PARTNERS IN CONTRACEPTIVE CHOICE AND KNOWLEDGE

LONG-ACTING REVERSIBLE CONTRACEPTION COVERAGE BILLING GUIDANCE

Version 1.0

Guidance on how to accurately bill for Long-acting reversible contraception (LARC) supplies and services.

PICCK is an innovative clinical and public health program designed to promote contraceptive choice and effective contraceptive counseling across the Commonwealth of Massachusetts.

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INTRODUCTION

This document provides guidance on how to accurately bill for Long-Acting Reversible Contraception (LARC) supplies and services. It is important to remember that there is no one correct way to bill for health care services. Each provider has its own established policies and procedures, and each payer (commercial insurance carrier, MassHealth, etc.) has its own set of billing requirements. Rather than hard and fast rules, this document outlines billing "best practices," meaning that by following the steps outlined here you will improve your success in billing for (and getting paid for!) these services.

NOTE: The information provided should be considered general guidelines. All information noted is as of February 2020. Rules, regulations, and guidelines can and do change frequently. Website links are included throughout this document so you can keep up to date with billing rules.

BILLING LOCATION

Health insurance carriers each have their own requirements for what can be billed at what location. Certain health insurance policies dictate that supplies can be billed from a physician's office, while other insurance carriers require that the supplies must be billed from a pharmacy.

If insurance requires that the supplies must be billed from their pharmacy benefits, your IUD or implant supplier will provide instructions for your patient on how to directly obtain the device from the supplier. Once the patient's device arrives at the office, the patient can be scheduled for an appointment. (See page 4)

If the device can be billed from the provider's supply, include the supply code on your claim when submitting to the insurance carrier. (See page 11)

If you have devices in your office that you do not plan to bill for (such as those obtained through a grant program), you can work with your billing department to create a "non-billable device" code to prevent accidental charges from being processed.

If the device is not covered by the patient's insurance, reach out to the various manufacturers' assistance programs, which often provide help for low-income individuals. (See page 2)

BILLING LOCATION

If you have any issues obtaining reimbursement for LARC procedures and/or devices reach out to the following boards for assistance by sending an e-mail through the "contact us" portion of their websites. Each site gives preference to members when responding to billing related questions.

Board	URL
American Board of Obstetrics and Gynecology (ABOG)	https://www.abog.org/
American College of Obstetrics and Gynecology (ACOG)	https://www.acog.org/About-ACOG/ACOG-Sections/Massachusetts-Section
American Academy of Professional Coders (AAPC)	https://www.aapc.com/

Each manufacturer typically provides billing codes for their products on their websites, along with suggested covered diagnosis codes.

Model or Device	Billing/Reimbursement Information from Manufacturer Website
Mirena, Kyleena, and Sklya	Bayer - https://www.whcsupport.com/forms/
Liletta	Allergan - https://www.lilettahcp.com/en/resources#access-connect
Paragard	ParaGard- https://hcp.paragard.com/ordering-paragard/billing-codes/
Nexplanon	Merck - https://www.merckconnect.com/nexplanon/coverage/billing-codes/

Useful contact information for manufacturers' assistance programs, which provide prescription medicine at no cost to eligible patients.

Model or Device	Assistance Program Contact Information
Mirena, Kyleena, and Sklya	Bayer's ARCH (Access and Resources in Contraceptive Health) Patient Assistance Program. Visit https://www.patientassistance.bayer.us/ or call 1-877-393-9071.
Liletta	Allergan's Patient Assistance Program. Visit https://allergan-web-cdn-prod.azureedge.net/actavis/actavis/media/pdfdocuments/patientassistanceprogram/allergan-us-pap-application.pdf or call 1-844-424-6727.
Paragard	ParaGard Patient Assistance Program. Visit https://www.rxhope.com/PAP/pdf/duramed_paragard_0209.pdf or call 1-800-685-2577.
Nexplanon	Merck's MerckHelps Patient Assistance Program. Visit https://www.merckhelps.com/programs.aspx or call 1-800-727-5400.

COVERAGE

The following includes LARC coverage information, as of February 2020. We provide an insurance verification form that can be used to assist in the coverage determination process. Remember, receiving the correct reimbursement for services and supplies is not simply about submitting a claim. Billing is just one part of a process that begins with scheduling and intake and ends with the claim submission. The insurance verification form will assist in this process.

When a device is not covered at full cost by a payer, contact the contracting department for that payer immediately. Let your contracting representative know that you are not being reimbursed at a rate that covers your cost for the device. They will typically ask you to send them a copy of your invoice. Forward them a copy of your invoice. The payer will then—most of the time—change your contracted rate to a percentage higher (10-20%) than your cost. You can

have the rate be retroactive to the date you began having payment issues. Once the rate is in effect, have your claims reprocessed.

You may have to periodically contact the commercial carriers, particularly if a new IUD comes on the market or an IUD increases in cost and your contract with the payer has not increased enough to cover the cost.

Payer	Information
MassHealth	The MassHealth program covers the following drugs for eligible beneficiaries: • Kyleena • Paragard • Nexplanon • Skyla • Liletta • Mirena MassHealth Drug List - https://masshealthdruglist.ehs.state.ma.us/MHDL/pubdruglistget.do?searchBy=Drug+Brand+Name&searchFor
State of Massachusetts Employees (active and retired)	All active or retired employees of the State of Massachusetts have contraceptive coverage as defined by Chapter 120 or the Acts of 2017. (https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter120).
Health Connector	According to Heathcare.gov, health plans in the Massachusetts health insurance marketplace must cover contraceptive methods and counseling as prescribed by a healthcare provider. Covered contraceptive methods: FDA-approved contraceptive methods prescribed by a patient's doctor are covered, including: • Barrier methods, like diaphragms and sponges • Hormonal methods, like birth control pills and vaginal rings • Implanted devices, like intrauterine devices (IUDs) • Emergency oral contraception, like Plan B and Ella • Sterilization procedures • Patient education and counseling Plans must cover these services without charging a copayment or coinsurance when provided by an in-network provider — even if the member hasn't met their deductible. Exceptions include: • Religious Employers – Certain exempt religious employers do have to cover contraceptive counseling
Commercial Insurance	Under the Affordable Care Act (ACA) commercial carriers must cover contraceptive methods and counseling. Covered contraceptive methods: FDA-approved contraceptive methods prescribed by a patient's doctor are covered, including: • Barrier methods, like diaphragms and sponges • Hormonal methods, like birth control pills and vaginal rings • Implanted devices, like intrauterine devices (IUDs) • Emergency contraception, like Plan B and Ella • Sterilization procedures • Patient education and counseling Exceptions include the following: • Religious Employers – Certain exempt religious employers do not have to cover contraceptive counseling • Non-Profit Religious Organization – May opt out of paying for some or all contraception. You will need to check with the plan's benefits administrator for detailed information.

USING THE INSURANCE VERIFICATION FORM

Not every device or method is covered by every carrier. It is good practice to check with every payer to confirm coverage. The following form can assist you in determining coverage of LARC procedures and devices.

The insurance verification form provided in Appendix 1 allows for your biller/verification staff to collect information needed to verify coverage, including co-payments, deductibles, and co-insurance, and determine whether the supply/device is covered under the patient's medical or pharmacy benefits. The typical workflow for using the insurance verification form is as follows:

1. Patient determines they want LARC contraception;
2. Front desk staff or medical assistant fills out first two sections of the verification form and indicates which type of LARC device the patient and provider have determined the patient will use;
3. Biller/verification staff contacts insurance company;
4. Biller/verification staff documents the information in Section 3 and includes any pertinent notes. Note that biller/verification staff may talk to one insurance representative to discuss the medical coverage of the provider services and then be transferred to another representative to discuss information about the device. Keep notes of all information and note numbers of both representatives.
5. During the call the biller/verification staff will ask if the patient has coverage for the CPT/HCPCS codes, and if they do is there a co-payment, co-insurance, or deductible for the procedure and/or device. They will also verify if the device is covered under the patient's medical benefits (meaning the physician may supply the device from office supply) or if the device is covered under the patient's pharmacy benefits (meaning the patient will need to have the script called into the manufacturer/vendor and the device will be shipped to the provider's office paid by the patient and their pharmacy benefits – provider does not bill for supply).
6. Once verification is completed and documented, the patient can be notified. Co-payment is typically collected up front at the time of visit. Best practice is to collect in full any co-payment required for the device. This insurance verification form can be used for same-day services. If a patient is seen by the provider and it is determined that an IUD or implant should be provided during same-day, it is recommended that the provider move onto the next patient while benefits are checked on the patient that requires the device. By the time the provider is finished, the insurance verification form should be completed. The provider/medical assistant can then discuss with the patient. The patient does not need to move from the exam room (unless you use a special room for procedures) and they usually don't mind waiting for benefits to be checked, as long as they can receive the device the same day.

Best Practices:

- Contact the patient prior to the appointment to discuss expectations for payment upon arrival at appointment, and
- Many manufacturers will provide assistance to patients with IUDs and implants if they are not covered by insurance.

CODING

Documentation is the key to proper coding, whether you are utilizing an electronic health record or a paper record, ensure that you meet the requirements for codes suggested throughout this guide.

IUD Coding

Below are the ICD10 and CPT/HCPCS codes used for IUD:

Procedural Codes for both copper and hormonal IUDs (CPT)	
58300	Insertion of an IUD
58301	Removal of an IUD

HCPCS Codes for IUD Supplies	
J7296	Kyleena – Levonorgestrel-releasing intrauterine contraceptive system 19.5 mg
J7297	Liletta – Levonorgestrel-releasing intrauterine contraceptive system 52 mg
J7298	Mirena – Levonorgestrel-releasing intrauterine contraceptive system 52 mg
J7300	Paragard – Copper intrauterine contraceptive
J7301	Skyla – Levonorgestrel-releasing intrauterine contraceptive system 13.5 mg

Diagnosis Codes (ICD10)	
Z30.014	Encounter for initial prescription of intrauterine contraceptive device (this code includes the initial prescription of the IUD, counseling and advice, but excludes the insertion)
Z30.430	Encounter for the insertion of intrauterine contraception device
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.432	Encounter for removal of intrauterine contraceptive device
Z30.433	Encounter for the removal and reinsertion of intrauterine contraceptive device

CODING

Subdermal Implant Coding

Below are the ICD10 and CPT/HCPCS codes used for Subdermal Implant:

Procedural Codes for etonogestrel-releasing subdermal implant contraception (CPT)	
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant

HCPCS Codes for Implant Supplies	
J7307	Etonogestrel contraceptive implant system, including implant and insertion supplies

Diagnosis Codes (ICD10)	
Z30.017	Encounter for initial prescription and insertion of implantable subdermal contraceptive • Initial prescription • Counseling and advice • Insertion of device (even if it happens at a different encounter)*
Z30.46	Encounter for the checking and removal of implantable subdermal contraceptive • Checking • Reinsertion • Removal**

* Note for Subdermal Implants the insertion of the device is included in the diagnosis code for the initial prescription and counseling; for IUDs there is a separate code.

** Note for Subdermal Implants checking, reinsertion and removal are all covered under one diagnosis code. For IUDs there are separate diagnosis codes for the checking, removal, and reinsertion.

IMPORTANT:

Monitoring of code changes is imperative to ensure you are utilizing the most appropriate codes. Websites such as ACOG, AMA, or coding tools such as Select Coder will provide you with the yearly updates made to CPT, HCPCS, and ICD10 codes.

MODIFIERS

Modifiers are used in healthcare billing to indicate that a procedure or service has been altered by a specific circumstance, but not changed in its definition or code (CPT/HCPCS). Modifiers change the description of service in order to improve accuracy or specificity when billing to an insurance company. Modifiers are added after the CPT or HCPCS code and can be alphabetic, numeric, or a combination of both, but will always be two digits.

Modifier	Definition	Scenarios	Notes
22	Increased procedural services	Complex or difficult insertion, including: • Increased service intensity or procedure time • Increased technical difficulty of performing the procedure • Increased severity of the patient's condition • Increased physical and mental effort required An example is an unsuccessful first attempt at IUD insertion, followed by successful insertion during the same visit	Modifier would be placed on the insertion code. Modifier 22 cannot be used on an E/M code Documentation in the record or procedural note is required describing the additional work performed or time spent. Notes in the chart should always support the use of modifier 22 Submit claim to payer at an increased rate depending on what you are looking to be paid (or with cover letter)
25	Significant, separately identifiable E/M service	Patient has well-women exam same time as LARC procedure	E/M service must be documented separately, meet all criteria of E/M coding, and represent significant work over and above that required for a LARC procedure
51	Multiple Procedures	Patient has an IUD removal and implant insertion on same day	Modifier 51 would be appended to the implant insertion as a multiple procedure on the same day
52	Reduced Service	Provider elected to terminate the procedure for anatomic reasons	Example – patient has cervical stenosis preventing IUD insertion Document in the record the amount of work performed and the reason for not performing all of the work described by the CPT code billed
53	Discontinued Procedure	Provider had to stop procedure due to well-being of patient	Examples – vasovagal reaction, severe pain, uterine perforation Document in the record that the procedure was started, why the procedure was discontinued, and the percentage of the procedure that was performed
76	Repeat Procedure	Successful insertion but the IUD is expelled or accidentally removed during the visit, followed by a repeat insertion	Document in record the need for the repeat procedure

When should I use modifier -52 versus -53?

Modifier -52 should be used to indicate a procedure that could not be completed (reduced procedure) due to *anatomical reasons.* Examples include cervical stenosis, severe uterine retroversion, or body habitus preventing IUD insertion.

Modifier -53 should be used to indicate a procedure that could not be completed (discontinued procedure) due to the ***well-being of the patient***. Examples include perforating the uterus on an IUD insertion, vasovagal reaction, or severe pain intolerance.

PLACE OF SERVICE CODES

Place of service codes are used on professional claims (box 24b) to indicate where a service(s) was rendered. Although there are 99 Place of Service Codes, the most frequently used codes for LARC procedures are indicated below.

Place of Service	Code	Description per Center for Medicare and Medicaid Service
Office	11	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
Inpatient Hospital	21	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
Outpatient Hospital	22	A portion of a hospital's main campus, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
Ambulatory Surgical Center	24	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
Birthing Center	25	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care, as well as immediate care of newborn infants.

Below is a link to Center for Medicare and Medicaid Service Centers Place of Service Codes, short and long descriptions for all active codes:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

BILLING SCENARIOS

Within this document we have provided you a form to collect insurance verification, the appropriate CPT/HCPCS codes for LARC devices and services, and the common modifiers and place of service codes that are needed to accurately bill for LARC services.

In this section you will find the most common scenarios you will likely encounter in your own practice, replete with guidance on how that visit should be billed. The scenarios are similar for both IUDs and implants—the procedure codes and supply codes would change, but the same rules would apply. Services can only be billed separately for IUD insertion if documentation in the patient's chart meets the billing criteria for each visit type (for example, a well-woman exam and an IUD insertion).

These scenarios are meant to be for guidance purposes only; you should code for services provided and for those documented in the patient's chart.

BILLING SCENARIOS

1.0 Scenarios for Subdermal Implant

Scenario 1.1– Well-Woman Visit

Patient comes in for their established well-woman exam and decides they would like an implant during the same visit. The patient is not currently on birth control, so the provider determines a urine pregnancy test (UPT) is recommended, which comes back negative. A full well-woman exam has been documented in their record.

Services	CPT	Modifier	ICD-10
Exam	993XX – (dependent on age) Well-Women Exam	25	Z01.419 – Encounter for gynecological examination without abnormal findings
Procedure	11981 – Insertion of implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive
Labs	81025 – UPT		Z32.02 – Encounter for pregnancy test, negative results
Supply	J7307 – Nexplanon implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive

For both services to be paid correctly, add a modifier 25 to the well-woman exam CPT code to indicate the visit is separate and distinct from the IUD insertion procedure.

You do not bill the code Z30.014 for IUD counseling, since you are billing the visit under the Well-Woman Exam code. If you add the Z30.014 code, the payer may choose to bundle the visit.

Scenario 1.2 – Visit for a Medical Problem

Patient comes in for evaluation of a breast lump. While they are in the exam room, they discuss with the provider wanting a subdermal implant. The visit for the breast lump is documented in full and meets the criteria for a 99213. The patient would like to have the implant while they are in the office and staff determines the implant is covered under their medical benefits.

Services	CPT	Modifier	ICD-10
Exam	99213 – Evaluation and management code	25	N60.21 – Fibroadenosis of right breast
Procedure	11981 – Insertion of implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive
Supply	J7307 – Nexplanon implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive

BILLING SCENARIOS

Scenario 1.3 – Post-Insertion Problem

Patient who had an implant inserted three weeks ago comes into the office, complaining of upper left arm pain around the insertion site. The provider exams their arm and has a 15-minute counseling session with them to determine if they would like to keep the implant or have it removed. The patient determines they will keep the implant and will return if the issue continues. Provider documents the exam and counseling in patient's record.

Services	CPT	Modifier	ICD-10
Exam	99213 – Established E/M visit based on documentation in record		M79.622 – Pain in left upper arm Z30.46 – Encounter for surveillance of implant (includes the removal and reinsertion)

Scenario 1.4 – Removal and Reinsertion

Patient presents for an implant removal and reinsertion only.

Services	CPT	Modifier	ICD-10
Procedure	11983 – Implant removal and reinsertion		Z30.46 – Encounter for surveillance of implant (includes the removal and reinsertion)
Supply	J7307 – Nexplanon implant		Z30.46 – Encounter for surveillance of implant (includes the removal and reinsertion)

BILLING SCENARIOS

Scenario 1.5 – Termination of Pregnancy and Insertion

A new patient comes in to meet the provider. They are pregnant and want a termination of pregnancy and a contraceptive implant placed at the time of the procedure. The provider counsels the patient on the termination procedure (D&C) and on birth control options. Patient consents to D&C and confirms they would like to have an implant at the time of the procedure. Consents are signed. Procedure will be performed on the next day.

Day 1 Billing			
Services	**CPT**	**Modifier**	**ICD-10**
Exam	99202 – New patient, typical time spent 20 minutes		Z64.0 – Problems related to unwanted pregnancy Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive (for counseling)

Day 2 Billing			
Services	**CPT**	**Modifier**	**ICD-10**
Procedure	59840 – Induced abortion by D&C		Z33.2 – Encounter for elective termination of pregnancy
Procedure	11981 – Insertion of implant	51	Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive (for implant)
Supply	J7307 – Nexplanon implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive

***Surgery Scheduled for Same Day**			
Services	**CPT**	**Modifier**	**ICD-10**
Exam	99202 – New patient, typical time spent 20 minutes	25	Z64.0 – Problems related to unwanted pregnancy. Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive
Procedure	59840 – Induced abortion by D&C		Z33.2 – Encounter for elective termination of pregnancy
Procedure	11981 – Insertion of implant	51	Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive
Supply	J7307 – Nexplanon implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive

*If surgery instead is performed on the same day as initial encounter

Scenario 1.6 – Post-delivery and Insertion

The patient is currently being seen for obstetrical care and determines they would like an implant immediately postpartum, while still in the hospital. The provider should bill the OB global billing as normal. The addition of the implant billing would be as follows:

Immediately Following Delivery			
Services	**CPT**	**Modifier**	**ICD-10**
Procedure	59400 – Routine Obstetric Care		080 – Encounter for routine uncomplicated delivery Z37.0 – Single Live Birth Z3A.XX – Weeks gestation
Procedure	11981 – Insertion of implant	51*	Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive
Supply	J7307 – Nexplanon implant		Z30.017 – Encounter for initial prescription of implantable subdermal contraceptive (assuming the provider brings the implant from their office stock)

*Some payers may require a modifier -59 (Distinct Procedure) to be reported instead of modifier -51.

IMPORTANT:

If the hospital provides the device, the Supply code J7307 Nexplanon implant (device) will not be included on your professional claim.

2.0 Scenarios for Intrauterine Devices

Scenario 2.1 – Well-Woman Visit and IUD Insertion

A 24-year-old new patient presents to your office, seeking a new method of birth control and for their well-visit exam. After receiving counseling, they decide on a Liletta IUD and would like to have it inserted during the same appointment. A urine pregnancy test (UPT) is done, and the result is negative. The IUD is supplied from the office and billable on the claim. The IUD is inserted without issues.

Services	CPT	Modifier	ICD-10
Exam	993XX – (dependent on age) Well-Women Exam	25	Z01.419 – Encounter for gynecological examination without abnormal findings
Procedure	58300 – IUD insertion		Z30.430 – Encounter for IUD insertion
Labs	81025 – UPT		Z32.02 – Encounter for pregnancy test, negative results
Supply	J7297 – Liletta IUD		Z30.430 – Encounter for IUD insertion

For both services to be paid correctly, add a modifier 25 to the well-woman exam CPT code to indicate the visit is separate and distinct from the IUD insertion procedure.

You do not bill the code Z30.014 for IUD counseling, since you are billing the visit under the Well-Woman Exam code. If you add the Z30.014 code, the payer may choose to bundle the visit.

BILLING SCENARIOS

Scenario 2.2 – Medical Problem Visit and Failed IUD Insertion

An established patient comes in for evaluation of heavy irregular bleeding. While the patient is in the office, they determine they would also like to discuss contraception. After a documented exam for their irregular bleeding (criteria met for a 99213), and after receiving counseling for birth control, the patient decides they would like to have an IUD inserted during this visit as well. The IUD is supplied from the office and billable on the claim. IUD insertion is not successful due to inability to sound the uterus or pass the IUD inserter.

Services	CPT	Modifier	ICD-10
Exam	99213 – Established E/M visit based on documentation in record	25	N92.1 – Excessive and frequent menstruation with irregular cycle
Procedure	58300 – IUD insertion	52	Z30.430 – Encounter for insertion of intrauterine contraceptive device N88.2 – Structure and stenosis of cervix
Supply*	J7297 – Liletta IUD		Z30.430 – Encounter for insertion of intrauterine contraceptive device

*The IUD, if opened, may not be reimbursed by the payer if it was not inserted. The provider should seek assistance from the manufacturer for a replacement IUD. Best practice is to ascertain if there is stenosis before opening the product.

Scenario 2.3 – IUD Removal and Reinsertion

Patient requests removal and reinsertion of IUD. They have had no issues with their current IUD and wish to continue with the same birth control method.

Services	CPT	Modifier	ICD-10
Procedure	58301 – Removal of IUD		Z30.433 – Removal and reinsertion of an IUD
Procedure	58300 – IUD insertion	51	Z30.433 – Removal and reinsertion of an IUD
Supply	J7300 – Paragard IUD		Z30.433 – Removal and reinsertion of an IUD

IMPORTANT:

IUD removal and reinsertion on the same day requires the use of modifier 51 on the reinsertion CPT code. This indicates that there were two separate procedures performed.

BILLING SCENARIOS

Scenario 2.4 – IUD Insertion with Difficulty

Patient requests IUD insertion. The insertion is difficult due to patient's habitus (their weight is 245 pounds) and increased procedure time which is documented in the medical record.

Services	CPT	Modifier	ICD-10
Procedure	58300 – IUD insertion	22	Z30.430 – Insertion of an IUD E66.01 – Morbid obesity
Supply	J7300 – Paragard IUD		Z30.430 – Insertion of an IUD

Scenario 2.5 – Post-Delivery IUD Insertion

Patient under obstetrical care would like to have an IUD inserted right after delivery during their hospital stay. The provider should bill for the global obstetrical charges based on the patient's delivery. For the IUD insertion the provider should bill the following:

Immediate Insertion Following Delivery			
Services	**CPT**	**Modifier**	**ICD-10**
Delivery	Applicable Vaginal or Cesarean codes		
Procedure	58300 – IUD insertion	51	Z30.430 – Insertion of intrauterine contraceptive device
Supply	J7300 – Paragard IUD		Z30.430 – Insertion of intrauterine contraceptive device (assuming supply is coming from provider's office)

Insertion Following Delivery Pre-Discharge			
Services	**CPT**	**Modifier**	**ICD-10**
Procedure	58300 – IUD insertion	51 (Unrelated procedure during global period)	Z30.430 – Insertion of intrauterine contraceptive device
Supply	J7300 – Paragard IUD		Z30.430 – Insertion of intrauterine contraceptive device (assuming supply is coming from provider's office)

This is the same for immediately postpartum after vaginal delivery, c-section delivery, and pre-discharge vaginal insertion of intrauterine contraceptive device.

IMPORTANT:

If the hospital provides the device, the Supply code J7300 Paragard IUD (device) will not be included on your professional claim.

APPENDIX

Appendix 1:

Insurance Verification Form For IUD and Implantable Subdermal Contraception
https://picck.org/wp-content/uploads/2020/02/Insurance-Verification-Form-For-IUD-and-Implantable-Subdermal-Contraception.pdf

INSURANCE VERIFICATION FORM FOR IUD AND IMPLANTABLE SUBDERMAL CONTRACEPTION

Patient Information

Patient Name:		Date of Birth:	
Patient Insurance Carrier:		ID#:	
Insured:		Group ID:	
Insured Date of Birth:			

Provider Information

Provider performing service:		Tax ID of Group:	
Provider's NPI:		Expected DOS:	

Payer Information

Payer Contact Name:		Payer Contact Telephone:	
Payer Contact Email:		Call ID:	

Notes:

When calling the payer, ask the following questions:

1. Does the patient have coverage for the following CPT/HCPCS codes?

2. Is the device covered under their pharmacy benefits or under their medical benefits? If under pharmacy benefits, how should they obtain the device?

3. Does the patient have a co-payment, deductible, or co-insurance for any of these services (including device and provider services?

Covered pharmacy benefit	Covered medical benefit	Not covered	CPT/ HCPCS Code	Procedure/Device	Co-payment	Deductible	Co-insurance
			11981	Insert implantable device			
			11982	Removal implantable device			
			11983	Removal and insert implantable device			
			J7307	Etonogestrel implant system			
			58300	Insertion of IUD			
			58301	Removal of IUD			
			J7296	Kyleena			
			J7297	Liletta			
			J7298	Mirena			
			J7300	Paragard			
			J7301	Skyla			

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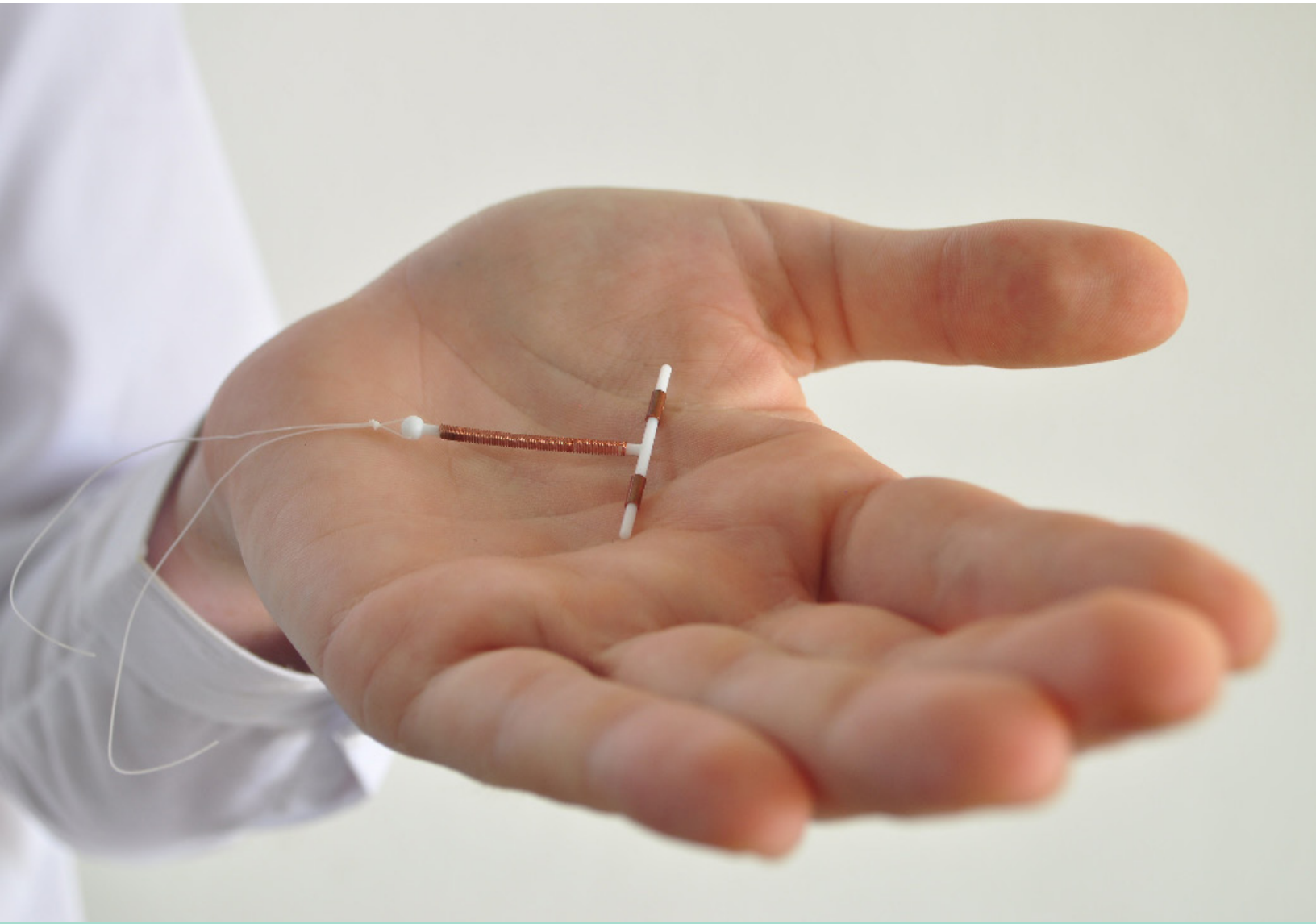

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