Optum

Coding Companion

OB/GYN

A comprehensive illustrated guide to coding and reimbursement

2026

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, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

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 30.3, 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 2026 edition password is: **XXXXX.** 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

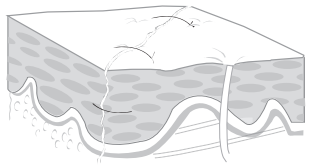
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

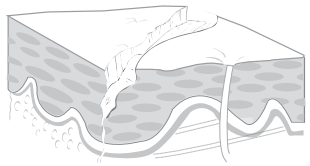
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

12020-12021

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The physician cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips

For extensive or complicated secondary wound closure, see 13160. Medicare and some other payers may require G0168 be reported for wound closure by tissue adhesives only. 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.

ICD-10-CM Diagnostic Codes

O90.0	Disruption of cesarean delivery wound
O90.1	Disruption of perineal obstetric wound
T81.31XA	Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter
T81.33XA	Disruption of traumatic injury wound repair, initial encounter

Associated HCPCS Codes

G0168	Wound closure utilizing tissue adhesive(s) only

AMA: **12020** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov **12021** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.94	0.42	9.03
12021	1.89	3.15	0.31	5.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.57	0.42	5.66
12021	1.89	2.05	0.31	4.25

	FUD	Status	MUE	Modifiers				IOM Reference
12020	10	A	2(3)	51	N/A	N/A	N/A	None
12021	10	A	3(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

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

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

perineal. Pertaining to the pelvic floor area between the thighs; the diamond-shaped area bordered by the pubic symphysis in front, the ischial tuberosities on the sides, and the coccyx in back.

subcutaneous. Below the skin.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

wound repair. Surgical closure of a wound is divided into three categories: simple, intermediate, and complex. ***simple repair:*** Surgical closure of a superficial wound, requiring single layer suturing of the skin epidermis, dermis, or subcutaneous tissue. ***intermediate repair:*** Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin; contaminated wounds with single layer closure that need extensive cleaning or foreign body removal. ***complex repair:*** Repair of wounds requiring more than layered closure (debridement, scar revision, stents, retention sutures).

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2026.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2026.
- ▲ This CPT code description is revised for 2026.
- ✚ 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. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

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	96041
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 a 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
- ☑ 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 2025.

The 2026 Medicare edits were not available at the time this book went to press. Updated 2026 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2026 edition password is **XXXXX**.

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 when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

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 has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services 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** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 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 **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 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 **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 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 **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

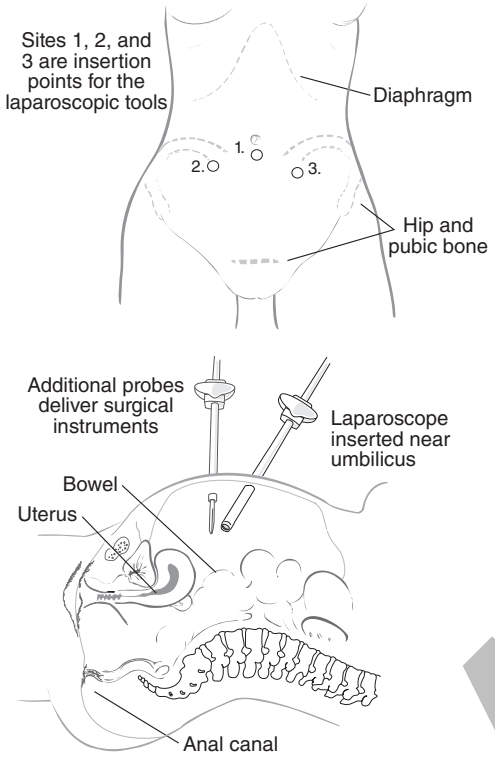
	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

49320

49320 Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)



Explanation

The physician makes a 1.0-centimeter incision in the umbilicus through which the abdomen is inflated and a fiberoptic laparoscope is inserted. Other incisions are also made through which trocars can be passed into the abdominal cavity to deliver instruments, a video camera, and when needed an additional light source. The physician manipulates the tools so that the pelvic organs, peritoneum, abdomen, and omentum can be viewed through the laparoscope and/or video monitor. Biopsy from any or all of the areas observed are obtained by brushing the surface and collecting the cells or by washing (bathing) the area with a saline solution, and suctioning out the cell rich solution. When the procedure is complete, the laparoscope, instruments, and light source are removed and the incisions are closed with sutures. If biopsy of pelvic organs is performed, the physician may also insert an instrument through the vagina to grasp the cervix and pass another instrument through the cervix, into the uterus to manipulate the uterus.

Coding Tips

Surgical laparoscopy always includes diagnostic laparoscopy. 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 or services it may be report. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. For exploratory laparotomy (open approach), exploratory celiotomy, with or without biopsies, see 49000. For surgical laparoscopy, report a code from the appropriate anatomical section in CPT. For fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface via laparoscopy, see 58662.

ICD-10-CM Diagnostic Codes

C26.9	Malignant neoplasm of ill-defined sites within the digestive system
C48.1	Malignant neoplasm of specified parts of peritoneum
C48.2	Malignant neoplasm of peritoneum, unspecified
C48.8	Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C57.3	Malignant neoplasm of parametrium
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
C76.2	Malignant neoplasm of abdomen
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.89	Secondary malignant neoplasm of other specified sites
D09.8	Carcinoma in situ of other specified sites
D20.1	Benign neoplasm of soft tissue of peritoneum
D36.7	Benign neoplasm of other specified sites
D48.4	Neoplasm of uncertain behavior of peritoneum
D48.7	Neoplasm of uncertain behavior of other specified sites
D49.0	Neoplasm of unspecified behavior of digestive system
D49.89	Neoplasm of unspecified behavior of other specified sites

AMA: **49320** 2023,Dec; 2022,Dec; 2021,Aug; 2021,Jul; 2020,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
49320	5.14	3.58	1.22	9.94
Facility RVU	**Work**	**PE**	**MP**	**Total**
49320	5.14	3.58	1.22	9.94

	FUD	Status	MUE	Modifiers				IOM Reference
49320	10	A	1(3)	51	N/A	N/A	80	None

* with documentation

Terms To Know

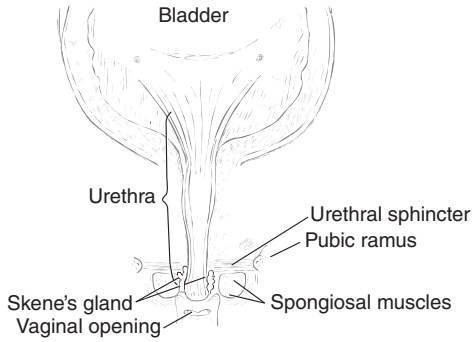
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

omentum. Fold of peritoneal tissue suspended between the stomach and neighboring visceral organs of the abdominal cavity.

peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.

53060

53060 Drainage of Skene's gland abscess or cyst



Frontal section of the female bladder and urethra showing Skene's (or paraurethral) gland

Explanation

The physician drains an abscess or a cyst of the Skene's gland, the paraurethral glands in the female. The physician makes an incision through the skin, subcutaneous tissue, and overlying layers of muscle, fat, and tissue (fascia) over the site of the abscess. By blunt or sharp dissection, the incision is carried into the abscess or cyst. Several drains are inserted and the incision is closed in layers.

Coding Tips

For removal or destruction by electric current (fulguration) of Skene's glands, see 53270. Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For drainage of a subcutaneous abscess, see 10060–10061. Dilation or manipulation of the urethra is not separately identified. 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.

ICD-10-CM Diagnostic Codes

N34.0 Urethral abscess

N36.8 Other specified disorders of urethra

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
53060	2.68	2.59	0.45	5.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
53060	2.68	1.87	0.45	5.0

	FUD	Status	MUE	Modifiers				IOM Reference
53060	10	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

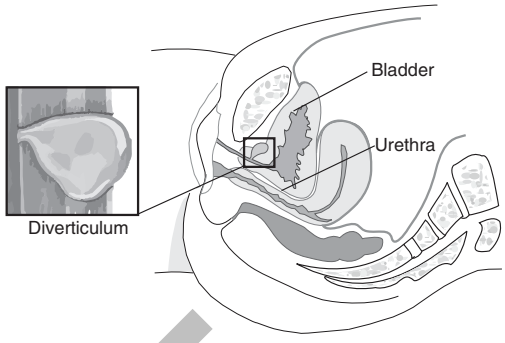
Terms To Know

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

Skene's gland. Paraurethral ducts that drain a group of the female urethral glands into the vestibule.

53230

53230 Excision of urethral diverticulum (separate procedure); female



A diverticulum of the urethra is excised. Typically the urethra is reconstructed around a temporary catheter

Explanation

The physician removes a urethral diverticulum. A longitudinal incision is made in the anterior vaginal wall and the urethral diverticulum is separated from the vaginal wall by a combination of blunt and sharp dissection. The urethra may be opened back to the orifice of the diverticulum in order to facilitate identification. A balloon catheter may be inserted and inflated. Once the diverticulum has been excised, the urethra is closed over a catheter and the vaginal wall is repaired with a layered closure.

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 or 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. Dilation or manipulation of the urethra is not reported separately. For marsupialization of the urethral diverticulum, see 53240. For excision or fulguration of urethral polyps, see 53260. 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.

ICD-10-CM Diagnostic Codes

N36.1 Urethral diverticulum

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
53230	10.44	6.43	1.43	18.3
Facility RVU	**Work**	**PE**	**MP**	**Total**
53230	10.44	6.43	1.43	18.3

	FUD	Status	MUE	Modifiers				IOM Reference
53230	90	A	1(3)	51	N/A	62*	80	None

* with documentation

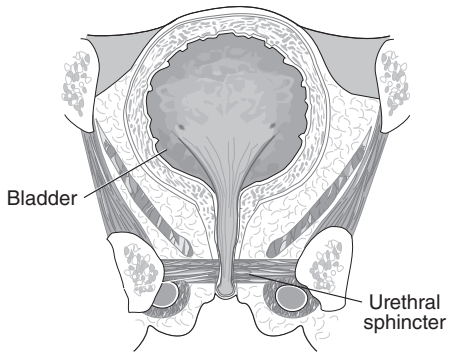
Terms To Know

diverticulum. Pouch or sac in the walls of an organ or canal.

excision. Surgical removal of an organ or tissue.

57220

57220 Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)



Cross section of female bladder

Explanation

The physician accesses the urethral sphincter from the vagina. With a catheter in the urethra, the physician dissects the midline vaginal wall separating it from the bladder and the proximal urethra. Sutures are placed at the junction of the bladder and urethra on each side of the urethra. This supports the area. Excess vaginal tissue is excised and the vaginal wall is closed.

Coding Tips

For a Marshall-Marchetti-Krantz urethral suspension, abdominal approach, see 51840-51841. For laparoscopic repair of stress incontinence only, see 51990-51992.

ICD-10-CM Diagnostic Codes

N39.3 Stress incontinence (female) (male)

AMA: **57220** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
57220	4.85	4.86	0.78	10.49
Facility RVU	**Work**	**PE**	**MP**	**Total**
57220	4.85	4.86	0.78	10.49

	FUD	Status	MUE	Modifiers				IOM Reference
57220	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

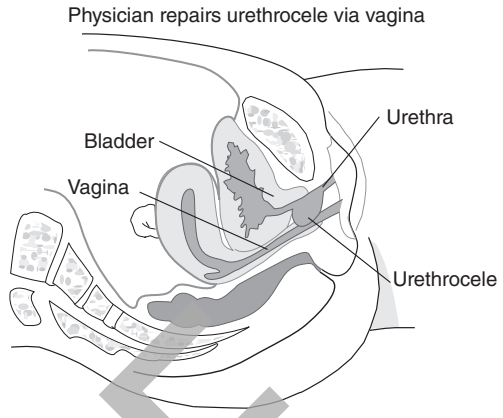
approach. Method or anatomical location used to gain access to a body organ or specific area for procedures.

plication. Surgical technique involving folding, tucking, or pleating to reduce the size of a hollow structure or organ.

stress incontinence. Involuntary escape of urine at times of minor stress against the bladder, such as coughing, sneezing, or laughing.

57230

57230 Plastic repair of urethrocele



Explanation

The physician repairs a urethrocele, which is a sagging or prolapse of the urethra through its opening or a bulging of the posterior wall of the urethra against the vaginal canal. The prolapsed urethral tissue is excised from the meatus in a circular manner. The cut edges of urethral mucosa and vaginal mucosa are sutured.

Coding Tips

For a Marshall-Marchetti-Krantz urethral suspension, abdominal approach, see 51840-51841. For laparoscopic repair of stress incontinence only, see 51990-51992.

ICD-10-CM Diagnostic Codes

N36.8 Other specified disorders of urethra
N81.0 Urethrocele
N81.10 Cystocele, unspecified
N81.11 Cystocele, midline
N81.12 Cystocele, lateral
Q64.71 Congenital prolapse of urethra

AMA: **57230** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
57230	6.3	5.32	1.08	12.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
57230	6.3	5.32	1.08	12.7

	FUD	Status	MUE	Modifiers				IOM Reference
57230	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

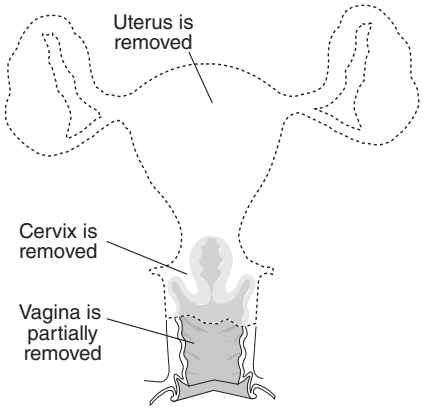
prolapse. Falling, sliding, or sinking of an organ from its normal location in the body.

urethrocele. Urethral herniation into the vaginal wall.

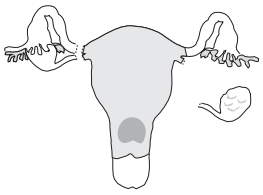
● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

58200

58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)



Surgeon may elect to leave any combination of tubes and ovaries



Explanation

Through a horizontal incision just within the pubic hairline, the physician removes the uterus, including the cervix and part of the vagina. The supporting pedicles containing the tubes, ligaments and arteries are clamped and cut free and the uterus, cervix, and part of the vagina are removed. A biopsy is taken of the para-aortic and pelvic lymph nodes. The physician may elect to remove one or both of the ovaries and one or both of the fallopian tubes (salpingo-oophorectomy). The abdominal incision is closed by suturing.

Coding Tips

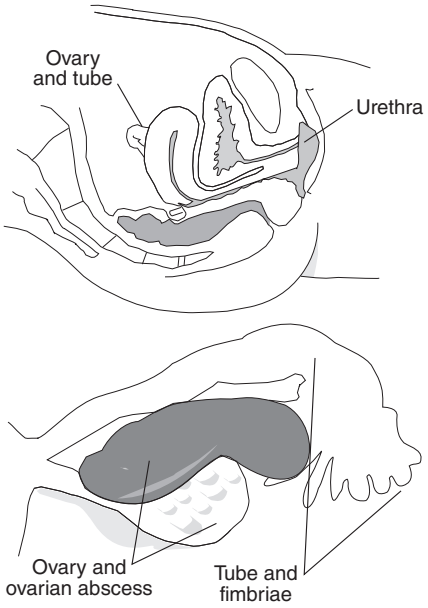
Removal of the tubes and ovaries is included in this procedure and should not be reported separately. For a hysterectomy with a pelvic lymphadenectomy, see 58210. Several hysterectomy codes exist, see 58150–58294 for open procedures and 58541–58544, 58548–58554, and 58570–58575 for a laparoscopic hysterectomy.

ICD-10-CM Diagnostic Codes

C52	Malignant neoplasm of vagina
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 ☑
C57.01	Malignant neoplasm of right fallopian tube ☑
C57.11	Malignant neoplasm of right broad ligament ☑
C57.21	Malignant neoplasm of right 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
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C79.61	Secondary malignant neoplasm of right ovary ☑
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 ☑
D39.2	Neoplasm of uncertain behavior of placenta ♂
D39.8	Neoplasm of uncertain behavior of other specified female genital organs
D49.59	Neoplasm of unspecified behavior of other genitourinary organ
N70.01	Acute salpingitis
N70.02	Acute oophoritis
N70.03	Acute salpingitis and oophoritis
N70.11	Chronic salpingitis
N70.12	Chronic oophoritis
N70.13	Chronic salpingitis and oophoritis
N71.0	Acute inflammatory disease of uterus
N71.1	Chronic inflammatory disease of uterus
N72	Inflammatory disease of cervix uteri
N73.0	Acute parametritis and pelvic cellulitis
N73.1	Chronic parametritis and pelvic cellulitis
N73.3	Female acute pelvic peritonitis
N73.4	Female chronic pelvic peritonitis
N73.6	Female pelvic peritoneal adhesions (postinfective)
N73.8	Other specified female pelvic inflammatory diseases
N80.01	Superficial endometriosis of the uterus
N80.02	Deep endometriosis of the uterus
N80.03	Adenomyosis of the uterus
N80.101	Endometriosis of right ovary, unspecified depth ☑
N80.111	Superficial endometriosis of right ovary ☑
N80.121	Deep endometriosis of right ovary ☑
N80.201	Endometriosis of right fallopian tube, unspecified depth ☑
N80.211	Superficial endometriosis of right fallopian tube ☑
N80.221	Deep endometriosis of right fallopian tube ☑
N81.2	Incomplete uterovaginal prolapse
N81.3	Complete uterovaginal prolapse
N81.89	Other female genital prolapse
N83.01	Follicular cyst of right ovary ☑
N83.11	Corpus luteum cyst of right ovary ☑

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	4.8	0.79	10.29
58822	11.81	7.77	2.0	21.58
Facility RVU	**Work**	**PE**	**MP**	**Total**
58820	4.7	4.8	0.79	10.29
58822	11.81	7.77	2.0	21.58

	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.

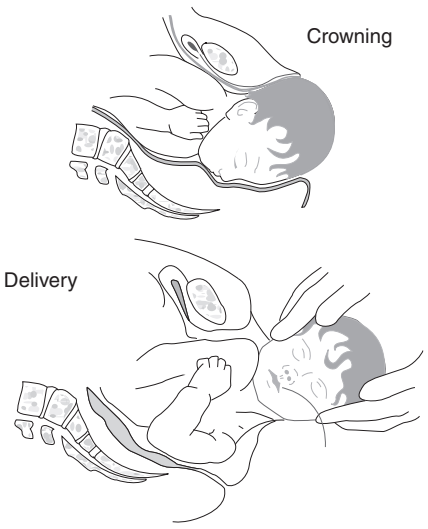
parametritis. Inflammation and infection of the tissue in the structures around the uterus.

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.

59612-59614

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59614 including postpartum care



The physician successfully delivers the infant through the vagina

Explanation

The physician delivers an infant and placenta through the vagina. The patient has previously delivered by cesarean section. The physician may elect to assist the delivery with the use of forceps. The physician may also elect to do an episiotomy, which is an incision in the perineum to widen the external opening. Episiotomy and laceration repair are included. Because of the previous cesarean delivery, the physician monitors the patient during labor and delivery. Code 59614 includes postpartum care, hospital office visits following delivery.

Coding Tips

If services provided do not match the code description of vaginal delivery only after previous cesarean (59612) or vaginal delivery including postpartum care, following a previous cesarean delivery (59614), use the appropriate stand-alone code. See notes in CPT for directions on the use of maternity care and delivery codes. For vaginal delivery, after previous cesarean delivery, with antepartum and postpartum care, see 59610.

ICD-10-CM Diagnostic Codes

O11.5 Pre-existing hypertension with pre-eclampsia, complicating the puerperium M
O12.05 Gestational edema, complicating the puerperium M
O12.15 Gestational proteinuria, complicating the puerperium M
O12.25 Gestational edema with proteinuria, complicating the puerperium M
O13.5 Gestational [pregnancy-induced] hypertension without significant proteinuria, complicating the puerperium M
O14.05 Mild to moderate pre-eclampsia, complicating the puerperium M
O14.15 Severe pre-eclampsia, complicating the puerperium M
O14.25 HELLP syndrome, complicating the puerperium M
O24.435 Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs M
O34.211 Maternal care for low transverse scar from previous cesarean delivery M
O34.212 Maternal care for vertical scar from previous cesarean delivery M
O34.218 Maternal care for other type scar from previous cesarean delivery M
O34.22 Maternal care for cesarean scar defect (isthmocele) M
O70.0 First degree perineal laceration during delivery M
O70.1 Second degree perineal laceration during delivery M
O70.21 Third degree perineal laceration during delivery, IIIa M
O70.22 Third degree perineal laceration during delivery, IIIb M
O70.23 Third degree perineal laceration during delivery, IIIc M
O70.3 Fourth degree perineal laceration during delivery M
Z39.0 Encounter for care and examination of mother immediately after delivery M
Z39.1 Encounter for care and examination of lactating mother M
Z39.2 Encounter for routine postpartum follow-up M

AMA: **59612** 2019,Jul **59614** 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
59612	16.09	6.2	4.92	27.21
59614	20.48	8.4	6.27	35.15
Facility RVU	**Work**	**PE**	**MP**	**Total**
59612	16.09	6.2	4.92	27.21
59614	20.48	8.4	6.27	35.15

	FUD	Status	MUE	Modifiers				IOM Reference
59612	N/A	A	2(3)	51	N/A	N/A	80*	None
59614	N/A	A	1(2)	51	N/A	N/A	80*	

* with documentation

Terms To Know

eclampsia. Tetany and toxemia producing seizure activity or coma in a pregnant patient who most often has presented with prior preeclampsia (i.e., hypertension, albuminuria, and edema).

elderly primigravida. Female in her first pregnancy who will be 35 years or older at her expected date of delivery. Women in this category are considered to be at high risk during pregnancy.

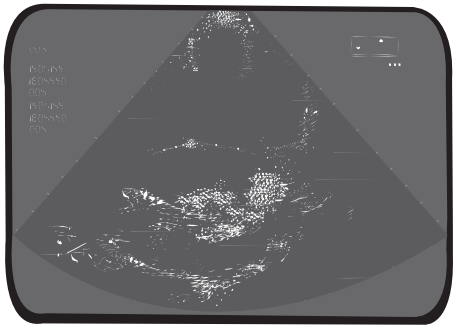
episiotomy. Deliberate incision in the perineal tissue to facilitate delivery of the fetus and avoid traumatic tearing. In a midline or median episiotomy, the incision is made from the vagina straight down toward the anus. In a mediolateral episiotomy, the incision slants to one side.

multiparity. Condition of having had two or more pregnancies that resulted in viable fetuses; producing more than one fetus or offspring in the same gestation.

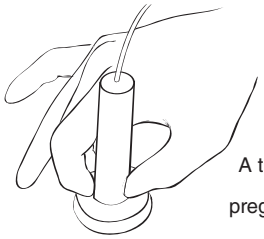
76813-76814

76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation

\+ **76814** Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)



A real time ultrasound is taken of a pregnant uterus to examine nuchal translucency measurement of transabdominal or transvaginal approach



A transducer is passed over the patient's pregnant abdominal area

Explanation

Fetal nuchal translucency provides a noninvasive method to screen for chromosomal abnormalities or heart defects in the first trimester. Nuchal pertains to the back of the neck. Until the lymphatic system of the fetus develops, the back of the neck is a good predictor of fetal health, because the fetus will lie on its back and edema will form in the neck if circulatory problems are present. In a fetal nuchal translucency test, ultrasound transducers on the maternal abdomen or vagina focus on the fetal neck, and the depth of tissue there is measured. The examination includes a calculation of fetal length, and the two measurements are correlated. Fetal nuchal edema does not provide a definitive diagnosis, but would warrant further testing (e.g., chorionic villus sampling). Report 76813 for fetal nuchal translucency testing of one fetus and 76814 for each additional fetus.

Coding Tips

Report 76814 in addition to 76813. For fetal and maternal evaluation performed with detailed fetal anatomic examination, see 76811–76812.

ICD-10-CM Diagnostic Codes

O09.511 Supervision of elderly primigravida, first trimester 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

Z03.73 Encounter for suspected fetal anomaly ruled out M

Z36.82 Encounter for antenatal screening for nuchal translucency M

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
76813	1.18	2.25	0.04	3.47
76814	0.99	1.21	0.03	2.23
Facility RVU	**Work**	**PE**	**MP**	**Total**
76813	1.18	2.25	0.04	3.47
76814	0.99	1.21	0.03	2.23

	FUD	Status	MUE	Modifiers				IOM Reference
76813	N/A	A	1(2)	N/A	N/A	N/A	80*	None
76814	N/A	A	2(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures.

fetal nuchal translucency. Fluid collection residing behind the neck of the fetus that occurs, in part, due to the fetus position, primarily on its' back, as well as the laxity of the neck skin. Fluid collection in the nuchal or neck area in the fetus, like fluid collection in the ankle (edema), can point to a number of pathological processes, such as heart failure. The process of fluid collecting behind the fetal neck may be identified and measured on ultrasound as nuchal translucency with more fluid present representing a higher risk for abnormalities.

fetus. Unborn offspring past the embryonic stage that has developed major structures. It is the period defined from nine weeks after fertilization until birth.

gestation. Carrying of offspring in the womb throughout the period of development of the fetus(es) during pregnancy.

real-time. Immediate imaging, with movement as it happens.

trimester. Normal pregnancy has a duration of approximately 40 weeks and is grouped into three-month periods consisting of three trimesters. ICD-10-CM counts trimesters from the first day of the last menstrual period as follows: 1st trimester less than 14 weeks and 0 days; 2nd trimester 14 weeks, 0 days to less than 28 weeks and 0 days; and 3rd trimester 28 weeks and 0 days until delivery.

ultrasound. Imaging using ultra-high sound frequency bounced off body structures.

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

Z31.82 Encounter for Rh incompatibility status

Associated HCPCS Codes

J2788 Injection, Rho D immune globulin, human, minidose, 50 mcg (250 IU)

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

J2791 Injection, Rho D immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU

J2792 Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU

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

antibody. Protein that B cells of the immune system produce in response to the presence of a foreign antigen.

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 or route of administration.

intramuscular. Within a muscle.

intravenous. Within a vein or veins.

passive immunity. Immunity acquired through the passing of antibodies from person to person or through antibody-containing blood products rather than being produced by the individual's own immune system. Passive immunity is immediate but typically provides protection for only a short period of time.

Rh incompatibility. Incompatible RhD antigen in which a pregnant patient has RhD negative blood and the baby is RhD positive or when an RhD negative patient receives an RhD positive blood transfusion. Pregnancy complications are often prevented with an injection of RhoGAM, which prevents antibodies from attacking the baby's RhD positive blood cells.

trimester. Normal pregnancy has a duration of approximately 40 weeks and is grouped into three-month periods consisting of three trimesters. ICD-10-CM counts trimesters from the first day of the last menstrual period as follows: 1st trimester less than 14 weeks and 0 days; 2nd trimester 14 weeks, 0 days to less than 28 weeks and 0 days; and 3rd trimester 28 weeks and 0 days until delivery.

Correct Coding Initiative Update 30.3

❖Indicates Mutually Exclusive Edit

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