Gynecological Procedures

Global and Physician Professional Payment

CPT® and HCPCS Code[1]	Description	Site of Service Component	RVU[2]	2018 National Average Medicare Rate[3]
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	Office/Freestanding (Global)	3.40	$122.40
		Facility (Professional)	1.66	$59.76
58353	Endometrial ablation, thermal, without hysteroscopic guidance	Office/Freestanding (Global)	28.41	$1,022.75
		Facility (Professional)	6.17	$222.12
58555	Hysteroscopy, diagnostic (separate procedure)	Office/Freestanding (Global)	7.60	$273.60
		Facility (Professional)	4.37	$157.32
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	Office/Freestanding (Global)	38.52	$1,386.70
		Facility (Professional)	6.67	$240.12
58561	Hysteroscopy, surgical; with removal of leiomyomata	Office/Freestanding (Global)	NA	NA
		Facility (Professional)	10.30	$370.80
58563*	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	Office/Freestanding (Global)	44.95	$1,618.18
		Facility (Professional)	7.09	$255.24
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	Office/Freestanding (Global)	52.68	$1,896.46
		Facility (Professional)	12.19	$438.84
74740	Hysterosalpingography, radiological supervision and interpretation	Office/Freestanding (Global)	2.11	$75.96
		Facility (Professional)	0.54	$19.44
76830	Ultrasound, transvaginal	Office/Freestanding (Global)	3.48	$125.28
		Facility (Professional)	0.99	$35.64
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed	Office/Freestanding (Global)	3.41	$122.76
		Facility (Professional)	1.05	$37.80

Additional Procedural Codes

58300**	Insertion of intrauterine device (IUD)	Office/Freestanding (Global)	2.09	$75.24
		Facility (Professional)	1.54	$55.44
58301	Removal of intrauterine device (IUD)	Office/Freestanding (Global)	2.70	$97.20
		Facility (Professional)	1.92	$69.12
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	Office/Freestanding (Global)	Non-allowed service for Medicare May be subject to review for payment by commercial payor/health plan	
		Facility (Professional)		

* Hysteroscopy is not required with the NovaSure® system.

** This code is not payable by Medicare.

Site of Service[4]

Site of Service Code	Site of Service Name	Site of Service Description
11	Office	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.
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

1. American Medical Association (AMA), 2018 Current Procedural Terminology (CPT), Professional Edition. CPT codes and descriptions only are copyright 2017 AMA. All rights reserved. The AMA assumes no liability for data contained herein. No fee schedules, basic units, relative or related listings are included in CPT. Applicable FARS/DFARS Restrictions Apply for Government Use. Centers for Medicare & Medicaid Services (CMS), 2018 Healthcare Common Procedure Coding System (HCPCS) codes, available at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
2. The 2018 physician relative value units (RVUs) are from the 2018 RVU file available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending.
3. The national average 2018 Medicare rates to physicians shown are based on the 2018 conversion factor of $35.9996 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2018 should be available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Any payment rates listed may be subject to change without notice. Actual payment to a physician will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
4. AMA, 2018 CPT, Professional Edition.

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CPT® and HCPCS Code[1]	Description	Site of Service	APC[2]	Status Indicator	2018 National Average Medicare Rate[2]
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	Hospital	NA	N	Packaged
		ASC	NA	N1	Packaged
58353	Endometrial ablation, thermal, without hysteroscopic guidance	Hospital	5415	J1	$4,111.52
		ASC	5415	A2	$1,839.48
58555	Hysteroscopy, diagnostic (separate procedure)	Hospital	5414	J1	$2,272.61
		ASC	5414	A2	$1,122.14
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	Hospital	5414	J1	$2,272.61
		ASC	5414	A2	$1,122.14
58561	Hysteroscopy, surgical; with removal of leiomyomata	Hospital	5415	J1	$4,111.52
		ASC	5415	A2	$1,839.48
58563*	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	Hospital	5415	J1	$4,111.52
		ASC	5415	A2	$1,839.48
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	Hospital	5415	J1	$4,111.52
		ASC	5415	A2	$1,839.48
74740	Hysterosalpingography, radiological supervision and interpretation	Hospital	5523	Q2	$245.22
		ASC	NA	N1	Packaged

Additional Procedural Codes

58300	Insertion of intrauterine device (IUD)	Hospital	NA	E1	Non-allowed/not paid by Medicare
		ASC	NA	NA	Not payable in the ASC setting
58301	Removal of intrauterine device (IUD)	Hospital	5411	Q2	$160.69
		ASC	5412	P3	$46.08
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	Hospital	NA	E1	Non-allowed/not paid by Medicare
		ASC	NA	NA	Not payable in the ASC setting

*Hysteroscopy is not required with the NovaSure® system.

Modifier Information[3]

Modifier	Description	Explanation
52	Reduced services	Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
53	Discontinued procedure	Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

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2. The national average 2018 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2018 Medicare rates for the ambulatory surgical center setting are from the Ambulatory Surgical Center Approved HCPCS Codes and Payment Rates Addenda AA and BB, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.
3. AMA, 2018 CPT, Professional Edition.

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Status and Payment Indicator Information[1]

Status and Payment Indicator	Explanation
HOPPS Status Indicator	
E1	Not paid by Medicare when submitted on outpatient claims
J1	Comprehensive APC paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with status indicator "F", "G", "H", "L" and "U"
N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
Q2	Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T"
S	Significant procedure not subject to multiple procedure discount
T	Paid separately under OPPS but multiple procedure reduction applies
ASC Payment Indicator	
A2	Payment based on OPPS relative payment weight
N1	Packaged service/item; no separate payment made
P3	Payment based on MPFS nonfacility practice expense RVU

1. The national average 2018 Medicare rates for the hospital outpatient setting are from Hospital Outpatient Prospective Payment System (OPPS) Addendum B, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The national average 2018 Medicare rates for the ambulatory surgical center setting are from the Ambulatory Surgical Center Approved HCPCS Codes and Payment Rates Addenda AA and BB, January 2018, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. Any payment rates listed are Medicare national averages that may be subject to change without notice and do not reflect payment cuts due to sequestration. Actual payment to a hospital or ambulatory surgical center will vary based on geographic location and may also differ based on policies and fee schedules outlined as terms in your health plan and/or payer contracts.

Hologic provides this coding guide for informational purposes only. This guide is not an affirmative instruction as to which codes and modifiers to use for a particular service, supply, procedure or treatment. It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any service, supply, procedure or treatment rendered. Actual codes and/or modifiers used are at the sole discretion of the treating physician and/or facility. Contact your local payer for specific coding guidelines. Hologic cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide.