Optum

Coding Companion

OB/GYN

A comprehensive illustrated guide to coding and reimbursement

2025

optumcoding.com

Contents

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/HCPCS code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- E/M
- 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 29.3, 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 2025 edition password is: **XXXXXX.** 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 xv 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

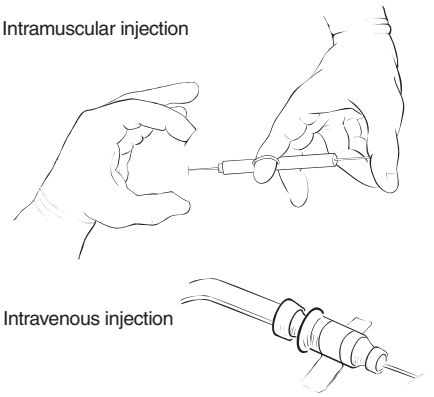
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

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.

90384-90386

90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use
90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use
90386 Rho(D) immune globulin (RhIgIV), human, for intravenous use



Explanation

Code 90384 identifies the human Rho(D) immune globulin (RhIg) for intramuscular use, full-dose; 90385 is for a mini-dose. Code 90386 identifies the human Rho(D) immune globulin (RhIgIV) for intravenous use. This immune globulin is a passive immunization agent that gives protection against reactions between blood that is negative for the presence of Rh antigens on the surface of red blood cells to blood that is positive for the presence of Rh antigens on the RBC. Report these codes with the appropriate administration code.

Coding Tips

Modifier 51 should not be reported with the immune globulin codes when performed with another procedure. Report with the appropriate administration code. Assign the appropriate E/M service code when a significant and separately identifiable service is performed in addition to the administration of the vaccine/toxoid. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

O36.0111 Maternal care for anti-D [Rh] antibodies, first trimester, fetus 1 M ♀
O36.0121 Maternal care for anti-D [Rh] antibodies, second trimester, fetus 1 M ♀
O36.0131 Maternal care for anti-D [Rh] antibodies, third trimester, fetus 1 M ♀
O36.0911 Maternal care for other rhesus isoimmunization, first trimester, fetus 1 M ♀
O36.0921 Maternal care for other rhesus isoimmunization, second trimester, fetus 1 M ♀
O36.0931 Maternal care for other rhesus isoimmunization, third trimester, fetus 1 M ♀
Z41.8 Encounter for other procedures for purposes other than remedying health state

Associated HCPCS Codes

J2790 Injection, Rho D immune globulin, human, full dose, 300 mcg (1500 IU)

AMA: **90384** 2020,Nov; 2020,Jan **90385** 2020,Nov; 2020,Jan **90386** 2020,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90384	0.0	0.0	0.0	0.0
90385	0.0	0.0	0.0	0.0
90386	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90384	0.0	0.0	0.0	0.0
90385	0.0	0.0	0.0	0.0
90386	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90384	N/A	I	0(3)	N/A	N/A	N/A	N/A	None
90385	N/A	E	1(2)	N/A	N/A	N/A	N/A	
90386	N/A	I	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

immune globulin. Serum immunoglobulins, glycoproteins that function as antibodies, are injected to provide passive immunity by increasing the amount of circulating antibodies. It is used to help prevent infections in patients exposed to certain pathogens and to boost immune systems in patients who suffer primary humoral immunodeficiency. Correct code assignment is dependent upon dosage. May be sold under the brand names Flebogamma, Gammagard, Gamunex, Hepagam B, Octagam, Privigen, and Vivaglobin.

intramuscular. Within a muscle.

intravenous. Within a vein or veins.

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 services that may be performed via telehealth. 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	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
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 2023.

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 2025 edition password is **XXXXXX**.

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 nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs

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.

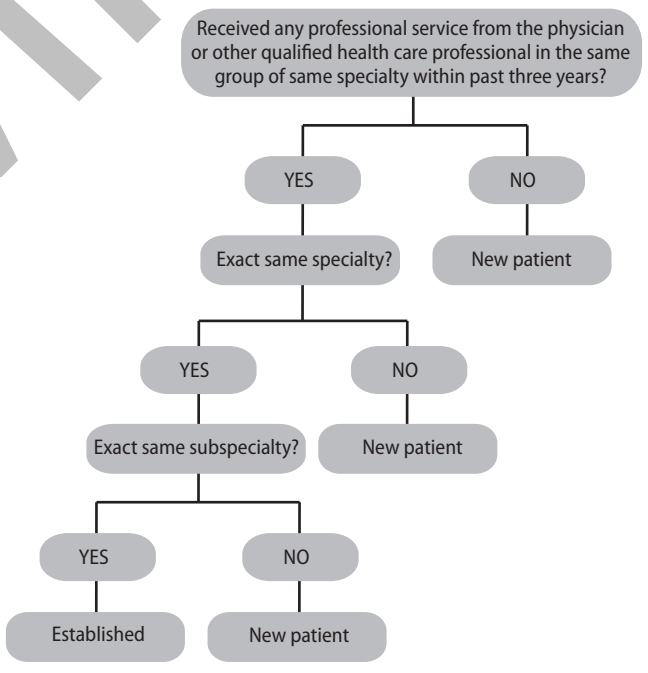
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the 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



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

▲★**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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

▲★**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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

▲★**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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 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. Alternatively, 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. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

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** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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 **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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 **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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 **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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

Relative Value Units/Medicare Edits

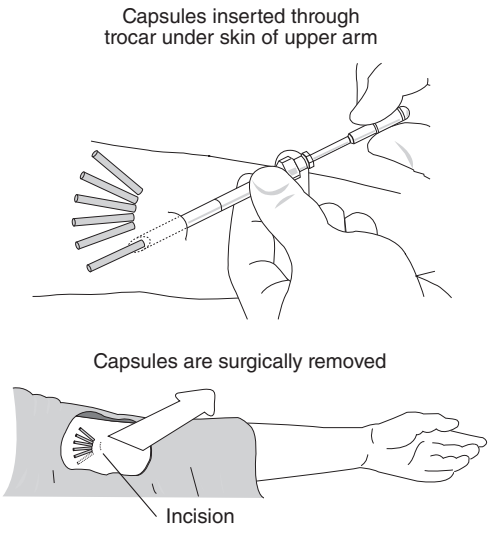
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
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

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. This type of contraception is no longer utilized. For removal of contraceptive capsules with subsequent non-biodegradable drug delivery implant insertion, 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

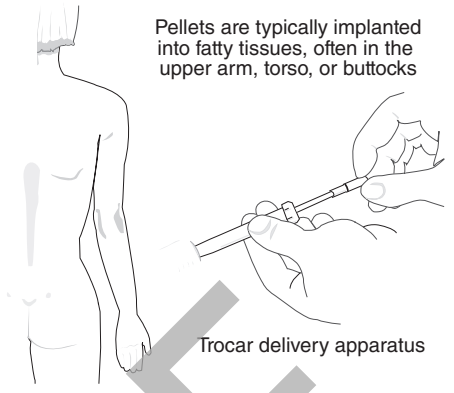
Non-Facility RVU	Work	PE	MP	Total
11976	1.78	2.27	0.29	4.34
Facility RVU	**Work**	**PE**	**MP**	**Total**
11976	1.78	0.69	0.29	2.76

	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.

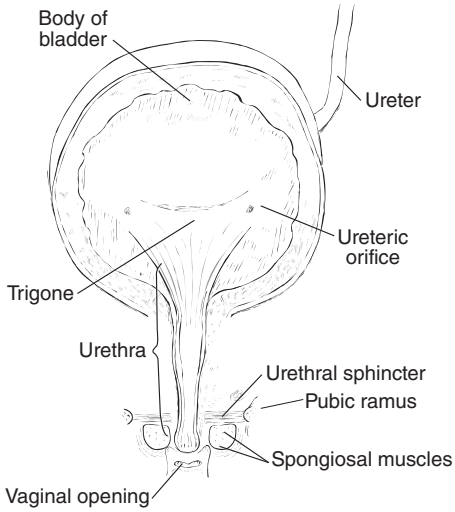
ICD-10-CM Diagnostic Codes

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

51020-51030

51020 Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material

51030 with cryosurgical destruction of intravesical lesion



Frontal section of the female bladder, urethra, and select bone and musculature

Explanation

The physician makes an incision (cystotomy) or creates an opening (cystostomy) into the bladder to destroy abnormal tissue. To access the bladder, the physician makes an incision in the skin of the lower abdomen and cuts the corresponding muscles, fat, fibrous membranes (fascia), and bladder wall. Report 51020 if the physician uses electric current (fulguration) or inserts radioactive material to destroy a lesion on the bladder (usually with the aid of a radiation oncologist). Report 51030 if the physician uses cryosurgery to destroy the lesion. The bladder wall and lower abdomen is sutured closed. If a cystostomy is made, the cystostomy tube is sutured in place and the bladder and abdominal wall is closed.

Coding Tips

For a cystotomy with insertion of a ureteral catheter or stent, see 51045.

ICD-10-CM Diagnostic Codes

C67.0	Malignant neoplasm of trigone of bladder
C67.1	Malignant neoplasm of dome of bladder
C67.2	Malignant neoplasm of lateral wall of bladder
C67.3	Malignant neoplasm of anterior wall of bladder
C67.4	Malignant neoplasm of posterior wall of bladder
C67.5	Malignant neoplasm of bladder neck
C67.6	Malignant neoplasm of ureteric orifice
C67.7	Malignant neoplasm of urachus
C67.8	Malignant neoplasm of overlapping sites of bladder
C79.11	Secondary malignant neoplasm of bladder
D09.0	Carcinoma in situ of bladder
D30.3	Benign neoplasm of bladder
D41.4	Neoplasm of uncertain behavior of bladder
D49.4	Neoplasm of unspecified behavior of bladder
N21.0	Calculus in bladder
N30.10	Interstitial cystitis (chronic) without hematuria
N30.11	Interstitial cystitis (chronic) with hematuria
N32.89	Other specified disorders of bladder

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
51020	7.69	5.33	0.91	13.93
51030	7.81	5.29	0.91	14.01
Facility RVU	**Work**	**PE**	**MP**	**Total**
51020	7.69	5.33	0.91	13.93
51030	7.81	5.29	0.91	14.01

	FUD	Status	MUE	Modifiers				IOM Reference
51020	90	A	1(2)	51	N/A	62*	80	None
51030	90	A	1(2)	51	N/A	N/A	80*	

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

cryosurgery. Application of intense cold, usually produced using liquid nitrogen, to locally freeze diseased or unwanted tissue and induce tissue necrosis without causing harm to adjacent tissue.

cystostomy. Formation of an opening through the abdominal wall into the bladder.

cystotomy. Surgical incision into the gallbladder or urinary bladder.

destruction. Ablation or eradication of a structure or tissue.

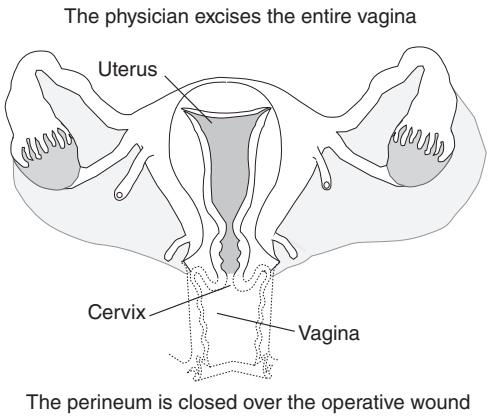
electrocautery. Division or cutting of tissue using high-frequency electrical current to produce heat, which destroys cells.

fulguration. Destruction of living tissue by using sparks from a high-frequency electric current.

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.

57110-57111

57110 Vaginectomy, complete removal of vaginal wall;
57111 with removal of paravaginal tissue (radical vaginectomy)



Explanation

The physician performs a complete removal of the vaginal wall in 57110. This is sometimes proceeded by injection of medication to constrict blood vessels to control bleeding. The vagina is everted. An incision circumscribes the hymen, and the vagina is marked into four quadrants. Each quadrant of vaginal wall is removed by sharp and blunt dissection. In 57111, the physician also removes surrounding diseased and/or damaged tissue. The remaining support tissues are inverted and sutured in place obliterating the space formerly occupied by the vagina. The perineum is closed over the former vaginal opening.

Coding Tips

For vaginectomy with partial removal of the vaginal wall, see 57106; with removal of paravaginal tissue (radical vaginectomy), see 57107; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling, see 57109.

ICD-10-CM Diagnostic Codes

C52	Malignant neoplasm of vagina ♀
C79.82	Secondary malignant neoplasm of genital organs
D07.2	Carcinoma in situ of vagina ♀
D28.1	Benign neoplasm of vagina ♀
D39.8	Neoplasm of uncertain behavior of other specified female genital organs ♀
D49.59	Neoplasm of unspecified behavior of other genitourinary organ
N89.0	Mild vaginal dysplasia ♀
N89.1	Moderate vaginal dysplasia ♀
N89.4	Leukoplakia of vagina ♀

AMA: **57110** 2019,Jul **57111** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
57110	15.48	9.16	2.48	27.12
57111	28.4	18.63	4.67	51.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
57110	15.48	9.16	2.48	27.12
57111	28.4	18.63	4.67	51.7

	FUD	Status	MUE	Modifiers				IOM Reference
57110	90	A	1(2)	51	N/A	62*	80	None
57111	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

blunt dissection. Surgical technique used to expose an underlying area by separating along natural cleavage lines of tissue, without cutting.

dysplasia. Abnormality or alteration in the size, shape, and organization of cells from their normal pattern of development.

malignant neoplasm. Any cancerous tumor or lesion exhibiting uncontrolled tissue growth that can progressively invade other parts of the body with its disease-generating cells.

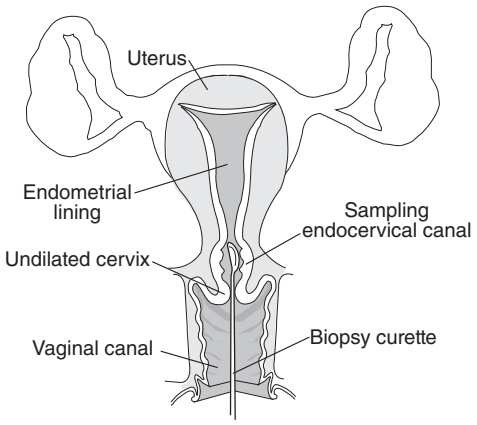
radical. Extensive surgery.

secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

vaginectomy. Surgical excision of all or a portion of the vagina.

58100

58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)



Explanation

The physician inserts a speculum into the vagina to view the cervix. A tool is used to grasp the cervix and pull it down. The physician places a curette in the endocervical canal and passes it into the uterus. The endometrial lining of the uterus is scraped on all sides to obtain tissue for diagnosis. Biopsy(ies) may also be taken from the endocervix. Cervical dilation is not required.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For endometrial sampling/biopsy performed with a colposcopy (57420-57421, 57452-57461), see 58110. For endocervical curettage (not done as part of a dilation and curettage), see 57505. For dilation and curettage, diagnostic and/or therapeutic (nonobstetrical), see 58120. For curettage for postpartum hemorrhage, see 59160.

ICD-10-CM Diagnostic Codes

C53.0 Malignant neoplasm of endocervix ♀
C54.1 Malignant neoplasm of endometrium ♀
C79.82 Secondary malignant neoplasm of genital organs
D06.0 Carcinoma in situ of endocervix ♀
D07.0 Carcinoma in situ of endometrium ♀
D25.0 Submucous leiomyoma of uterus ♀
D25.1 Intramural leiomyoma of uterus ♀
D25.2 Subserosal leiomyoma of uterus ♀
D26.0 Other benign neoplasm of cervix uteri ♀
D26.1 Other benign neoplasm of corpus uteri ♀
D39.0 Neoplasm of uncertain behavior of uterus ♀
D49.59 Neoplasm of unspecified behavior of other genitourinary organ
E28.2 Polycystic ovarian syndrome ♀
N71.0 Acute inflammatory disease of uterus ♀
N71.1 Chronic inflammatory disease of uterus ♀
N72 Inflammatory disease of cervix uteri ♀
N80.01 Superficial endometriosis of the uterus ♀
N80.02 Deep endometriosis of the uterus ♀
N80.03 Adenomyosis of the uterus ♀
N84.0 Polyp of corpus uteri ♀
N84.1 Polyp of cervix uteri ♀
N85.01 Benign endometrial hyperplasia ♀
N85.02 Endometrial intraepithelial neoplasia [EIN] ♀
N85.2 Hypertrophy of uterus ♀
N85.6 Intrauterine synechiae ♀
N85.7 Hematometra ♀
N85.8 Other specified noninflammatory disorders of uterus ♀
N87.0 Mild cervical dysplasia ♀
N87.1 Moderate cervical dysplasia ♀
N88.2 Stricture and stenosis of cervix uteri ♀
N89.7 Hematocolpos ♀
N89.8 Other specified noninflammatory disorders of vagina ♀
N91.0 Primary amenorrhea ♀
N91.1 Secondary amenorrhea ♀
N91.3 Primary oligomenorrhea ♀
N91.4 Secondary oligomenorrhea ♀
N92.0 Excessive and frequent menstruation with regular cycle ♀
N92.1 Excessive and frequent menstruation with irregular cycle ♀
N92.2 Excessive menstruation at puberty P ♀
N92.3 Ovulation bleeding ♀
N92.4 Excessive bleeding in the premenopausal period ♀
N92.5 Other specified irregular menstruation ♀
N93.8 Other specified abnormal uterine and vaginal bleeding ♀
N94.89 Other specified conditions associated with female genital organs and menstrual cycle ♀
N95.0 Postmenopausal bleeding ♀
N95.8 Other specified menopausal and perimenopausal disorders ♀
N97.0 Female infertility associated with anovulation ♀
N97.2 Female infertility of uterine origin ♀

AMA: **58100** 2021,Oct; 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
58100	1.21	1.66	0.19	3.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
58100	1.21	0.48	0.19	1.88

	FUD	Status	MUE	Modifiers				IOM Reference
58100	0	A	1(3)	51	N/A	N/A	N/A	100-03,240.4

* with documentation

Terms To Know

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

curette. Spoon-shaped instrument used to scrape out abnormal tissue from a cavity or bone.

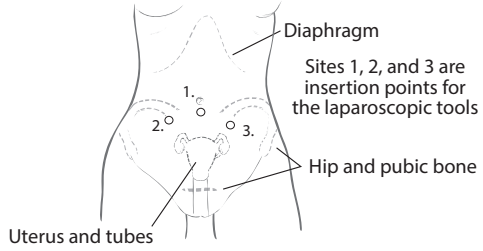
endocervix. Region of the cervix uteri that opens into the uterus or the mucous membrane lining the cervical canal.

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

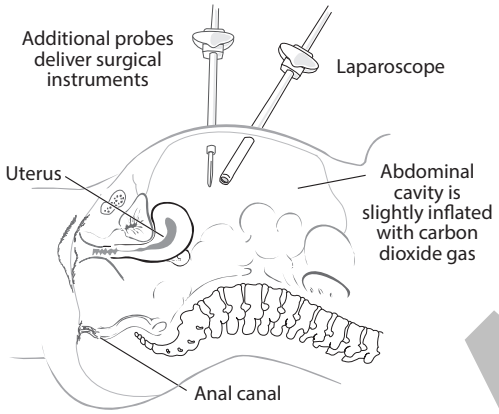
58550-58552

58550 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;

58552 with removal of tube(s) and/or ovary(s)



A vaginal hysterectomy is performed with laparoscopic assistance. Tubes and/or ovaries may also be removed



Explanation

The physician performs surgical laparoscopy with vaginal hysterectomy for a uterus with a total weight of 250 gm or less. The laparoscope is used to perform the initial operative portion of the hysterectomy. The patient is placed in the dorsal lithotomy position for the endoscopic portion. For the vaginal portion, the patient is positioned in stirrups. A trocar is inserted periumbilically and the abdomen is insufflated with gas. Additional trocars are placed in the right and left lower quadrants. An intra-abdominal and pelvic survey is done and any adhesions are lysed. The round ligaments are ligated and incised. Starting on the left round ligament, the vesicouterine peritoneal fold is incised and the peritoneal vessels are dissected and desiccated. The physician continues the incision across the lower uterine segment to the round ligament on the other side and dissects the bladder off the uterus and cervix. Staples are inserted through one port on the side to be stapled or a bipolar coagulation unit is inserted for electrocautery. At this point, if tubes and/or ovaries are to be removed, the infundibulopelvic ligament is now ligated lateral to the ovary. If not, the ligation is done medial to the ovary. Staple ligation or electrodesiccation of the uterine vasculature is accomplished on both sides, followed by ligation or electrodesiccation of the cardinal ligaments. An anterior colpotomy incision is made to enter the vagina and the vaginal portion of the procedure is begun. The remaining supporting structures attached to the cervix and uterus are detached and the hysterectomy proceeds through a posterior cul-de-sac incision. The uterus is removed, the vaginal incision is closed, and hemostasis is confirmed before the trocars are removed and the skin incisions are closed. Report 58550 for removal of uterus or 58552 if uterus, tubes, and/or ovaries are removed.

Coding Tips

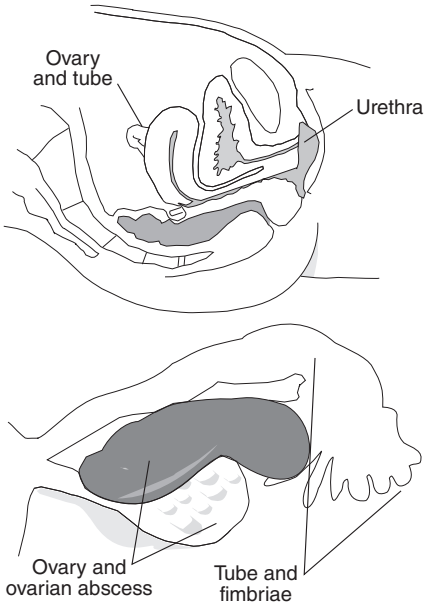
Surgical laparoscopy always includes a diagnostic laparoscopy; the diagnostic laparoscopy should not be reported separately. For a vaginal hysterectomy for a uterus 250 gm or less without laparoscopy, see 58260; with removal of the tubes and/or ovaries, see 58262; and with repair of enterocele, see 58270. For a vaginal hysterectomy for a uterus 250 gm or less without laparoscopy with removal of the tubes and/or ovaries and repair of enterocele, see 58263. For a vaginal hysterectomy for a uterus greater than 250 gm without laparoscopy, see 58290; with removal of the tubes and/or ovaries, see 58291; and with repair of enterocele, see 58294. For a vaginal hysterectomy for a uterus greater than 250 gm without laparoscopy with removal of the tubes and/or ovaries and repair of enterocele, see 58292. For surgical laparoscopy with a vaginal hysterectomy for a uterus greater than 250 gm, see 58553; with removal of tubes and/or ovaries, see 58554.

ICD-10-CM Diagnostic Codes

C53.0	Malignant neoplasm of endocervix ♀
C53.1	Malignant neoplasm of exocervix ♀
C53.8	Malignant neoplasm of overlapping sites of cervix uteri ♀
C54.0	Malignant neoplasm of isthmus uteri ♀
C54.1	Malignant neoplasm of endometrium ♀
C54.2	Malignant neoplasm of myometrium ♀
C54.3	Malignant neoplasm of fundus uteri ♀
C54.8	Malignant neoplasm of overlapping sites of corpus uteri ♀
C56.1	Malignant neoplasm of right ovary ♀ ☑
C56.2	Malignant neoplasm of left ovary ♀ ☑
C56.3	Malignant neoplasm of bilateral ovaries ♀ ☑
C57.01	Malignant neoplasm of right fallopian tube ♀ ☑
C57.02	Malignant neoplasm of left fallopian tube ♀ ☑
C57.11	Malignant neoplasm of right broad ligament ♀ ☑
C57.12	Malignant neoplasm of left broad ligament ♀ ☑
C57.21	Malignant neoplasm of right round ligament ♀ ☑
C57.22	Malignant neoplasm of left round ligament ♀ ☑
C57.3	Malignant neoplasm of parametrium ♀
C57.7	Malignant neoplasm of other specified female genital organs ♀
C57.8	Malignant neoplasm of overlapping sites of female genital organs ♀
C79.61	Secondary malignant neoplasm of right ovary ♀ ☑
C79.62	Secondary malignant neoplasm of left ovary ♀ ☑
C79.63	Secondary malignant neoplasm of bilateral ovaries ♀ ☑
C79.82	Secondary malignant neoplasm of genital organs
D06.0	Carcinoma in situ of endocervix ♀
D06.1	Carcinoma in situ of exocervix ♀
D06.7	Carcinoma in situ of other parts of cervix ♀
D07.0	Carcinoma in situ of endometrium ♀
D07.39	Carcinoma in situ of other female genital organs ♀
D25.0	Submucous leiomyoma of uterus ♀
D25.1	Intramural leiomyoma of uterus ♀
D25.2	Subserosal leiomyoma of uterus ♀
D39.0	Neoplasm of uncertain behavior of uterus ♀
D39.11	Neoplasm of uncertain behavior of right ovary ♀ ☑
D39.12	Neoplasm of uncertain behavior of left ovary ♀ ☑
D39.2	Neoplasm of uncertain behavior of placenta Ⓜ ♀
D39.8	Neoplasm of uncertain behavior of other specified female genital organs ♀

58820-58822

58820 Drainage of ovarian abscess; vaginal approach, open
58822 abdominal approach



Explanation

The physician drains an abscess (infection) on the ovary through an incision in the vagina in 58820 and through a small abdominal incision just above the pubic hairline in 58822. The abscess is drained, cleaned out, and irrigated with antibiotics. Temporary catheters and tubes are often left in place to help drainage.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For drainage of an ovarian cyst, vaginal approach, see 58800; abdominal approach, see 58805. For transrectal or transvaginal image-guided drainage of a peritoneal or retroperitoneal fluid collection via catheter, see 49407.

ICD-10-CM Diagnostic Codes

N70.02 Acute oophoritis ♀
N70.03 Acute salpingitis and oophoritis ♀
N70.12 Chronic oophoritis ♀
N70.13 Chronic salpingitis and oophoritis ♀

AMA: **58820** 2019,Jul **58822** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
58820	4.7	4.76	0.78	10.24
58822	11.81	7.74	1.94	21.49
Facility RVU	**Work**	**PE**	**MP**	**Total**
58820	4.7	4.76	0.78	10.24
58822	11.81	7.74	1.94	21.49

	FUD	Status	MUE	Modifiers				IOM Reference
58820	90	A	1(3)	51	50	N/A	80	None
58822	90	A	1(3)	51	50	62*	80	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

acute. Sudden, severe. Documentation and reporting of an acute condition is important to establishing medical necessity.

aspiration. Drawing fluid out by suction.

cellulitis. Infection of the skin and subcutaneous tissues, most often caused by *Staphylococcus* or *Streptococcus* bacteria secondary to a cutaneous lesion. Progression of the inflammation may lead to abscess and tissue death, or even systemic infection-like bacteremia.

chronic. Persistent, continuing, or recurring.

incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

oophoritis. Inflammation or infection of one or both ovaries that can cause chronic pelvic pain, ectopic pregnancy, or sterilization.

parametritis. Inflammation and infection of the tissue in the structures around the uterus.

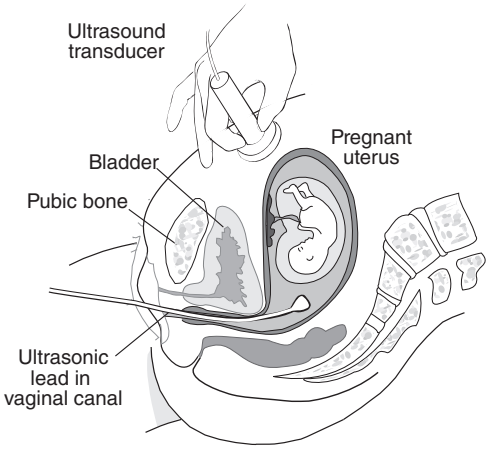
salpingitis. Inflammation of the fallopian tubes, usually caused by a bacterial infection and occurring in conjunction with inflammation of the ovaries (oophoritis).

seroma. Swelling caused by the collection of serum, or clear fluid, in the tissues.

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

76820-76821

76820 Doppler velocimetry, fetal; umbilical artery
76821 middle cerebral artery



Ultrasonography or echography is performed

Explanation

Doppler ultrasonography, or echography, is performed for fetal surveillance to determine the velocity of blood flow through the umbilical artery (76820) or the middle cerebral artery (76821). Doppler works off the principle that when emitted sound waves reflect back off a moving object, the frequency of the reflected waves will vary in relation to the speed of the moving object. The frequency of sound waves bouncing back off moving blood cells is converted to the velocity of blood flow through the vessel and is seen on screen as a wave with peak, systole, and diastole. Velocity waveforms through the umbilical artery of a normally growing fetus are different from those of a growth-retarded fetus. The peak systolic velocity through the middle cerebral artery is inversely related to the amount of hematocrit in fetal blood. These tests determine the timing of labor induction and when fetal anemia is severe enough to require a transfusion. The ultrasound is carried out transabdominally or endovaginally.

Coding Tips

For fetal Doppler echocardiography, see 76827–76828.

ICD-10-CM Diagnostic Codes

O35.01X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, agenesis of the corpus callosum, fetus 1 M ♀

O35.02X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, anencephaly, fetus 1 M ♀

O35.03X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, choroid plexus cysts, fetus 1 M ♀

O35.04X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, encephalocele, fetus 1 M ♀

O35.05X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, holoprosencephaly, fetus 1 M ♀

O35.06X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, hydrocephaly, fetus 1 M ♀

O35.07X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, microcephaly, fetus 1 M ♀

O35.08X1 Maternal care for (suspected) central nervous system malformation or damage in fetus, spina bifida, fetus 1 M ♀

O35.11X1 Maternal care for (suspected) chromosomal abnormality in fetus, Trisomy 13, fetus 1 M ♀

O35.12X1 Maternal care for (suspected) chromosomal abnormality in fetus, Trisomy 18, fetus 1 M ♀

O35.13X1 Maternal care for (suspected) chromosomal abnormality in fetus, Trisomy 21, fetus 1 M ♀

O35.14X1 Maternal care for (suspected) chromosomal abnormality in fetus, Turner Syndrome, fetus 1 M ♀

O35.15X1 Maternal care for (suspected) chromosomal abnormality in fetus, sex chromosome abnormality, fetus 1 M ♀

O35.19X1 Maternal care for (suspected) chromosomal abnormality in fetus, other chromosomal abnormality, fetus 1 M ♀

O35.2XX1 Maternal care for (suspected) hereditary disease in fetus, fetus 1 M ♀

O35.3XX1 Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 1 M ♀

O35.4XX1 Maternal care for (suspected) damage to fetus from alcohol, fetus 1 M ♀

O35.5XX1 Maternal care for (suspected) damage to fetus by drugs, fetus 1 M ♀

O35.6XX1 Maternal care for (suspected) damage to fetus by radiation, fetus 1 M ♀

O35.8XX1 Maternal care for other (suspected) fetal abnormality and damage, fetus 1 M ♀

O36.8211 Fetal anemia and thrombocytopenia, first trimester, fetus 1 M ♀

O36.8221 Fetal anemia and thrombocytopenia, second trimester, fetus 1 M ♀

O36.8231 Fetal anemia and thrombocytopenia, third trimester, fetus 1 M ♀

O43.112 Circumvallate placenta, second trimester M ♀

O43.113 Circumvallate placenta, third trimester M ♀

O43.812 Placental infarction, second trimester M ♀

O43.813 Placental infarction, third trimester M ♀

O44.02 Complete placenta previa NOS or without hemorrhage, second trimester M ♀

O44.03 Complete placenta previa NOS or without hemorrhage, third trimester M ♀

O44.12 Complete placenta previa with hemorrhage, second trimester M ♀

O44.13 Complete placenta previa with hemorrhage, third trimester M ♀

O45.012 Premature separation of placenta with afibrinogenemia, second trimester M ♀

O45.013 Premature separation of placenta with afibrinogenemia, third trimester M ♀

O45.022 Premature separation of placenta with disseminated intravascular coagulation, second trimester M ♀

O45.023 Premature separation of placenta with disseminated intravascular coagulation, third trimester M ♀

O45.092 Premature separation of placenta with other coagulation defect, second trimester M ♀

O45.093 Premature separation of placenta with other coagulation defect, third trimester M ♀

O46.012 Antepartum hemorrhage with afibrinogenemia, second trimester M ♀

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

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	0.65	0.07	1.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0101	0.45	0.3	0.07	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

M80.0B1A Age-related osteoporosis with current pathological fracture, right pelvis, 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 ☑

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