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®)

October 2021 / www.reproductiveaccess.org
**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:

<table>
<thead>
<tr>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
<th>E/M Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity</td>
<td>99202; 99212</td>
</tr>
<tr>
<td>Low</td>
<td>Limited</td>
<td>Low risk of morbidity</td>
<td>99203; 99213</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>99204; 99214</td>
</tr>
<tr>
<td>High</td>
<td>Extensive</td>
<td>High risk of morbidity</td>
<td>99205; 99215</td>
</tr>
</tbody>
</table>

**Coding by Time**

<table>
<thead>
<tr>
<th>New Patient Time</th>
<th>Established Patient Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 15-29 min</td>
<td>99212 10-19 min</td>
</tr>
<tr>
<td>99203 30-44 min</td>
<td>99213 20-29 min</td>
</tr>
<tr>
<td>99204 45-59 min</td>
<td>99214 30-39 min</td>
</tr>
<tr>
<td>99205 60-74 min</td>
<td>99215 40-54 min</td>
</tr>
</tbody>
</table>

- **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