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2023 Hysteroscopy Reimbursement Reference Guide

All payments shown in this reimbursement reference guide are 2023 Medicare national averages; actual rates can vary by geography and/or by facility.

Medicare Reimbursement: Physician, Hospital Outpatient, and ASC

In the hospital outpatient prospective payment system, CMS assigns all CPT and HCPCS codes a status indicator (SI) which indicates when and how a service is considered for payment. In the ASC, CMS has assigned all hysteroscopy procedures an "J1" Status Indicator. When a procedure with a J1 Status Indicator appears on a claim, payment for all other procedure appearing on the claim are packaged, except services with a Status Indicator of F, G, H, L or U. (Note: in the ASC, comprehensive APCs do not apply; procedures are paid separately if applicable.)

CPT	Descriptor	Opps		ASC	Physician	
		SI	Payment	Payment	Non-Facility	Facility
58555	Hysteroscopy, diagnostic (separate procedure)	J1	$2,827.44	$1,438.12	$371.74	$152.83
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	J1	$2,827.44	$1,438.12	$1,372.43	$233.48
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	J1	$4,635.11	$2,007.73	NA	$286.35
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	J1	$4,635.11	$2,007.73	NA	$315.15
58561	Hysteroscopy, surgical; with removal of leiomyomata	J1	$4,635.11	$2,007.73	NA	$360.90
58562	Hysteroscopy, surgical; with removal of impacted foreign body	J1	$2,827.44	$1,438.12	$443.24	$223.66
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electro-surgical ablation, thermoablation)	J1	$4,635.11	$2,007.73	$2,184.03	$248.39
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	J1	$4,635.11	$2,580.66	$1,719.78	$466.97

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Inpatient Procedure Coding

The International Classification of Diseases, Tenth Revision Procedure Coding System (ICD-10-PCS) codes are used by facilities to report procedures performed in the inpatient setting. The first three characters outline the section, body system and operation. Once these have been identified, the procedure can be coded to greater specificity by choosing the most appropriate body part, approach, device, and qualifier as identified in the code set. Providers should code to the highest level of specificity possible. The ICD-10-PCS codes and/or code families associated with the hysteroscopy procedures are listed below. When feasible, the full code and descriptor are provided. It is not intended to be a comprehensive list of all possible ICD-10-PCS codes that may be reported.

ICD-10-PCS	Descriptor
OU5B – – –	Medical and Surgical, Female Reproductive System, Release, Destruction
OUC98ZZ	Extirpation of Matter from Uterus, Via Natural or Artificial Opening Endoscopic
OUB9 – – –	Medical and Surgical, Female Reproductive System, Excision, Uterus
OUFD8ZZ	Inspection of Uterus and Cervix, Via Natural or Artificial Opening Endoscopic
OUH98HZ	Insertion of Contraceptive Device into Uterus, Via Natural or Artificial Opening Endoscopic
OUJ – – – –	Medical and Surgical, Female Reproductive System, Inspection
OUL – – – –	Medical and Surgical, Female Reproductive System, Release, Occlusion
OUN9 – – –	Medical and Surgical, Female Reproductive System, Release, Uterus

Inpatient Reimbursement

Diagnostic Related Groups (DRGs) are assigned using the principal diagnosis and additional diagnoses; the principal procedure and additional procedures; sex; and discharge status. The DRGs provided represent the most likely assignment for a patient admitted for hysteroscopy procedure. It is not intended to be a comprehensive list of all possible DRGs that a patient may be assigned to upon discharge.

DRG	Descriptor	Payment
736	Uterine & Adnexa Procedures for Ovarian or Adnexal Malignancy w/MCC	$29,257.14
737	Uterine & Adnexa Procedures for Ovarian or Adnexal Malignancy w/CC	$13,880.20
738	Uterine & Adnexa Procedures for Ovarian or Adnexal Malignancy w/o CC/MCC	$9,629.37
739	Uterine & Adnexa Procedures for Non-Ovarian and Non-Adnexal Malignancy w/MCC	$26,767.83
740	Uterine & Adnexa Procedures for Non-Ovarian and Non-Adnexal Malignancy w/CC	$12,363.56
741	Uterine & Adnexa Procedures for Non-Ovarian and Non-Adnexal Malignancy w/o CC/MCC	$9,005.84
742	Uterine & Adnexa Procedures for Non- Malignancy with CC/MCC	$12,361.50
743	Uterine & Adnexa Procedures for Non- Malignancy without CC/MCC	$8,029.73
744	D&C Colonization Laparoscopy and Tubal Interruption with CC/MCC	$13,021.39
745	D&C Colonization Laparoscopy and Tubal Interruption without CC/MCC	$7,893.91

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References

1. CY 2023 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY2023 Payment Rates (CMS-1772-FC); Addendum B and ASC Addenda.

2. CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1770-F); Addendum B. All MPFS Fee Schedules calculated using CF of $33.8872 effective January 1, 2023.

3. DRG values were calculated using a base rate of $6,375.74 and Capital Standard Payment of $483.76. The base payment rate assumes the hospital submitted quality data and is a user of EHR. A hospital's base payment rate will change if the hospital does not meet either or both of these measures. Calculations were based on data provided in FY 2023 IPPS Final Rule CN (Tables 1A, 1D, and 5CN).

4. ICD-10-PCS 2023, ©2022 Optum360, LLC. All rights reserved

5. 2023 CPT Professional, ©American Medical Association