LEEP

Loop Electrosurgical Excision Procedure

CooperSurgical®

2025 Coding Guide

For More Information

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

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 2025 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	$3,180	$191	Payment	$156	$299
				Total RVU's	4.81	9.24
				Work RVU's	2.83	2.83
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix	$3,180	$205	Payment	$178	$334
				Total RVU's	5.5	10.34
				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	$3,180	$1,674	Payment	$250	$294
				Total RVU's	7.73	9.10
				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.

Sources: 2025 AMA CPT Professional Edition, 2025 National Physician Fee Schedule Relative Value File CY 2025 Final Rule November 1, 2024, Medicare - National Correct Coding Policy Manual, Physician Effective January 2025