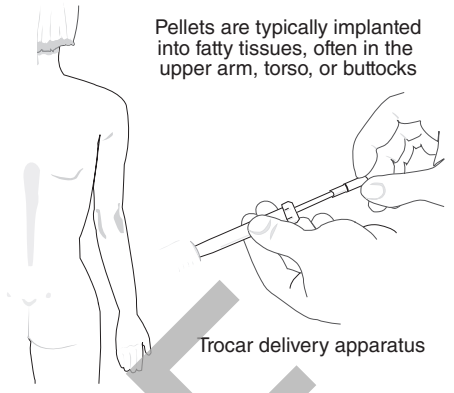
Non-Facility RVU	Work	PE	MP	Total
11976	1.78	2.23	0.28	4.29
Facility RVU	**Work**	**PE**	**MP**	**Total**
11976	1.78	0.68	0.28	2.74

	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

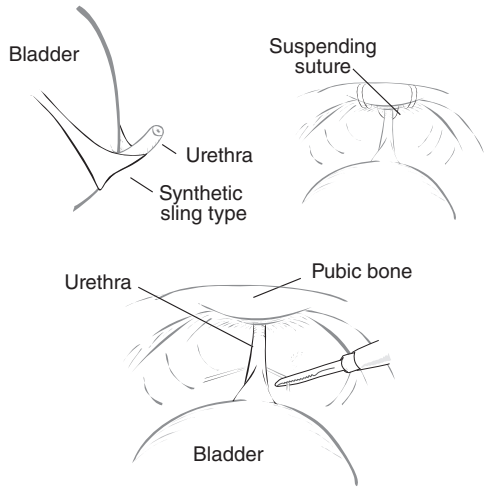
When 11980 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Report supplies and materials separately using 99070 or the appropriate HCPCS Level II code for the cost of 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 A ♀
E28.319 Asymptomatic premature menopause A ♀
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 A

51990-51992

51990 Laparoscopy, surgical; urethral suspension for stress incontinence
51992 sling operation for stress incontinence (eg, fascia or synthetic)



Laparoscopic views showing suspension of urethra

Explanation

The physician makes a 1 cm incision just below the umbilicus through which a fiberoptic laparoscope is inserted. A second incision is made on the left or right side of the abdomen and a second instrument is passed into the abdomen. The physician manipulates the tools so that the pelvic organs can be observed through the laparoscope. The bladder is suspended by placing several sutures through the tissue surrounding the urethra and into support structures. The sutures are pulled tight so that the urethra is elevated and moved forward. In 51992, a sling is placed under the junction of the urethra and bladder. A catheter is inserted into the bladder and an incision is made in the anterior wall of the vagina. Tissue is folded and tacked around the urethra. A sling is formed out of synthetic material or from fascia harvested from the sheath of the rectus abdominis muscle. The loop end of the sling is sutured around the junction of the urethra. An incision is made into the lower abdomen and the ends of the sling are grasped with a clamp and pulled into the incision and sutured to the rectus abdominis sheath. The instruments are removed and incisions are closed with sutures.

Coding Tips

Surgical laparoscopy always includes diagnostic laparoscopy. For removal or revision of sling for stress incontinence, see 57287; open approach for sling procedure, see 57288.

ICD-10-CM Diagnostic Codes

N39.3 Stress incontinence (female) (male)
N39.46 Mixed incontinence

AMA: **51990** 2021,Jul; 2020,Jan; 2019,Feb **51992** 2021,Jul; 2020,Jan; 2019,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
51990	13.36	6.83	1.64	21.83
51992	14.87	7.55	2.23	24.65
Facility RVU	**Work**	**PE**	**MP**	**Total**
51990	13.36	6.83	1.64	21.83
51992	14.87	7.55	2.23	24.65

	FUD	Status	MUE	Modifiers				IOM Reference
51990	90	A	1(2)	51	N/A	62*	80	100-03,230.10
51992	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

mixed incontinence. Type of incontinence that reflects a combination of symptoms from two different types of incontinence: stress and urge incontinence. Stress urinary incontinence results from an increase of pressure on the bladder from actions such as coughing, laughing, or sneezing and urge incontinence is characterized by a sudden and strong need to urinate.

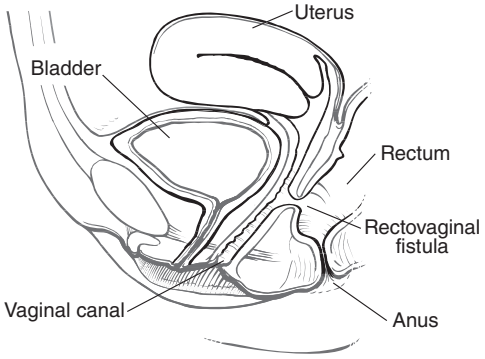
sling operation. Procedure to correct urinary incontinence. A sling of fascia or synthetic material is placed under the junction of the urethra and bladder in females, or across the muscles surrounding the urethra in males.

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

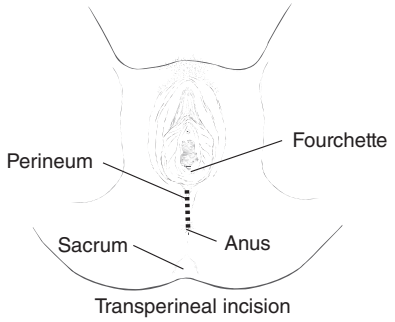
suspension. Fixation of an organ for support; temporary state of cessation of an activity, process, or experience.

57308

57308 Closure of rectovaginal fistula; transperineal approach, with perineal body reconstruction, with or without levator plication



A rectovaginal fistula is surgically closed by transperineal approach



Explanation

Through a transperineal approach, the physician closes a rectovaginal fistula, which is an abnormal passage between the rectum and vagina. The physician also repairs the perineum, fascia, and muscle-supporting structures between the rectum and vagina. The scar tissue and tract between the rectum and vagina are excised and the clean edges sutured together. Often a flap of tissue is transplanted in between the vagina and rectum and the area is closed in multiple layers. The rectal wall opening created during the excision is closed by inverting the mucosa into the rectal canal. The vaginal wall opening is closed by inverting the mucosal layer into the vaginal canal. The vaginal side may be left open for drainage. The perineal body is reconstructed with or without a levator plication.

Coding Tips

For closure of a rectovaginal fistula, abdominal approach, with concomitant colostomy, see 57307; without colostomy, see 57305. For closure of a rectovaginal fistula, vaginal or transanal approach, see 57300. For closure of a urethrovaginal fistula, see 57310 and 57311. For vaginal closure of a vesicovaginal fistula, see 57320 and 57330; abdominal approach, see 51900.

ICD-10-CM Diagnostic Codes

N82.3 Fistula of vagina to large intestine ♀

AMA: **57308** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
57308	10.59	7.66	1.4	19.65
Facility RVU	**Work**	**PE**	**MP**	**Total**
57308	10.59	7.66	1.4	19.65

	FUD	Status	MUE	Modifiers				IOM Reference
57308	90	A	1(3)	51	N/A	62*	80	None

* with documentation

Terms To Know

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures. The approach is not coded separately although it may be a specified component of the procedure, such as laparoscopic versus incisional, or spinal procedures in which the amount of dissection required to expose the spine significantly alters with the site of approach.

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.

plication. Surgical technique involving folding, tucking, or pleating to reduce the size of a hollow structure or organ.

reconstruction. Recreating, restoring, or rebuilding a body part or organ.

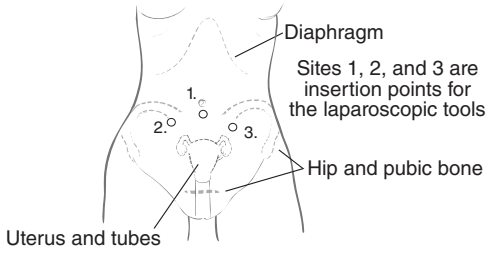
rectovaginal fistula. Abnormal communication between the rectum and the vagina that may follow obstetrical laceration repair, vaginal or rectal surgery, radiation therapy, trauma, or infection with fecal incontinence or leakage into the vaginal canal.

scar tissue. Fibrous connective tissue that forms around a wounded area or injury, composed mainly of fibroblasts or collagenous fibers.

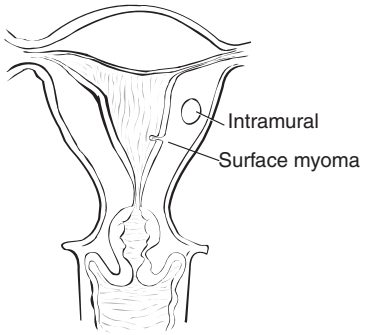
N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

58545

58545 Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas



Intramural myoma(s) are removed



Explanation

The physician performs a laparoscopic myomectomy, removing one to four fibroid tumors from the wall of the uterus (intramural myomas) with a total weight of 250 gm or less and/or removes surface myomas. The patient is placed in the dorsal lithotomy position. A trocar is inserted periumbilically and the abdomen is insufflated with gas. Additional trocars are placed in the right and left lower quadrants. Electrocautery instruments and/or laser may be used to remove small surface myomas. Pedunculated myomas are removed by ligating, twisting, or snaring the stalk. The physician incises the uterus through the myometrium to expose the myoma, which is dissected free from the surrounding myometrium. The pedicle is isolated, clamped, and ligated and the myoma is dissected down to the pedicular blood supply. The adjacent myomas may be reached and removed by tunneling further through the initial incision. The uterine wall defects are sutured laparoscopically, the trocars are removed, and the wounds are closed.

Coding Tips

Surgical laparoscopy always includes diagnostic laparoscopy. For diagnostic laparoscopy, see 49320. Myomectomy performed via an abdominal (open) approach is reported with 58140 or 58146; vaginal approach, see 58145. Hysteroscopy with removal of leiomyomata should be reported with 58561.

ICD-10-CM Diagnostic Codes

D25.0	Submucous leiomyoma of uterus ♀
D25.1	Intramural leiomyoma of uterus ♀
D25.2	Subserosal leiomyoma of uterus ♀
D25.9	Leiomyoma of uterus, unspecified ♀

AMA: **58545** 2021,Aug; 2021,Jul; 2020,Jan; 2019,Jul; 2017,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
58545	15.55	8.63	2.62	26.8
Facility RVU	**Work**	**PE**	**MP**	**Total**
58545	15.55	8.63	2.62	26.8

	FUD	Status	MUE	Modifiers				IOM Reference
58545	90	A	1(2)	51	N/A	62	80	None

* with documentation

Terms To Know

dissect. Cut apart or separate tissue for surgical purposes or for visual or microscopic study.

electrocautery. Division or cutting of tissue using high-frequency electrical current to produce heat, which destroys cells.

insufflation. Blowing air or gas into a body cavity.

intramural uterine leiomyoma. Benign, smooth muscle tumor within the wall of the uterus.

laparoscopy. Direct visualization of the peritoneal cavity, outer fallopian tubes, uterus, and ovaries utilizing a laparoscope, a thin, flexible fiberoptic tube.

ligate. To tie off a blood vessel or duct with a suture or a soft, thin wire (ligature wire).

myometrium. Muscular middle layer of the uterine wall responsible for contractions associated with childbirth.

submucous uterine leiomyoma. Benign, smooth muscle tumor beneath the inner lining of the uterus.

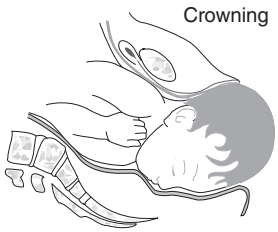
subserous uterine leiomyoma. Benign, smooth muscle tumor beneath the serous membrane lining of the uterus.

trocar. Cannula or a sharp pointed instrument used to puncture and aspirate fluid from cavities.

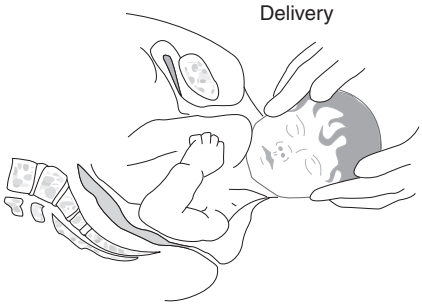
 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

59409-59410

59409 Vaginal delivery only (with or without episiotomy and/or forceps);
59410 including postpartum care



The physician delivers the infant through the vagina



Explanation

The physician delivers an infant and placenta through the uterus and vagina. The physician may elect to assist the delivery with the use of forceps, vacuum extraction, or rupture of membranes. The physician may also elect to do an episiotomy, which is an incision in the perineum to widen the external opening. Episiotomy and laceration repair are included as well. Code 59409 represents the vaginal delivery only and does not include antepartum or postpartum care. Code 59410 covers the vaginal delivery with postpartum care, which includes hospital and office visits following delivery.

Coding Tips

If services provided do not match the code description of vaginal delivery only (59409) or vaginal delivery with postpartum care (59410), use the appropriate stand-alone code (e.g., postpartum care only, 59430, or total OB care, 59400). If care rendered was less than the listed service (i.e., the one that most closely describes the service performed), append modifier 52 and reduce the cost of the service. See notes in CPT for directions on the use of the maternity care and delivery codes. For a vaginal delivery with routine obstetric care including antepartum and postpartum care, see 59400. For cesarean delivery only, see 59514. For cesarean delivery including postpartum care, see 59515. For vaginal delivery after previous cesarean section, see 59610–59614.

ICD-10-CM Diagnostic Codes

O11.5 Pre-existing hypertension with pre-eclampsia, complicating the puerperium M ♀

O12.05 Gestational edema, complicating the puerperium M ♀

O12.15 Gestational proteinuria, complicating the puerperium M ♀

O12.25 Gestational edema with proteinuria, complicating the puerperium M ♀

O13.5 Gestational [pregnancy-induced] hypertension without significant proteinuria, complicating the puerperium M ♀

O14.05 Mild to moderate pre-eclampsia, complicating the puerperium M ♀

O14.15 Severe pre-eclampsia, complicating the puerperium M ♀

O14.25 HELLP syndrome, complicating the puerperium M ♀

O24.435 Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs M ♀

O36.0930 Maternal care for other rhesus isoimmunization, third trimester, not applicable or unspecified M ♀

O36.1130 Maternal care for Anti-A sensitization, third trimester, not applicable or unspecified M ♀

O36.1930 Maternal care for other isoimmunization, third trimester, not applicable or unspecified M ♀

O36.4XX0 Maternal care for intrauterine death, not applicable or unspecified M ♀

O36.5130 Maternal care for known or suspected placental insufficiency, third trimester, not applicable or unspecified M ♀

O36.5930 Maternal care for other known or suspected poor fetal growth, third trimester, not applicable or unspecified M ♀

O36.63X0 Maternal care for excessive fetal growth, third trimester, not applicable or unspecified M ♀

O36.8130 Decreased fetal movements, third trimester, not applicable or unspecified M ♀

O36.8230 Fetal anemia and thrombocytopenia, third trimester, not applicable or unspecified M ♀

O36.8930 Maternal care for other specified fetal problems, third trimester, not applicable or unspecified M ♀

O70.0 First degree perineal laceration during delivery M ♀

O80 Encounter for full-term uncomplicated delivery M ♀

Z39.0 Encounter for care and examination of mother immediately after delivery M ♀

Z39.2 Encounter for routine postpartum follow-up M ♀

AMA: **59409** 2022,Feb; 2019,Jul **59410** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
59409	14.37	5.63	3.73	23.73
59410	18.34	8.29	4.75	31.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
59409	14.37	5.63	3.73	23.73
59410	18.34	8.29	4.75	31.38

	FUD	Status	MUE	Modifiers				IOM Reference
59409	N/A	A	2(3)	51	N/A	N/A	80*	None
59410	N/A	A	1(2)	51	N/A	N/A	N/A	

* with documentation

G0101

G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination

Explanation

This code reports a cervical or vaginal cancer screening and a pelvic and clinical breast examination. The specimen for cancer screening is collected by cervical, endocervical, or vaginal scrapings or by aspiration of vaginal fluid and cells. The pelvic and breast exams are done manually by the physician to check for abnormalities, pain, and/or any palpable lumps or masses.

Coding Tips

If a separately identifiable service is performed in addition to this procedure, an E/M service may be reported with modifier 25 appended. Some payers may require this service to be reported using CPT preventive medicine service codes, new patient, see 99384-99387; established patient, see 99394-99397. Check with specific payers to determine coverage.

ICD-10-CM Diagnostic Codes

Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings ♀

Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings ♀

Z12.39 Encounter for other screening for malignant neoplasm of breast

Z12.4 Encounter for screening for malignant neoplasm of cervix ♀

Z12.72 Encounter for screening for malignant neoplasm of vagina ♀

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0101	0.45	0.63	0.08	1.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0101	0.45	0.29	0.08	0.82

	FUD	Status	MUE	Modifiers				IOM Reference
G0101	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

endocervical canal. Opening between the uterus and the vagina, through the cervix, lined with mucous membrane.

examination. Comprehensive visual and tactile screening and specific testing leading to diagnosis or, as appropriate, to a referral to another practitioner.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

screening pap smear. Diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the early detection of cervical or vaginal cancer. The exam includes a clinical breast examination and a physician's interpretation of the results.

specimen. Tissue cells or sample of fluid taken for analysis, pathologic examination, and diagnosis.

G0130

G0130 Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Explanation

Bone mineral density studies are used to evaluate diseases of bone and/or the responses of bone disease to treatment. Densities are measured at the wrist, radius, hip, pelvis, spine, or heel. The studies assess bone mass or density associated with such diseases as osteoporosis, osteomalacia, and renal osteodystrophy. Single energy x-ray absorptiometry (SEXA) utilizes an x-ray tube as the radiation source that is pulsed at a certain energy level. SEXA is used to scan bone that is in a superficial location with little adjacent soft tissue, such as the wrist or heel. There is a differential attenuation between bone and soft tissue for the energy beam. Excessive soft tissue renders the measurement incorrect. An attenuation profile of the bony components is calculated and the results are given in two scores, which are reported as standard deviations from the normal bone density of a person the same sex, 30 years old, which is the age of peak bone mass, and from the normal bone density of an "age matched" that compares the patient's bone density to what is expected in someone the same age, sex, and size.

Coding Tips

When medically necessary, Medicare may cover a bone mass measurement for a patient once every two years or more for specific conditions. For non-Medicare patients, check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

E83.31 Familial hypophosphatemia

E83.32 Hereditary vitamin D-dependent rickets (type 1) (type 2)

M80.011A Age-related osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture A ☑

M80.021A Age-related osteoporosis with current pathological fracture, right humerus, initial encounter for fracture A ☑

M80.031A Age-related osteoporosis with current pathological fracture, right forearm, initial encounter for fracture A ☑

M80.041A Age-related osteoporosis with current pathological fracture, right hand, initial encounter for fracture A ☑

M80.051A Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture A ☑

M80.061A Age-related osteoporosis with current pathological fracture, right lower leg, initial encounter for fracture A ☑

M80.071A Age-related osteoporosis with current pathological fracture, right ankle and foot, initial encounter for fracture A ☑

M80.0AXA Age-related osteoporosis with current pathological fracture, other site, initial encounter for fracture A

M80.811A Other osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture ☑

M80.821A Other osteoporosis with current pathological fracture, right humerus, initial encounter for fracture ☑

M80.831A Other osteoporosis with current pathological fracture, right forearm, initial encounter for fracture ☑

M80.841A Other osteoporosis with current pathological fracture, right hand, initial encounter for fracture ☑

M80.851A Other osteoporosis with current pathological fracture, right femur, initial encounter for fracture ☑

M80.861A Other osteoporosis with current pathological fracture, right lower leg, initial encounter for fracture ☑

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

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0071T 0213T, 0216T, 0694T, 0708T-0709T, 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

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