Coding For Inserting And Removing Progestin Implants

In an outpatient setting

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

**ICD-10 Diagnosis Codes**

- **Z30.017** Encounter for initial prescription of implantable subdermal contraceptive
- **Z30.46** Encounter for surveillance of implantable subdermal contraceptive (includes removal, checking, reinsertion of implant)
- **Z32.02** Pregnancy test/exam – negative
- **Z30.09** Encounter for other general counseling and advice on contraception

**Outpatient Procedure Codes – 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
- **81025** Pregnancy test

**Medication Administration Codes – HCPCS**

- **J7307** Etonogestrel (contraceptive) implant system, including implant and supplies.

**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</th>
<th>Time</th>
<th>Established Patient</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>15-29 min</td>
<td>99212</td>
<td>10-19 min</td>
</tr>
<tr>
<td>99203</td>
<td>30-44 min</td>
<td>99213</td>
<td>20-29 min</td>
</tr>
<tr>
<td>99204</td>
<td>45-59 min</td>
<td>99214</td>
<td>30-39 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
  - Evaluation and Management Codes Job Aid
  - Elements of Medical Decision Making During Family Planning Visits

- ACOG LARC Quick Coding Guide