Coding for Inserting and Removing IUDs

The following codes can be used when inserting and removing contraceptive IUDs in an out-patient 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

Issues with IUDs

T83.31 Breakdown (mechanical) of intrauterine contraceptive device

T83.32 Displacement of intrauterine contraceptive device

T83.39 Other mechanical complication of intrauterine contraceptive device

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

81025 Pregnancy test

Medication Administration Codes – HCPCS

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

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

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

J7300: Intrauterine copper contraceptive, 10-year duration (ParaGard® T-380A)

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

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

-25 Use this modifier 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

Telehealth Encounter Codes – CPT Codes

-95 Use this modifier with the appropriate E/M code to indicate a real-time audio and video telehealth visit.

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