Coding for Pediatric Preventive Care 2016

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American Academy of Pediatrics

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NOTE: This resource contains comprehensive listings of codes that may not be used by your practice on a regular basis. We recommend that you identify the codes most relevant to your practice and include those on your encounter form/billing sheet.

Following are the *Current Procedural Terminology* (*CPT*®), Healthcare Common Procedure Coding System (HCPCS) Level II, and *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) codes most commonly reported by pediatricians in providing preventive care services. It is strongly recommended that the pediatrician, not the staff, select the appropriate code(s) to report.

Preventive Medicine Service Codes

- To report the appropriate preventive medicine service code, first determine if the patient qualifies as new or established (defined in the next 2 sections), and then select the appropriate code within the new or established code family based on patient age.
- Preventive medicine service codes are not time-based; therefore, time spent during the visit is not relevant in selecting the appropriate preventive medicine services code.
- If an illness or abnormality is encountered or a preexisting problem is addressed in the process of performing the preventive medicine service, and if the illness, abnormality, or problem is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service (history, physical examination, medical decision-making), the appropriate office or other outpatient service code (**99201–99215**) should be reported in addition to the preventive medicine service code. Modifier **25** should be appended to the office or other outpatient service code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.
- An insignificant or trivial illness, abnormality, or problem encountered in the process of performing the preventive medicine service that does not require additional work and performance of the key components of a problem-oriented E/M service should not be reported.
- The comprehensive nature of the preventive medicine service codes reflects an age- and gender-appropriate history

and physical examination and is not synonymous with the comprehensive examination required for some other E/M codes (eg, **99204**, **99205**, **99215**).

- Immunizations and ancillary studies involving laboratory, radiology, or other procedures, or screening tests (eg, vision, developmental, and hearing screening) identified with a specific *CPT*® code, are reported separately from the preventive medicine service code.

Preventive Medicine Services: New Patients

Initial comprehensive preventive medicine E/M of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.

***CPT*® Codes**		***ICD-10-CM* Codes**	
99381	Infant (younger than 1 year)	**Z00.110**	Health supervision for newborn under 8 days old **or**
		Z00.111	Health supervision for newborns 8 to 28 days old **or**
		Z00.121	Routine child health exam *with abnormal findings*
		Z00.129	Routine child health exam *without abnormal findings*
99382	Early childhood (age 1–4 years)	**Z00.121** **Z00.129**	
99383	Late childhood (age 5–11 years)		
99384	Adolescent (age 12–17 years)		
99385	18 years or older	**Z00.00**	General adult medical exam *without abnormal findings*
		Z00.01	General adult medical exam *with abnormal findings*

A new patient is defined as one who has not received any professional face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services and reported by a specific *CPT*® code(s) from a physician/other qualified health care professional, or another physician/other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years.

Preventive Medicine Services: Established Patients

Periodic comprehensive preventive medicine reevaluation and management of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.

***CPT*® Codes**		***ICD-10-CM* Codes**	
99391	Infant (younger than 1 year)	**Z00.110**	Health supervision for newborn under 8 days old **or**
		Z00.111	Health supervision for newborns 8 to 28 days old **or**
		Z00.121	Routine child health exam *with abnormal findings*
		Z00.129	Routine child health exam *without abnormal findings*
99392	Early childhood (age 1–4 years)	**Z00.121** **Z00.129**	
99393	Late childhood (age 5–11 years)		
99394	Adolescent (age 12–17 years)		
99395	18 years or older	**Z00.00**	General adult medical exam *without abnormal findings*
		Z00.01	General adult medical exam *with abnormal findings*

Counseling, Risk Factor Reduction, and Behavior Change Intervention Codes

- Used to report services provided for the purpose of promoting health and preventing illness or injury.
- They are distinct from other E/M services that may be reported separately when performed. However, there is one exception—you cannot report counseling codes (**99401–99404**) in addition to preventive medicine service codes (**99381–99385** and **99391–99395**).
- Counseling will vary with age and address such issues as family dynamics, diet and exercise, sexual practices, injury prevention, dental health, and diagnostic or laboratory test results available at the time of the encounter.
- Codes are time-based, where the appropriate code is selected based on the approximate time spent providing the service. Codes may be reported when the midpoint for that time has passed. For example, once 8 minutes are documented, one may report **99401**.
- Extent of counseling or risk factor reduction intervention must be documented in the patient chart to qualify the service based on time.
- Counseling or interventions are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.
- Cannot be reported with patients who have symptoms or established illness.

- For counseling individual patients with symptoms or established illness, report an office or other outpatient service code (**99201–99215**) instead.
- For counseling groups of patients with symptoms or established illness, report **99078** (physician educational services rendered to patients in a group setting) instead.

Preventive Medicine, Individual Counseling

99401 Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 15 minutes

99402 approximately 30 minutes

99403 approximately 45 minutes

99404 approximately 60 minutes

Behavior Change Interventions, Individual

- Used only when counseling a patient on smoking cessation (**99406–99407**).
- If counseling a patient's parent or guardian on smoking cessation, do not report these codes (**99406–99407**) under the patient; instead, refer to preventive medicine counseling codes (**99401–99404**) if the patient is not currently experiencing adverse effects (eg, illness) or include under the problem-related E/M service (**99201–99215**).

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 intensive, greater than 10 minutes

99408 Alcohol or substance (other than tobacco) abuse structured screening (eg, Alcohol Use Disorder Identification Test [AUDIT], Drug Abuse Screening Test [DAST]) and brief intervention (SBI) services; 15 to 30 minutes

99409 greater than 30 minutes

Preventive Medicine, Group Counseling

99411 Preventive medicine counseling or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 30 minutes

99412 approximately 60 minutes

ICD-10-CM Codes for Counseling Risk Factor Reduction and Behavior Change Interventions

- The diagnosis code(s) reported for counseling risk factor reduction and behavior change intervention codes will vary depending on the reason for the encounter.
- Remember that the patient cannot have symptoms or established illness; therefore, the diagnosis code(s) reported cannot reflect symptom(s) or illness(es).
- Examples of some possible diagnosis codes include

Z28.3 Underimmunized status

Z71.3 Dietary surveillance and counseling

Z71.41 Alcohol abuse counseling and surveillance of alcoholic

Z71.42 Counseling for family member/partner/friend of alcoholic

Z71.51 Drug abuse counseling and surveillance of drug abuser

Z71.52 Counseling for family member/partner/friend of drug abuser

Z71.6 Tobacco abuse counseling

Z71.89 Other specified counseling

Z71.9 Counseling, unspecified

Z87.891 Personal history of nicotine dependence

Z91.89 Other specified personal risk factors, presenting as hazards to health not elsewhere classified

Other Preventive Medicine Services

Oral Health

CPT® Code

99188 Application of topical fluoride varnish by a physician or other qualified health care professional

- Refer to page 21 for definition of other qualified health care professional.

ICD-10-CM Codes

Z00.121

Z00.129

Z41.8 Encounter for other procedures for purposes other than remedying health state

Pelvic Examination

- Preventive medicine service codes (**99381–99385** and **99391–99395**) include a pelvic examination as part of the age- and gender-appropriate examination.
- However, if the patient is having a problem, the physician can report an office or other outpatient E/M service code (**99212–99215**) for the visit and attach modifier **25**, which identifies that the problem-oriented pelvic visit is a separately identifiable E/M service by the same physician on the same date of service.
- Link the appropriate *ICD-10-CM* code for the well-child or well-adult exam with abnormal findings (**Z00.121** or **Z00.01**) to the preventive medicine service code, but link a different diagnosis code (eg, **N89.8** [vaginal discharge], **N94.4** [primary dysmenorrhea]) to the office or other outpatient E/M service code (eg, **99212**).
- Anticipatory or periodic contraceptive management is not a "problem" and therefore is included in the preventive medicine service code; however, if contraception creates a problem (eg, breakthrough bleeding, vomiting), the service can be reported separately with an office or other outpatient service code.

ICD-10-CM Codes

Z01.411 Gynecological exam *with abnormal findings*
Z01.419 Gynecological exam *without abnormal findings*
Z11.51 Screening for human papillomavirus (HPV)
Z12.72 Screening for malignant neoplasm of vagina
Z30.011 Initial prescription of contraceptive pills
Z30.012 Prescription of emergency contraception

Z30.013 Initial prescription of injectable contraceptive
Z30.014 Initial prescription of intrauterine contraceptive device (IUD)
Z30.02 Counseling and instruction in natural family planning to avoid pregnancy
Z30.09 General counseling and advice on contraception
Z30.40 Surveillance of contraceptives, unspecified
Z30.41 Surveillance of contraceptive pills
Z30.42 Surveillance of injectable contraceptive
Z30.430 Insertion of IUD
Z30.431 Routine checking of IUD
Z30.432 Removal of IUD
Z30.433 Removal and reinsertion of IUD
Z30.49 Surveillance of other contraceptives

Health Risk Assessment

CPT® Code

99420 Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)

NOTE: This code can be reported for a postpartum screening administered to a mother as part of a routine newborn check but can be billed under the baby's name. Link to *ICD-10-CM* code **Z00.121** or **Z00.129** for a normal screen during a routine well-baby exam. Check with your payers.

Unlisted Preventive Medicine Service

99429 Unlisted preventive medicine service

Report code **99429** only when a more specific preventive medicine service code does not exist.

Case Management or Care Plan Oversight Services

Telephone Services

CPT® Codes

99441 Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion

99442 11 to 20 minutes of medical discussion

99443 21 to 30 minutes of medical discussion

Online Medical Evaluation

CPT® Code

99444 Online E/M service provided by a physician or other qualified health care professional who may report E/M services provided to an established patient or guardian not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

Care Plan Oversight

CPT® Codes

99339 Individual physician supervision of a patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian), or key caregiver(s) involved in patient's care; integration of new information into medical treatment plan; or adjustment of medical therapy; within a calendar month; 15 to 29 minutes

99340 30 minutes or more

- Care plan oversight (CPO) codes are reported once per calendar month.
- Telephone service codes are reported for each physician telephone call made or received from a patient or parent, excluding those that occur 7 days after or 24 hours before a face-to-face visit.
- The online medical evaluation code is reported only once for the same episode of care during a 7-day period, although multiple physicians can report their exchanges with the same patient.

- If the online medical evaluation refers to an E/M service previously performed and reported by a physician within the previous 7 days (physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, the service is considered covered by the previous E/M service or procedure.
- For the online medical evaluation code, a reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter.
- The CPO codes include telephone calls and online medical evaluations; therefore, if you include time spent on a telephone call or an online medical evaluation toward your monthly CPO billing, you cannot also separately report that service.

Care Management Services

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

Chronic care management of less that 20 minutes is not separately reported. Do not report this code in addition to any other non–face-to-face service code (eg, CPO or telephone care) within the same calendar month.

99487 Complex chronic care management services, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code **99487**.)

- Do not report for complex chronic care management that is under 60 minutes in a calendar month.

Transitional Care Management Services

99495 Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Reporting of chronic care management and transitional care management requires a lot of criteria to be met and guidelines followed. Please refer to the 2016 *CPT*® manual for complete details.

Screening Codes

Vision Screening

***CPT*® Codes**		***ICD-10-CM* Codes**	
99173	Screening test of visual acuity quantitative, bilateral	**Z00.121**	Routine child health exam *with abonormal findings*
99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with remote-analysis and report	**Z00.129**	Routine child health exam *without abnormal findings*
99177	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with on-site analysis		

Z01.00 and **Z01.01** (examination of eyes and vision with and without abnormal findings) are reported for routine examination of eyes and vision only and not reported when a vision screen is done during a routine well-child exam.

- To report code **99173**, you must employ graduate visual acuity stimuli that allow a quantitative estimate of visual acuity (eg, Snellen chart).
- Codes **99174** and **99177** are reported for instrument-based ocular screening for esotropia, exotropia, anisometropia, cataracts, ptosis, hyperopia, and myopia.
- Code **99177** is reported in lieu of **99174** when the screening instrument provides you with immediate pass/fail results.
- When acuity (**99173**) or instrument-based ocular screening (eg, **99174**) is measured as part of a general ophthalmologic service or an E/M service of the eye (eg, for an eye-related problem or symptom), it is considered part of the diagnostic examination of the office or other outpatient service code (**99201–99215**) and is not reported separately.

- Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).
- Failed vision screenings will most likely result in a follow-up office visit (eg, **99212–99215**). Report the follow-up screen with **Z01.00** if normal or **Z01.01** if abnormal. If abnormal, link to the diagnosis code for the reason for the failure (eg, **H52.1-** [myopia]); when a specific disorder cannot be identified, report **R94.118** (abnormal results of other function studies of eye).

Hearing Screening

***CPT*® Codes**		***ICD-10-CM* Codes**	
92551	Screening test, pure tone, air only	**Z00.121**	Routine child health exam *with abnormal findings*
92552	Pure tone audiometry (threshold); air only	**Z00.129**	Routine child health exam *without abnormal findings*
92567	Tympanometry (impedance testing)		

Codes **Z01.10** (encounter for exam of ears and hearing without abnormal findings) and **Z01.118** (encounter for exam of ears and hearing with other abnormal findings) are only reported when a patient presents for an encounter specific to ears and hearing and not for a routine well-child exam where a hearing screen is performed.

- Requires use of calibrated electronic equipment; tests using other methods (eg, whispered voice, tuning fork) are not reported separately.
- Includes testing of both ears; append modifier **52** when a test is applied to only one ear.

- Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).
- Failed hearing screenings will most likely result in a follow-up office visit (eg, **99212–99215**). Code **Z01.110** (encounter for hearing exam following failed hearing screening) is reported when a specific disorder cannot be identified or when the follow-up hearing screen is normal. You can also report **Z01.118** (encounter for exam of ears and hearing with other abnormal findings) and include the code for the abnormal results, like **R94.120** (abnormal auditory function study).

Developmental Screening and Emotional/ Behavioral Assessment

***CPT*® Code**		***ICD-10-CM* Code**	
96110	Developmental screening, per instrument, scoring and documentation	**Z13.4**	Encounter for screening for certain developmental disorders in childhood (excludes developmental screening during a routine well child exam)
96127	Brief emotional/behavioral assessment (eg, depression inventory) with scoring and documentation, per standardized instrument	**Z13.89**	Encounter for screening for other disorder (eg, depression)

- Used to report administration of **standardized** developmental screening instruments (**96110**) or behavioral/ emotional assessments (**96127**).
- *ICD-10-CM* code **Z13.4** is not to be used for routine developmental screening performed during a routine well-child exam. *ICD-10-CM* code **Z13.89** is not necessary to report in addition to a well-child exam.

- Often reported when performed in the context of preventive medicine services but may also be reported when screening or assessement is performed with other E/M services such as acute illness or follow-up office visits.
- Clinical staff (eg, registered nurse) typically administers and scores the completed instrument while the physician incorporates the interpretation component into the accompanying E/M service.
- When a standardized screen or assessment is administered along with any E/M service (eg, preventive medicine service), both services should be reported and modifier **25** (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.
- Examples of **96110** instruments include, but are not limited to
  - Squires J, Bricker D. *Ages & Stages Questionnaires (ASQ-3).* 3rd ed. Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2009 and Squires J, Bricker D, Twombly E. *Ages & Stages Questionnaires: Social-Emotional (ASQ:SE).* Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
  - Robins D, Fein D, Barton M. Modified Checklist for Autism in Toddlers (M-CHAT). 1999
  - Ireton H. *Child Development Review System.* Minneapolis, MN: Behavior Science Systems, Inc
  - Glasco FP. *Parents' Evaluation of Developmental Status.* Nashville, TN: Ellsworth & Vandermeer Press LLC; 2006

- Examples of **96127** instruments include, but are not limited to
  - Australian Scale for Asperger's Syndrome. In: Attwood T. *Asperger's Syndrome: A Guide for Parents and Professionals.* London, England: Jessica Kingsley Publishers; 1997
  - Reynolds CR, Kamphaus RW. *BASC-2: Behavior Assessment Scale for Children.* 2nd ed. Upper Saddle River, NJ: Pearson School Publishing; 2004
  - Gioia GA, Isquith PK, Guy SC, Kenworthy L. *Behavioral Rating Inventory of Executive Function (BRIEF).* Lutz, FL: Psychological Assessment Resources, Inc; 2000
  - Wetherby AM, Prizant BM. *Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP).* Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
  - Jellinek M, Murphy M. Pediatric Symptom Checklist. http://www.massgeneral.org/psychiatry/services/psc_home.aspx. Accessed December 1, 2015
  - Vanderbilt Assessment Scales. In: *ADHD: Caring for Children With ADHD; A Resource Toolkit for Clinicians.* 2nd ed. Elk Grove Village, IL: 2011

Immunizations

Immunization Administration

Pediatric Immunization Administration Codes

90460 Immunization administration (IA) through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

+90461 each additional vaccine or toxoid component administered

Report **90461** in conjunction with **90460**.

Component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined previously.

A *qualified health care professional* is an individual who by education, training, licensure/regulation, facility credentialing (when applicable), and payer policy is able to perform a professional service within his or her scope of practice and independently report a professional service. These professionals are distinct from *clinical staff.* A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, facility, and payer policy to perform or assist in the performance of specified professional services but who does not individually report any professional services.

Code **90460** is used to report the first or only component in a single vaccine given during an encounter. You can report more than one **90460** during a single office encounter. Code **90461** is considered an *add-on* code to **90460** (hence the **+** symbol next to it). This means that the provider will use **90461** in addition to **90460** if more than one component is contained within a single vaccine administered. *CPT*® codes **90460** and **90461** are reported regardless of route of administration.

Pediatric IA codes (**90460–90461**) are reported only when *both* of the following requirements are met:

1) The patient must be 18 years or younger.
2) The physician or other qualified health care professional must perform face-to-face vaccine counseling associated with the administration. (Note: The clinical staff can do the actual administration of the vaccine.)

If *both* of these requirements are not met, report a nonage-specific IA code(s) (**90471–90474**) instead.

Nonage-Specific Immunization Administration Codes

Report a *CPT*® and an *ICD* code for each vaccine administration as well as for each vaccine product given during a patient encounter.

90471 IA (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
Do not report **90471** in conjunction with **90473**.

+90472 each additional vaccine (single or combination vaccine/toxoid) (List separately to code for primary procedure.)
Use **90472** in conjunction with **90460**, **90471**, or **90473**.

90473 IA (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)
Do not report **90473** in conjunction with **90471**.

+90474 each additional vaccine (single or combination vaccine/toxoid) (List separately to code for primary procedure.)

Use **90474** in conjunction with **90460**, **90471**, or **90473**.

Codes **90471** and **90473** are used to code for the first immunization given during a single office visit. Codes **90472** and **90474** are considered *add-on* codes (hence the **+** symbol next to them) to **90460**, **90471**, and **90473**. This means that the provider will use **90472** or **90474** in addition to **90460**, **90471**, or **90473** if more than one vaccine is administered during a visit. Note that there can only be one first administration during a given visit. (See vignettes #3, 4, and 5 on pages 28–30.)

If during a single encounter for a patient 18 years or younger, a physician or other qualified health care professional only counsels on some of the vaccines, report code **90460** (and **90461** when applicable) for those counseled on and defer to codes **90472** or **90474** as appropriate for those that are not counseled on.

The following vignettes may help illustrate their correct use (please note that these coding vignettes are for teaching purposes and do not necessarily follow every payer's reporting requirements):

Vignette #1

A 5-year-old established patient is at a physician's office for her annual well-child examination. The patient is scheduled to receive her first hepatitis A vaccine; her fifth diphtheria, tetanus, and acellular pertussis (DTaP) vaccine; and the influenza vaccine. After distributing the Vaccine Information Statements

and discussing the risks and benefits of immunizations with her parents, the physician administers the vaccines.

How are the appropriate code(s) for this service selected?

Step 1: Select appropriate E/M code.

99393 Preventive medicine service, established patient, age 5 to 11 years

Step 2: Select appropriate vaccine product code(s).

90633 Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use

90700 DTaP, for use in individuals younger than 7 years, for intramuscular use

90672 Influenza virus vaccine, live, quadrivalent, for intranasal use

Step 3: Select appropriate immunization administration code(s) by considering the following questions:

- Is the patient 18 years or younger?
- If the patient is younger than 18 years, did the physician or other qualified health care professional perform the face-to-face vaccine counseling, discussing the specific risks and benefits of the vaccine(s)?

If the answer to both questions is "yes," select a code(s) from the pediatric IA code family (**90460–90461**). If the answer to one of the questions is "no," select a code from the nonage-specific IA code family (**90471–90474**).

In this vignette, the answer to both questions is "yes." Therefore, the following IA codes will be reported:

90460 IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

+90461 each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure.)

Step 4: Select the appropriate *ICD-10-CM* diagnosis code(s).

Diagnosis codes are used along with *CPT*® codes to reflect the outcome of a visit. *CPT* codes tell a carrier what was done and *ICD-10-CM* codes tell a carrier why it was done.

The vaccine product *CPT* code and its corresponding IA *CPT* code are always linked to the same *ICD-10-CM* code. This is because the vaccine product and the work that goes into administering that product are intended to provide prophylactic vaccination against a certain type of disease.

ICD-10-CM lists only a single code to describe an encounter in which a patient does receive a vaccine. The code is **Z23** and it is reported at any encounter when a vaccine is given, including routine well-child or adult exams.

The diagnosis codes for the 3 vaccines and the 3 IA codes used in this vignette are as follows:

***CPT*® Codes**		***ICD-10-CM* Codes**
99393[a]	Preventive medicine service, established patient, 5–11 years	**Z00.129**
90633	Hepatitis A vaccine product	**Z23**
90460	Pediatric IA (hepatitis A vaccine), first component	**Z23**
90700	DTaP vaccine product	**Z23**
90460	Pediatric IA (DTaP vaccine), first component	**Z23**
90461 (x2)	Pediatric IA (DTaP vaccine), each additional component	**Z23**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**Z23**
90460	Pediatric IA (influenza vaccine), first component	**Z23**

Alternative Coding

***CPT*® Codes**		***ICD-10-CM* Codes**
99393[a]	Preventive medicine service, established patient, 5–11 years	**Z00.129**
90633	Hepatitis A vaccine product	**Z23**
90700	DTaP vaccine product	**Z23**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**Z23**
90460 (x3)	Pediatric IA (hepatits A, DTaP, influenza vaccines), first component	**Z23**
90461 (x2)	Pediatric IA (DTaP vaccine), second and third components	**Z23**

[a]At time of publication there was a National Correct Coding Initiative (NCCI) edit on all E/M services and IA codes. Append modifier **25** to the E/M service when also reporting IA codes.

Please note that *most* payers do not want multiple line items of codes **90460** or **90461**; therefore, follow the alternative coding.

Rationale

Because the patient is younger than 18 years and there is physician counseling, pediatric IA codes are reported (**90460**, **90461**). Each vaccine administered will be reported with its own **90460** (hepatitis A, DTaP, influenza). The only vaccine with multiple components is DTaP. Because the first component (ie, diphtheria) was counted in **90460**, only the second and third components (tetanus and acellular pertussis) are reported with

90461 with 2 units. Also, even though an intranasal vaccine is administered, **90460** is still reported because the code descriptor reads "any route."

Vignette #2

A 2-month-old established patient presents for her checkup. The following vaccines are ordered: DTaP-*Haemophilus influenzae* type b (Hib)-inactivated poliovirus (IPV) (Pentacel), pneumococcal, and rotavirus. The physician counsels the parents on all of them and the nurse administers them all.

***CPT*® Codes**		***ICD-10-CM* Codes**
99391[a]	Preventive medicine service, established patient, <1 year	**Z00.129**
90698	DTaP-Hib-IPV (Pentacel) product	**Z23**
90670	Pneumococcal product	**Z23**
90680	Rotavirus vaccine, oral use	**Z23**
90460 (x3)	Pediatric IA (Pentacel, pneumococcal, rotavirus), first component	**Z23**
90461 (x4)	Pediatric IA (Pentacel), each additional component	**Z23**

[a]At time of publication there was an NCCI edit on all E/M services and IA codes. Append modifier **25** to the E/M service when also reporting IA codes.

Rationale

Because the patient is younger than 18 years and there is physician counseling, pediatric IA codes are reported (**90460**, **90461**). Clinical staff may administer the vaccine. Even though an oral vaccine is administered, **90460** is still reported because the code descriptor reads "any route."

Vignette #3

A 19-year-old patient presents to the office to complete a college physical examination (in college the patient will be living in a dorm). He is due for a tetanus-diphtheria-acellular pertussis (Tdap) booster, meningococcal vaccine, and intranasal influenza vaccine. The physician counsels the patient on each and the nurse administers each.

***CPT*® Codes**		***ICD-10-CM* Codes**
99395[a]	Preventive medicine service, established patient, 18–39 years	**Z02.0**
90715	Tdap product	**Z23**
90471	IA, first injection	**Z23**
90734	Meningococcal (MCV4) product	**Z23**
90472	IA, each additional injection	**Z23**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**Z23**
90474	IA, each additional oral or intranasal	**Z23**

[a]At time of publication there was an NCCI edit on all E/M services and IA codes. Append modifier **25** to the E/M service when also reporting IA codes.

Rationale

The patient is older than 18 years; therefore, despite physician counseling, pediatric IA codes cannot be reported. Instead, codes **90471–90474** must be used. Because the patient received 2 injections and 1 intranasal vaccine, code **90471** is reported for the first injection, **90472** for the second injection, and **90474** for the intranasal vaccine. It is important to remember that a first injection code (**90471**) cannot be reported in addition to a first oral or intranasal code (**90473**); therefore, code **90474** must be used.

Vignette #4

A 17-year-old patient presents to the office for her annual checkup and to complete a college physical examination (in college the patient will be living in a dorm). The patient is healthy and due for a Tdap booster, meningococcal vaccine, first HPV (9-valent) vaccine, and intranasal influenza vaccine. The physician counsels the patient only on the meningococcal and HPV vaccines and the nurse administers each. The patient is then asked to return in 4 to 6 weeks for her second HPV vaccine.

***CPT*® Codes (First Visit Only)**		***ICD-10-CM* Codes (First Visit Only)**
99394[a]	Preventive medicine service, established patient, 12–17 years	**Z00.00** and **Z02.0**
90734	Meningococcal (MCV4) product	**Z23**
90651	HPV (9-valent) product	**Z23**
90460 (x2)	Pediatric IA (meningococcal) and HPV, first component	**Z23**
90715	Tdap product	**Z23**
90472	IA, each additional injection (Tdap)	**Z23**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**Z23**
90474	IA, each additional oral or intranasal	**Z23**

[a]At time of publication there was an NCCI edit on all E/M services and IA codes. Append modifier **25** to the E/M service when also reporting IA codes.

Rationale

Because the physician only documents counseling for the meningococcal and HPV vaccines, code **90460** can only be reported for those vaccines because the patient meets the age criteria. For the Tdap and intranasal influenza vaccines, defer to non-pediatric IA codes (**90471–90474**). In this case, however, a first vaccine code is already reported with code **90460**, so the additional IA codes (**90472**, **90474**) have to be reported based

on route of administration. While *ICD-10-CM* does not provide official ages for the "adult" *ICD-10-CM* codes (**Z00.00** and **Z00.01**) in lieu of the child well exam codes, many payers use age 17 years as the cutoff. Refer to specific payer policy for details.

Vignette #5

A 6-month-old patient presents to the office for her routine checkup and to receive vaccines. The patient is due for DTaP, pneumococcal, and hepatitis B vaccines. During the examination the physician finds an upper respiratory infection and fever. The physician counsels the parent on the vaccines but decides to defer for 2 weeks. The physician completes the well-baby check on that day.

Two weeks later the patient returns. The patient is afebrile and asymptomatic and is only seen by the nurse. The DTaP, pneumococcal, and hepatitis vaccines are administered.

***CPT*® Codes (First Visit)**		***ICD-10-CM* Codes (First Visit)**
99391	Preventive medicine service, established patient, <1 year	**Z00.121**

(An appropriate acute sick visit [eg, **99213**] may be reported in addition with modifier **25** and linked to an appropriate *ICD-10-CM* code.)

***CPT*® Codes (2 Weeks Later)**		***ICD-10-CM* Codes (2 Weeks Later)**
90700	DTaP product	**Z23**
90670	Pneumococcal product	**Z23**
90744	Hepatitis B vaccine product	**Z23**
90471	IA (DTaP), first vaccine	**Z23**
90472 (x2)	IA (pneumococcal, hepatitis B), each additional vaccine	**Z23**

Rationale

If counseling occurs outside of the IA service, there is no way to report it separately. Therefore, in this vignette, there is nothing separate to report during the well-child visit, and when the patient returns and sees the nurse only, pediatric IA codes cannot be reported; defer to codes **90471–90474**. During the preventive medicine service, when an acute illness is detected, a code from **99212–99215** can be reported if the service is significant and separately identifiable. Code **9921x** is reported with modifier **25**. When the patient returns *for vaccines only,* an E/M service is not reported. The *ICD-10-CM* code will be reported for "with abnormal findings" (**Z00.121**) because an abnormality was identified during the encounter.

For more information on IA codes, refer to the Coding at the AAP Web site and its page dedicated to vaccine coding (www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Vaccine-Coding.aspx).

How to Code When Immunizations Are Not Administered

- There are many reasons why immunizations are not given during routine preventive medicine services. Parents may refuse vaccines or defer them, a patient may be ill at the time and it is counteractive to administer, or the patient may already have had the disease or be immune.
- Due to tracking purposes and quality measures, it is important to report non-administration as part of the *ICD-10-CM* codes. The following *ICD-10-CM* codes were created to report why a vaccine(s) is not given:

Vaccination not carried out due to

Z28.01 Acute illness

Z28.02 Chronic illness or condition

Z28.03 Immunocompromised state

Z28.04 Allergy to vaccine or component

Z28.1 Religious reasons

Z28.20 Unspecified reason

Z28.21 Patient refusal

Z28.81 Patient has disease being vaccinated against

Z28.82 Caregiver refusal

Z28.89 Other reason

Vignette

A 1-year-old presents for his routine well-child examination. He is scheduled to receive his first measles, mumps, rubella; hepatitis A; and varicella vaccines. Because he had a documented case of varicella when he was 9 months old, the varicella vaccine is not given.

Report the following *ICD-10-CM* codes linked to the E/M service:

Z23 Encounter for immunization

Z28.81 Vaccination not carried out due to patient had disease being vaccinated against

Vaccines for Children Program

The rules for reporting vaccines for those patients who qualify for the Vaccines for Children (VFC) program will vary greatly. Some states require that the product code be submitted, while others

require the IA codes. Some require the use of modifiers, while others do not. Currently the VFC program does not recognize component-based vaccine counseling; therefore, you will not be paid for *CPT*® code **90461**. The American Academy of Pediatrics continues to work on changing this so that pediatric providers can be properly compensated for giving multiple-component vaccines.

Commonly Administered Pediatric Vaccines

CPT® Code	Separately report the administration with codes **90460–90461** or **90471–90474.**	Manufacturer	Brand	Number of Vaccine Components
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	Novartis	Bexsero	1
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	Pfizer	Trumenba	1
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	Sanofi Pasteur	Fluzone Intradermal Quad	1
90633	Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose, for intramuscular use	GlaxoSmithKline Merck	HAVRIX VAQTA	1
90644	Meningococcal conjugate vaccine, serogroups C & Y, and *Haemophilus influenzae* B vaccine (MenCY-Hib), 4-dose schedule, when administered to children 6 weeks–18 months of age, for intramuscular use	GlaxoSmithKline	MenHibrix	2
90647	*Haemophilus influenzae* B vaccine (Hib), PRP-OMP conjugate, 3 dose, for intramuscular use	Merck	PedvaxHIB	1
90648	*Haemophilus influenzae* B vaccine (Hib), PRP-T conjugate, 4 dose, for intramuscular use	Sanofi Pasteur GlaxoSmithKline	ActHIB HIBERIX	1
90649	Human Papillomavirus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use	Merck	GARDASIL	1
90650	Human Papillomavirus (HPV) vaccine, types 16 and 18, bivalent, 3 dose schedule, for intramuscular use	GlaxoSmithKline	CERVARIX	1
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use	Merck	Gardasil 9	1
90655	Influenza virus vaccine, trivalent, split virus, preservative free, for children 6-35 months of age, for intramuscular use	Sanofi Pasteur	Fluzone No Preservative Pediatric	1
90656	Influenza virus vaccine, trivalent, split virus, preservative free, when administered to 3 years of age and above, for intramuscular use	Merck Sanofi Pasteur Novartis GlaxoSmithKline GlaxoSmithKline	Afluria Fluzone No Preservative Fluvirin FLUARIX FLULAVAL	1

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CPT® Code	Separately report the administration with codes **90460–90461** or **90471–90474.**	Manufacturer	Brand	Number of Vaccine Components
90657	Influenza virus vaccine, trivalent, split virus, 6–35 months dosage, for intramuscular use	Sanofi Pasteur	Fluzone	1
90658	Influenza virus vaccine, trivalent, split virus, 3 years and older dosage, for intramuscular use	Merck GlaxoSmithKline Sanofi Pasteur Novartis	Afluria FLULAVAL Fluzone Fluvirin	1
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Pfizer	PREVNAR 13	1
90672	Influenza virus vaccine, quadrivalent, live, intranasal use	MedImmune	Flumist Quadrivalent	1
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	Merck	RotaTeq	1
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	GlaxoSmithKline	ROTARIX	1
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, for children 6-35 months of age, for intramuscular use	Sanofi Pasteur	Fluzone Quadrivalent	1
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to 3 years of age and above, for intramuscular use	GlaxoSmithKline Sanofi Pasteur	FLUARIX Quadrivalent Fluzone Quadrivalent	1
90687	Influenza virus vaccine, quadrivalent, split virus, 6–35 months dosage, for intramuscular use	Sanofi Pasteur	Fluzone Quadrivalent	1
90688	Influenza virus vaccine, quadrivalent, split virus, 3 years and older dosage, for intramuscular use	GlaxoSmithKline Sanofi Pasteur	FLULAVAL Fluzone Quadrivalent	1
90696	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	GlaxoSmithKline	KINRIX	4
90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	⚡	⚡	6
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenzae type b, PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-Hib-IPV), for intramuscular use	Sanofi Pasteur	Pentacel	5
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than seven years, for intramuscular use	Sanofi Pasteur GlaxoSmithKline	DAPTACEL INFANRIX	3
90702	Diphtheria and tetanus toxoids (DT), adsorbed when administered to younger than seven years, for intramuscluar use	Sanofi Pasteur	Diphtheria and Tetanus Toxoids Adsorbed	2
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use	Merck	M-M-R II	3
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	Merck	ProQuad	4
90713	Poliovirus vaccine (IPV), inactivated, for subcutaneous or intramuscular use	Sanofi Pasteur	IPOL	1

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CPT ®Code	Separately report the administration with codes **90460–90461** or **90471–90474.**	Manufacturer	Brand	Number of Vaccine Components
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to seven years or older, for intramuscular use	Sanofi Pasteur	TENIVAC	2
90715	Tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use	Sanofi Pasteur GlaxoSmithKline	ADACEL BOOSTRIX	3
90716	Varicella virus vaccine, live, for subcutaneous use	Merck	VARIVAX	1
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine (DTaP-Hep B-IPV), for intramuscular use	GlaxoSmithKline	PEDIARIX	5
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use	Merck	PNEUMOVAX 23	1
90733	Meningococcal polysaccharide vaccine, for subcutaneous use	Sanofi Pasteur	Menomune	1
90734	Meningococcal conjugate vaccine, serogroups A, C, Y, and W-135 (tetravalent), for intramuscular use	Sanofi Pasteur Novartis	Menactra Menveo	1
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3 dose, for intramuscular use	Merck	RECOMBIVAX HB	1
90743	Hepatitis B vaccine, adolescent, 2 dose, for intramuscular use	Merck	RECOMBIVAX HB	1
90744	Hepatitis B, pediatric/adolescent dosage, 3 dose, for intramuscular use	Merck GlaxoSmithKline	RECOMBIVAX HB ENERGIX-B	1
90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Merck GlaxoSmithKline	RECOMBIVAX HB ENERGIX-B	1
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4 dose, for intramuscular use	GlaxoSmithKline	ENERGIX-B	1
90748	Hepatitis B and Hib (Hep B-Hib), for intramuscular use	Merck	COMVAX	2
90749	**Unlisted vaccine or toxoid**			

⚡ Vaccine pending US Food and Drug Administration approval (www.ama-assn.org//ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-i-vaccine-codes.page).

Developed and maintained by the American Ademy of Pediatrics. Updated periodically at https://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Documents/Vaccine Coding Table.pdf. For reporting purposes only.

Healthcare Common Procedure Coding System Codes

- HCPCS Level II codes are procedure codes used to report services and supplies not included in the *CPT*® nomenclature.
- Like *CPT* codes, HCPCS Level II codes are part of the standard procedure code set under the Health Insurance Portability and Accountability Act of 1996.
- Certain payers may require that HCPCS codes be reported in lieu of or as a supplement to *CPT* codes.
- The HCPCS nomenclature contains many codes for reporting nonphysician provider patient education, which can be an integral service in the provision of pediatric preventive care.

Examples of HCPCS Level II codes relevant to pediatric preventive care include

S0302 Completed Early and Periodic Screening, Diagnosis, and Treatment service (List in addition to code for appropriate E/M service.)

S0610 Annual gynecologic examination; new patient

S0612 Annual gynecologic examination; established patient

S0613 Annual gynecologic examination, clinical breast examination without pelvic examination

S0622 Routine examination for college, new or established patient (List separately in addition to appropriate E/M code.)

S9444 Parenting classes, nonphysician provider, per session

S9445 Patient education, not otherwise classified, nonphysician provider, individual, per session

S9446 Patient education, not otherwise classified, nonphysician provider, group, per session

S9447 Infant safety (including cardiopulmonary resuscitation) classes, nonphysician provider, per session

S9451 Exercise classes, nonphysician provider, per session

S9452 Nutrition classes, nonphysician provider, per session

S9454 Stress management classes, nonphysician provider, per session

Laboratory Codes

There are 2 different practice models surrounding the conducting of laboratory tests: blood is drawn in office and specimen is sent to an outside laboratory for analysis, or blood is drawn and laboratory tests are performed in the physician's practice. Never report the laboratory code for a laboratory test that the practice does not run in-house or is not financially responsible for and billed by the outside laboratory. In those cases, only report the blood draw and specimen handling as appropriate.

Model 1: Blood is drawn in office and specimen is sent to an outside laboratory for analysis.

99000 Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory

Venipuncture

CPT® Codes

36406 Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture

36410 Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture)

36415 Collection of venous blood by venipuncture

36416 Collection of capillary blood specimen (eg, finger, heel, ear stick)

ICD-10-CM Codes

Link to *ICD-10-CM* code(s) for specific screening test(s).

Model 2: Blood is drawn and laboratory tests are performed in the physician's practice.

Venipuncture

CPT® Codes

36406 Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture

36410 Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture)

36415 Collection of venous blood by venipuncture

36416 Collection of capillary blood specimen (eg, finger, heel, ear stick)

ICD-10-CM Codes

Link to *ICD-10-CM* code(s) for specific screening test(s).

Cholesterol Screening

CPT® Codes

80061 Lipid panel (includes total cholesterol, high-density lipoprotein [HDL] cholesterol, and triglycerides)

82465 Cholesterol, serum, total

83718 Lipoprotein, direct measurement, high-density cholesterol (HDL cholesterol)

84478 Triglycerides

ICD-10-CM Codes

Z13.220 Encounter for screening for lipid disorders

Hematocrit/Hemoglobin

CPT® Codes

85014 Blood count; hematocrit

85018 Blood count; hemoglobin

ICD-10-CM Codes

Z13.0 Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (eg, anemia)

Lead Screening

CPT® Code

83655 Lead

ICD-10-CM Codes

Z13.88 Encounter for screening for disorder due to exposure to contaminants

Newborn Metabolic Screening

HCPCS Code

(Note: See Healthcare Common Procedure Coding System Codes on pages 36 and 37 for explanation of HCPCS codes.)

S3620 Newborn metabolic screening panel, includes test kit, postage, and the laboratory tests specified by the state for inclusion in this panel (eg, galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-D; phenylalanine [phenylketonuria (PKU)]; and thyroxine, total)

ICD-10-CM Codes

Report the diagnosis code(s) for the state-specific newborn screening test(s) conducted. Examples include

Z13.0 Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (eg, anemia, sickle cell)

Z13.21 Encounter for screening for nutritional disorder

Z13.228 Encounter for screening for other metabolic disorders (eg, PKU, galactosemia)

Z13.29 Encounter for screening for other suspected endocrine disorder (eg, thyroid)

Papanicolaou Smear

HCPCS Code

(Note: See "Healthcare Common Procedure Coding System Codes" on pages 36 and 37 for explanation of HCPCS codes.)

Q0091 Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory

CPT® Code

Collection of a cervical specimen via a pelvic examination is included in the preventive medicine service code (**99381–99385** and **99391–99395**).

ICD-10-CM Codes

Z12.4 Encounter for screening for malignant neoplasm of cervix (excludes HPV)

Z12.72 Encounter for screening for malignant neoplasm of vagina

Z12.79 Encounter for screening for malignant neoplasm of other genitourinary organs

Z12.89 Encounter for screening for malignant neoplasms of other sites

Tuberculosis Testing (Mantoux/Purified Protein Derivative [PPD])

Administration of PPD Test

CPT® Code		*ICD-10-CM* Code	
86580	Skin test; tuberculosis, intradermal	**Z11.1**	Encounter for screening for respiratory tuberculosis

NOTE: There is no separate administration code for the PPD test. Do not report one.

Reading of PPD Test

If patient returns to have a nurse read the test results, report

CPT® Code		*ICD-10-CM* Code	
99211	Office or other outpatient services (nurse visit)	**Z11.1**	Encounter for screening for respiratory tuberculosis *(if test is negative)*
			or
		R76.11	Nonspecific reaction to tuberculin skin test without active tuberculosis *(if test is positive)*

CPT® Codes

86701 Antibody; HIV-1

86703 Antibody; HIV-1 and HIV-2; single assay

87490 Infectious agent detection by nucleic acid (DNA or RNA); *C trachomatis,* direct probe technique

87491 Infectious agent detection by nucleic acid (DNA or RNA); *C trachomatis,* amplified probe technique

87590 Infectious agent detection by nucleic acid (DNA or RNA); *Neisseria gonorrhoeae,* direct probe technique

87591 Infectious agent detection by nucleic acid (DNA or RNA); *N gonorrhoeae,* amplified probe technique

87810 Infectious agent detection by immunoassay with direct optical observation; *C trachomatis*

87850 Infectious agent detection by immunoassay with direct optical observation; *N gonorrhoeae*

ICD-10-CM Codes

Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission (excludes HPV and HIV)

Z11.8 Encounter for screening for other infectious and parasitic diseases (eg, chlamydia)

Commonly Reported *ICD-10-CM* Codes for Preventive Services

ICD-10-CM Code	Descriptor	Special Coding Conventions
Encounter and Examination Codes		
Z00.110	Newborn check under 8 days old	Outpatient codes only
Z00.111	Newborn check 8 to 28 days old	Outpatient codes only
Z00.121 **Z00.129**	Routine child health examination *with abnormal findings* *without abnormal findings*	First-listed *ICD-10-CM* code only. Includes routine screening when performed at same encounter.
Z00.00 **Z00.01**	General adult medical examination *without abnormal findings* *with abnormal findings*	First-listed *ICD-10-CM* code only. Typically used for patients 18 years and older (payer policy).
Z02.0 **Z02.4** **Z02.5**	Examination for admission to educational institution Examination for driving license Examination for participation in sport	Not required in addition to a **Z00** code.
Z01.00 **Z01.01**	Examination of eyes and vision *without abnormal findings* *with abnormal findings*	First-listed *ICD-10-CM* code only. Do not report as a secondary code or in addition to a **Z00** code.
Z01.110	Hearing examination following failed hearing screening	First-listed *ICD-10-CM* code only. Do not report as a secondary code or in addition to a **Z00** code.
Z01.10 **Z01.118**	Encounter for examination of ears and hearing *without abnormal findings* *with other abnormal findings*	First-listed *ICD-10-CM* code only. Do not report as a secondary code or in addition to a **Z00** code.
Z23	Immunizations	This is the only code in *ICD-10-CM* for vaccines. Link to both the product and administration *CPT*® codes.
Screening Codes		
Z11.1	Respiratory tuberculosis	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z11.3	Infections with a predominantly sexual mode of transmission (*excludes* HPV and HIV)	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z12.4	Encounter for screening for malignant neoplasm of cervix (*excludes* HPV)	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z12.79 **Z12.89**	Malignant neoplasm of other genitourinary organs Malignant neoplasms of other sites	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.29	Other suspected endocrine disorder	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.1	Diabetes mellitus	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.

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ICD-10-CM **Code**	**Descriptor**	**Special Coding Conventions**
Screening Codes *continued*		
Z13.228	Other metabolic disorders (eg, inborn errors of metabolism, galactosemia, PKU)	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.220	Lipid disorders	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.21 **Z13.228** **Z13.29**	Nutritional disorder Other metabolic disorder Other suspected endocrine disorder	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.0	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (eg, anemia, sickle cell)	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.89	Other disorders (eg, depression)	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Z13.4	Developmental disorders in childhood (*excludes routine screening*) (eg, Autism)	Do not report in addition to a **Z00.12-** code; it is already included.
Z13.88	Disorder due to exposure to contaminants (eg, lead)	A screening code is not necessary if the screening is inherent to a routine examination. But can be reported.
Underimmunized Status and Vaccines Not Given		
Z28.3	Underimmunized status	A status code is informative and may affect the course of treatment and its outcome. Report when this is the case.
Z28.01	*Vaccine not given:* Acute illness	
Z28.04	Allergy to vaccine or components	
Z28.82	Caregiver refusal	
Z28.02	Chronic illness or condition	
Z28.03	Immune compromised state	
Z28.21	Patient refusal	
Z28.81	Pt had disease being vaccinated for	
Z28.1	Religious reasons	
Z28.89	Other reason	
Z28.20	Unspecified reason	

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