

2024 Coding Guide

For More Information

Contact the Reimbursement Center at
877.213.0459 or reimbursementsupport@coopersurgical.com

Current Procedural Terminology (CPT®) copyright 2024 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Reimbursement and coding information provided herein is gathered from third-party sources and is subject to change. This information is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice, and is not intended as a guarantee of coverage or payment at any particular payment rate. CooperSurgical makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. The decision about which code(s) to report must be made by the billing provider/physician considering the clinical facts, circumstances, and applicable coding rules. The code(s) selected should be supported by the contents of any clinical notes and/or chart documentation. Please contact your third-party payer for more specific guidance.

Rates listed are based on their respective site of care- physician office, ambulatory surgical center, or hospital outpatient department. All rates provided are for the Medicare unadjusted national average rounded to the nearest whole number for 2024 and do not represent adjustment specific to the provider's location or facility. Commercial rates are based on individual contracts. Providers are encouraged to review contracts to verify their specific contracted allowables. No additional HCPCS level II coding is recommended to report use of the device. Payment is included in the associated procedure.

LEEP

CPT Code	Description	Hospital Outpatient	Ambulatory Surgical Center	Physician	Facility	Non-Facility
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix	\$2,982	\$201	Payment	\$159	\$315
				Total RVU's	4.78	9.45
				Work RVU's	2.83	2.83
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix	\$2,982	\$214	Payment	\$182	\$351
				Total RVU's	5.47	10.53
				Work RVU's	3.43	3.43
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision	\$2,982	\$1,586	Payment	\$258	\$306
				Total RVU's	7.74	9.19
				Work RVU's	3.67	3.67

Modifier Information

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.