January
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coding & reimbursement guide

GYN SURGICAL SOLUTIONS

HOLOGIC® The Science of Sure

Gynecological Procedures
Global and Physician Professional Payment

CPT® and HCPCS Code[1]	Description	Site of Service Component	RVU[2]	2024 National Average Medicare Rate[3]
58300**	Insertion of intrauterine device (IUD)	Global (Office/Freestanding)	3.31	$108.38
		Professional (Facility)	1.50	$49.12
58301	Removal of intrauterine device (IUD)	Global (Office/Freestanding)	3.33	$109.04
		Professional (Facility)	1.98	$64.83
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	Global (Office/Freestanding)	7.26	$237.72
		Professional (Facility)	1.73	$56.65
58353	Endometrial ablation, thermal, without hysteroscopic guidance	Global (Office/Freestanding)	27.64	$905.05
		Professional (Facility)	6.97	$228.23
58555	Hysteroscopy, diagnostic (separate procedure)	Global (Office/Freestanding)	10.84	$354.95
		Professional (Facility)	4.53	$148.33
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	Global (Office/Freestanding)	39.55	$1,295.03
		Professional (Facility)	6.92	$226.59
58561	Hysteroscopy, surgical; with removal of leiomyomata	Global (Office/Freestanding)	NA	NA
		Professional (Facility)	10.70	$350.36
58563*	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	Global (Office/Freestanding)	62.67	$2,052.08
		Professional (Facility)	7.35	$240.67
58674	Laparoscopy, surgical, ablation of uterine fib oid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Global (Office/Freestanding)	NA	NA
		Professional (Facility)moni-	24.49	$801.91
74740	Hysterosalpingography, radiological supervision and interpretation	Global (Office/Freestanding)	2.81	$92.01
		Professional (Facility)	0.54	$17.68
76830	Ultrasound, transvaginal	Global (Office/Freestanding)	3.58	$117.22
		Professional (Facility)	0.97	$31.76
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed	Global (Office/Freestanding)	3.49	$114.28
		Professional (Facility)	1.02	$33.40

* Hysteroscopy is not required with the NovaSure® system.

** This code is not payable by Medicare.

Place-of-Service[4]

Place-of-Service Code	Place-of-Service Name	Place 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.

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Facility Payment

CPT® and HCPCS Code	Description	Place-of-Service	APC[5]	Status/ Payment Indicator	2024 National Average Medicare Rate[2]
58300	Insertion of intrauterine device (IUD)	Hospital	NA	E1	Non-allowed/not paid
		ASC	NA	NA	Not payable in the ASC setting
58301	Removal of intrauterine device (IUD)	Hospital	5412	Q2	$305.66
		ASC	NA	P3	$60.58
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	$4,739.10
		ASC	NA	A2	$2,135.57
58555	Hysteroscopy, diagnostic (separate procedure)	Hospital	5414	J1	$2,978.77
		ASC	NA	A2	$1,586.25
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	Hospital	5414	J1	$2,978.77
		ASC	NA	A2	$1,586.25
58561	Hysteroscopy, surgical; with removal of leiomyomata	Hospital	5415	J1	$4,739.10
		ASC	NA	A2	$2,135.57
58563*	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	Hospital	5415	J1	$4,739.10
		ASC	NA	A2	$2,135.57
58764	Laparoscopy, surgical, ablation of uterine fib oids(s) including intraoperative ultrasound guidance and monitoring, readiofrequency	Hospital	5362	J1	$9,807.76
		ASC	NA	G2	$4,540.64
74740	Hysterosalpingography, radiological supervision and interpretation	Hospital	5523	Q2	$233.47
		ASC	NA	N1	Packaged

*Hysteroscopy is not required with the NovaSure® system.

Devices

CPT® and HCPCS Code	Description	Place-of-Service	APC[5]	Status Indicator	2024 National Average Medicare Rate[5]
A4649	Surgical supply; miscellaneous	Hospital	NA	N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment
C1889*	Implantable/insertable device, not othewise classified	Hospital	NA	N	Payment is packaged into payment for other services. Therefore, there is no separate APC payment

* CMS created HCPCS code C1889 to recognize devices furnished during a procedure that are not described by a specific Level II HCPCS Category C-code. 85 Fed. Reg. 85,866 86,017 (Dec. 29, 2020). C1889 is appropriate for billing for implantable or insertable devices furnished in the hospital outpatient or ASC setting.

Modifier Information[1]

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 qualifie 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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Status and Payment Indicator Information[6]

Status and Payment Indicator	Explanation
	OPPS 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"
	ASC Payment Indicator
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
N1	Packaged service/item; no separate payment made
P3	Office-based surgical p ocedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs

1. Current Procedural Terminology (CPT) 2024 Professional Edition. CPT copyright 2023 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Centers for Medicare & Medicaid Services (CMS), 2024 Healthcare Common Procedure Coding System (HCPCS) codes, available at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update
2. The 2024 physician relative value units (RVUs) are from the January 2024 release of the Physician Fee Schedule (PFS) Relative Value Files, file RVU23A,available from the CMS website at https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.
3. The national average 2024 Medicare rates to physicians shown are based on the 2024 conversion factor of $32.7442 and do not reflect payment cuts due to sequestration. Medicare payment for a given procedure in a given locality in 2024 is available in the Medicare Physician Fee Schedule Look-up file accessible through the CMS website at https://www.cms.gov/medicare/physician-fee-schedule/search. 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. CMS, Place of Service Code Set, available at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.
5. The national average 2024 Medicare hospital outpatient rates and status indicators are from the January 2024 Hospital Outpatient Prospective Payment System (OPPS) release, Addendum B, accessible at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates. The national average 2024 Medicare ambulatory surgical center rates and payment indicators are from the January 2024 Ambulatory Surgical Center (ASC) Payment release, Addenda AA, BB, and DD1, accessible at https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda 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.
6. The OPPS Payment Status Indicators for CY 2024 are from the 2024 Hospital Outpatient Prospective Payment System (OPPS) Final Rule, Addendum D1, accessible at hhttps://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/hospital-outpatient-regulations-and/cms-1786-p. The ASC Payment Status Indicators for CY 2024 are from the 2024 Ambulatory Surgical Center Payment Final Rule, Addenda DD1, accessible at https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc

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