Coding for Inserting and Removing IUDs

The following codes can be used when inserting and removing contraceptive IUDs in an outpatient setting:

ICD-10 Diagnosis Codes

Z30.014 Encounter for initial prescription of intrauterine contraceptive device (excludes insertion)

Z30.430 Encounter for insertion of intrauterine contraceptive device

Z30.431 Encounter for routine checking of intrauterine contraceptive device (surveillance)

Z30.432 Encounter for removal of intrauterine contraceptive device

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

Z32.02 Pregnancy test/exam – negative

Z30.09 Encounter for other general counseling and advice on contraception

N92.0 Excessive and frequent menstruation with regular cycle

N92.1 Excessive and frequent menstruation with irregular cycle

N92.4 Excessive bleeding in the premenopausal period

ICD-10-CM Codes - Issues with Device

T83.31XA Breakdown (mechanical) of intrauterine contraceptive device. Initial encounter

T83.31XD Breakdown (mechanical) of intrauterine contraceptive device. Subsequent encounter.

T83.31XS Breakdown (mechanical) of intrauterine contraceptive device. Sequela.

T83.32XA Displacement of intrauterine contraceptive device. Initial encounter.

T83.32XD Displacement of intrauterine contraceptive device. Subsequent encounter.

T83.32XS Displacement of intrauterine contraceptive device. Sequela.

T83.39XA Other mechanical complications of intrauterine contraceptive device. Initial encounter

T83.39XD Other mechanical complications of intrauterine contraceptive device. Subsequent encounter.

T83.39XS Other mechanical complications of intrauterine contraceptive device. Sequela.

For further guidance on coding complex cases with IUDs see, Beyond the Pill's LARC Quick Coding Guide Supplement. For specific clinical scenarios, see The LARC Quick Coding Guide by ACOG's LARC Program.

Out-Patient Procedure Codes – CPT Codes

58300 Insertion, intrauterine device

58301 Removal, intrauterine device

76998 Ultrasonic guidance, intraoperative (U/S guidance must be medically justified and documented)*

76857 Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up*

76830 Ultrasound, transvaginal*

81025 Urine pregnancy test

*U/S must be medically justified with reason documented

HCPCS/J-Codes & National Drug Codes

Product	HCPCS Code	10 Digit NDC	11 Digit NDC**
Mirena→ - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7298	50419-423-01	50419042301
Kyleena→ - Levonorgestrel-releasing intrauterine contraceptive system, 19.5 mg	J7296	50419-424-01	50419042401
Skyla→ - Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg	J7301	50419-422-01	50419042201
Liletta→ - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7297	0023-5858-01	00023585801
ParaGard→ T-380A - Intrauterine copper contraceptive	J7300	59365-5128-1	59365512801

**Some payers, like Tricare and Medicaid, require the 11-digit NDC code for device billing. Check with individual payers for requirements.

Evaluation and Management (E/M) Codes

New (**99202 – 99205**) and established (**99212 – 99215**) client code selection is now based on an updated medical decision making (MDM) level OR time. Use the method most appropriate for the care given and results in the highest level code supported in the documentation. *For further guidance on using E/M codes, see the Reproductive Health National Training Center's E/M Job Aid.*

Coding by MDM: level is based on the highest 2 out of the 3 elements:

Problems	Data	Risk	E/M Code
Minimal	Minimal or none	Minimal risk of morbidity	99202; 99212
Low	Limited	Low risk of morbidity	99203; 99213
Moderate	Moderate	Moderate	99204; 99214
High	Extensive	High risk of morbidity	99205; 99215

Coding by Time

New Patient	Time	Established Patient	Time
99202	15-29 min	99212	10-19 min
99203	30-44 min	99213	20-29 min
99204	45-59 min	99214	30-39 min
99205	60-74 min	99215	40-54 min

Modifiers

- 22 – Increased procedural services for complex or difficult insertion
- 25 – Use with the appropriate E/M code to indicate that significant and separately identifiable E/M was provided on the same date of service as a procedure
- 51 – Multiple procedures performed on the same day, during the same session (e.g. removal of IUD or implant and IUD insertion)
- 52 – Failed procedure. Incomplete procedure due to anatomical factors (e.g. stenosis)

- 53 – Discontinued procedure. Incomplete procedure due to concern for patient's well-being (e.g. perforation, severe pain, perforation)
- 76 – Repeat procedure after IUD successfully inserted but expelled or accidentally removed during visit (same provider)
- 77 – Repeat procedure after IUD successfully inserted but expelled or accidentally removed (another provider)
- 95 – Use this modifier with the appropriate E/M code to indicate a real-time audio and video telehealth visit
- FP – For 340B-eligible entities only. Required for state family planning SPA and waiver programs
- UD – For 340B-eligible entities only. Required in some states for 340B-purchased product

Additional Coding Resources

- Reproductive Health National Training Center:
  - Coding for Telemedicine Visits
  - Elements of Medical Decision-Making During Family Planning Visits
  - Evaluation and Management Codes Job Aid
- ACOG LARC Quick Coding Guide
- ACOG LARC Program Help Desk
- PICCK LARC Billing Guidelines
- Sample Letter of Medical Necessity (Kyleena, Mirena, Skyla)
- Sample Letter of Appeals (Kyleena, Mirena, Skyla)
- NWLC Sample Appeal Letters