American Academy of Pediatrics
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Coding for Pediatric Preventive Care

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, Ninth Revision, Clinical Modification (ICD-9-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.

[A]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), 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 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 and hearing screening) identified with a specific *CPT* code, are reported separately from the preventive medicine service code.

[B]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-9-CM Codes

99381 Infant (younger than 1 year)	**V20.31** Health supervision for newborn under 8 days old
	V20.32 Health supervision for newborns 8 to 28 days old
	V20.2 Routine infant or child health check
99382 Early childhood (age 1–4 years)	**V20.2** Routine infant or child health check
99383 Late childhood (age 5–11 years)	**V20.2** Routine infant or child health check
99384 Adolescent (age 12–17 years)	**V20.2** Routine infant or child health check
99385 18 years or older	**V70.0** Routine general medical examination at a health care facility

A *new patient* is defined as one who has *not* received any professional services (face-to-face services rendered by a physician and reported by a specific *CPT* code[s]) from a physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years.

[B]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-9-CM* Codes
99391 Infant (younger than 1 year)	**V20.31** Health supervision for newborn under 8 days old
	V20.32 Health supervision for newborns 8 to 28 days old
	V20.2 Routine infant or child health check
99392 Early childhood (age 1–4 years)	**V20.2** Routine infant or child health check
99393 Late childhood (age 5–11 years)	**V20.2** Routine infant or child health check
99394 Adolescent (age 12–17 years)	**V20.2** Routine infant or child health check
99395 18 years or older	**V70.0** Routine general medical examination at a health care facility

[A]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.
- 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.
- 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.

[B]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

[B]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

[B]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

[C]*ICD-9-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
  - **V15.82** History of tobacco use
  - **V15.83** Underimmunized status (Lapsed immunization schedule)
  - **V15.89** Other specific personal history presenting as hazards to health
  - **V25.09** Encounter for contraceptive management; general counseling and advice; other
  - **V65.3** Dietary surveillance and counseling
  - **V65.40** Counseling not otherwise specified
  - **V65.41** Exercise counseling
  - **V65.42** Counseling on substance use and abuse
  - **V65.43** Counseling on injury prevention
  - **V65.49** Other specified counseling

[A]Other Preventive Medicine Services

[B]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 *ICD-9-CM* code **V20.2** to the preventive medicine service code, but link a different diagnosis code (eg, **623.5** [vaginal discharge], **625.3** [dysmenorrhea]) to the office or other outpatient E/M service code.
- 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.

[C]*ICD-9-CM* Codes

- **V25.11** Encounter for insertion of intrauterine contraceptive device
- **V25.12** Encounter for removal of intrauterine contraceptive device
- **V25.13** Encounter for removal and reinsertion of intrauterine contraceptive device
- **V25.40** Surveillance of previously prescribed contraceptive methods; contraceptive surveillance, unspecified
- **V25.41** Surveillance of previously prescribed contraceptive methods; contraceptive pill
- **V25.42** Surveillance of previously prescribed contraceptive methods; intrauterine contraceptive device
- **V25.43** Surveillance of previously prescribed contraceptive methods; implantable subdermal contraceptive
- **V25.49** Surveillance of previously prescribed contraceptive methods; other contraceptive method
- **V72.31** Routine gynecologic examination
- **V72.32** Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear

[B]Health Risk Assessment

[C]*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-9-CM* code **V20.2** for a normal screen. Check with your payers.

[C]*ICD-9-CM* Codes

V20.2 Routine infant or child health check (eg, for postpartum depression screening)
V79.8 Special screening for other specified mental disorders and developmental handicaps

[B]Unlisted Preventive Medicine Service

99429 Unlisted preventive medicine service

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

[A]Case Management or Care Plan Oversight Services

[B]Telephone Services

[C]*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

[B]Online Medical Evaluation

[C]*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

[B]Care Plan Oversight

[C]*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.

[A]Complex Chronic Care Coordination Services

99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

99488 first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, 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

[A]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

[A]Screening Codes

[B]Vision Screening

CPT Codes		*ICD-9-CM* Codes	
99173	Screening test of visual acuity quantitative, bilateral	**V20.2**	Routine infant or child health check
99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral	**V20.2**	Routine infant or child health check

V72.0 (examination of eyes and vision) is reported for diagnostic vision examinations only.

- To report code **99173,** you must employ graduate visual acuity stimuli that allow a quantitative estimate of visual acuity (eg, Snellen chart).
- Code **99174** is reported for instrument-based ocular screening for esotropia, exotropia, anisometropia, cataracts, ptosis, hyperopia, and myopia.

- When acuity **(99173)** or instrument-based ocular screening **(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)** linked to the diagnosis code for the reason for the failure (eg, **367.1** [myopia]); when a specific code cannot be identified, report **368.8** (other specified visual disturbance).

[B]Hearing Screening

CPT Codes		*ICD-9-CM* Codes	
92551	Screening test, pure tone, air only	**V20.2**	Routine infant or child health check
92552	Pure tone audiometry (threshold); air only	**V20.2**	Routine infant or child health check
92567	Tympanometry (impedance testing)	**V20.2**	Routine infant or child health check

Codes **V72.11** (encounter for hearing examination following failed hearing screening) and **V72.19** (other examination of ears and hearing) are reported for diagnostic hearing examinations only.

- 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)** linked to the diagnosis code for the reason for the failure; when a specific code cannot be identified, report **389.8** (other specified forms of hearing loss).

[B]Developmental Screening

CPT Code		*ICD-9-CM* Code	
96110	Developmental screening, per instrument, with interpretation and report	**V79.3**	Special screening for developmental handicaps in early childhood

- Used to report administration of *standardized* developmental screening instruments of a limited nature.
- Often reported when performed in the context of preventive medicine services but may also be reported when screening 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 limited standardized screening test is performed 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
    - Bricker D, Squires J, Mounts L. *Ages & Stages Questionnaire (ASQ).* 2nd ed. Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 1999 and Squires J, Bricker D, Twombly E. *Ages & Stages*

Questionnaires: Social-Emotional (ASQ:SE). Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
- 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 Functioning (BRIEF).* Lutz, FL: Psychological Assessment Resources, Inc; 2000
- Ireton H. *Child Development Review System*. Minneapolis, MN: Behavior Science Systems, Inc
- Wetherby AM, Prizant BM. *Communication and Symbolic Behavior Scales Developmental Profile* (*CSBS DP*). Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
- Glascoe FP. *Parents' Evaluation of Developmental Status.* Nashville, TN: Ellsworth & Vandermeer Press LLC; 2006
- Jellinek M, Murphy M. Pediatric Symptom Checklist. http://www.massgeneral.org/psychiatry/services/psc_home.aspx. Accessed January 30, 2013
- NICHQ Vanderbilt assessment scales. In: American Academy of Pediatrics. *Caring for Children With ADHD: A Resource Toolkit for Clinicians* [CD-ROM]. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2012

[A]Immunizations

[B]Immunization Administration

[C]Pediatric Immunization Administration Codes

Report a *CPT* and an *ICD-9-CM* code for *each component administered* as well as for *each vaccine product* given during a patient encounter.

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 (List separately in addition to code for primary procedure.)

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 above.

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.

[C]Nonage-Specific Immunization Administration Codes

Report a *CPT* and an *ICD-9-CM* 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 and 4 on pages 24 and 25.)

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):

[D]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 intranasal 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?

[E]Step 1: Select appropriate E/M code.

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

[E]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, quadrivalent, live, for intranasal use

[E]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.)

[E]Step 4: Select the appropriate *ICD-9-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-9-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-9-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-9-CM does list specific codes to describe an encounter in which a patient does receive a certain vaccine (ie, codes **V03–V05);** however, when immunizations are administered during a routine well-child visit, *ICD-9-CM* code **V20.2** should be linked to the individual vaccine product and administration code(s). This is due to *ICD-9-CM* guidelines that allow for the linkage of age-appropriate vaccines to be reported under **V20.2** during a routine well-baby or well-child encounter.

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

CPT Codes		*ICD-9-CM* Codes
99393	Preventive medicine service, established patient, 5–11 years	**V20.2**
90633	Hepatitis A vaccine product	**V20.2**
90460	Pediatric IA (hepatitis A vaccine), first component	**V20.2**
90700	DTaP vaccine product	**V20.2**
90460	Pediatric IA (DTaP vaccine), first component	**V20.2**
90461 (x2)	Pediatric IA (DTaP vaccine), each additional component	**V20.2**
90672	Influenza virus vaccine, quadrivalent, live product	**V20.2**
90460	Pediatric IA (influenza vaccine), first component	**V20.2**

Alternative Coding

CPT Codes		*ICD-9-CM* Codes
90633	Hepatitis A vaccine product	**V20.2**
90700	DTaP vaccine product	**V20.2**
90672	Influenza virus vaccine, quadrivalent, live product	**V20.2**
90460 (x3)	Pediatric IA (hepatits A, DTaP, influenza vaccines), first component	**V20.2**
90461 (x2)	Pediatric IA (DTaP vaccine), second and third components	**V20.2**

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 of age 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.

[D]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-9-CM* Codes
99391	Preventive medicine service, established patient, <1 year	**V20.2**
90698	DTaP-Hib-IPV (Pentacel) product	**V20.2**
90670	Pneumococcal product	**V20.2**
90680	Rotavirus vaccine **V20.2**	
90460 (x3)	Pediatric IA (Pentacel, pneumococcal, rotavirus), first component	**V20.2**
90461 (x4)	Pediatric IA (Pentacel), each additional component	**V20.2**

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. The vaccines are administered during the patient's routine well-baby visit; therefore, code **V20.2** is the appropriate *ICD-9-CM* code for all vaccines.

[D]Vignette #3
A 19-year-old patient presents to the office for his annual checkup and 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-9-CM* Codes
99395	Preventive medicine service, established patient, 18–39 years	**V70.0** and **V70.3**
90715	Tdap product	**V06.1**
90471	IA, first injection	**V06.1**
90734	Meningococcal (MCV4) product	**V03.89**
90472	IA, each additional injection	**V03.89**
90672	Influenza virus vaccine, quadrivalent, live product	**V04.81**
90474	IA, each additional oral or intranasal	**V04.81**

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. The patient's age also requires the reporting of *ICD-9-CM* code **V70.0;** therefore, the vaccine product and IA codes must be linked to their appropriate *ICD-9-CM* codes (eg, **V06.1).**

[D]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 due for a Tdap booster, meningococcal vaccine, and intranasal influenza vaccine. The physician counsels the patient only on the meningococcal vaccine and the nurse administers each.

CPT Codes		*ICD-9-CM* Codes
99394	Preventive medicine service, established patient, 12–17 years	**V20.2** and **V70.3**
90734	Meningococcal (MCV4) product	**V03.89**
90460	Pediatric IA (meningococcal), first component	**V03.89**
90715	Tdap product	**V06.1**
90472	IA, each additional injection (Tdap)	**V06.1**
90672	Influenza virus vaccine, quadrivalent, live product	**V04.81**
90474	IA, each additional oral or intranasal	**V04.81**

Rationale
Because the physician only documents counseling for the meningococcal vaccine, code **90460** can only be reported for that vaccine. 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. Because the encounter was also related to an examination for administrative purpose (eg, college examination), link the appropriate *ICD-9-CM* code to the vaccine product and IA codes (eg, **V04.81).**

[D]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.

First Visit:

CPT Codes		*ICD-9-CM* Codes
99391	Preventive medicine service, established patient, <1 year	**V20.2**

(An appropriate acute sick visit (eg, **99213**) may be reported in addition with modifier **25** and linked to an appropriate *ICD-9-CM* code.)

CPT Codes		*ICD-9-CM* Codes
90700	DTaP product	**V06.1**
90670	Pneumococcal product	**V03.82**
90744	Hepatitis B vaccine product	**V05.3**
90471	IA (DTaP), first vaccine	**V06.1**
90472 (x2)	IA (pneumococcal, hepatitis B), each additional component	**V03.82** and **V05.3**

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 because one is not completed or documented.

For more information on IA codes, see "Frequently Asked Questions for the Pediatric Immunization Administration Codes" and the Vaccine Coding Table at http://coding.aap.org/codingresources.aspx

[B]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-9-CM* codes. The following *ICD-9-CM* codes were created to report why a vaccine(s) is not given:

Vaccination not carried out due to
V64.00 Unspecified reason
V64.01 Acute illness
V64.02 Chronic illness or condition
V64.03 Immunocompromised state
V64.04 Allergy to vaccine or component
V64.05 Caregiver refusal
V64.06 Patient refusal

V64.08 Patient has disease being vaccinated against

[C]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-9-CM* codes linked to the E/M service:
V05.4 Need for prophylactic vaccination against varicella
V64.08 Vaccination not carried out due to patient had disease being vaccinated against

[A]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

[A]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.

In the first model, modifier **90** (reference [outside] laboratory) is appended to the laboratory procedure code when laboratory procedures are performed by a party other than the treating or reporting physician.

In the latter situation, the practice must have the appropriate Clinical Laboratory Improvement Amendments (CLIA) license to conduct non–CLIA-waived tests. Tests granted CLIA-waived status should be reported with modifier **QW** appended.

[B]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

[C]Venipuncture

[D]*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)

[D]*ICD-9-CM* Codes
Link to *ICD-9-CM* code(s) for specific screening test(s).

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

[C]Venipuncture

[D]*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)

[D]*ICD-9-CM* Codes
Link to *ICD-9-CM* code(s) for specific screening test(s).

[C]Cholesterol Screening

[D]*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

[D]*ICD-9-CM* Codes
V77.91 Screening for lipid disorders

V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].)

[C]Hematocrit/Hemoglobin

[D]*CPT* Codes
85014 Blood count; hematocrit
85018 Blood count; hemoglobin

[D]*ICD-9-CM* Codes
V78.0 Special screening for iron deficiency anemia
V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].)

[C]Lead Screening

[D]*CPT* Code
83655 Lead

[**D]*ICD-9-CM* Codes**
V82.5 Special screening for chemical poisoning and other contamination
V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].)

[C]Newborn Metabolic Screening

[D]HCPCS Code
(Note: See "Healthcare Common Procedure Coding System Codes" on pages 28 and 29 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)

[D]*ICD-9-CM* Codes
Report the diagnosis code(s) for the state-specific newborn screening test(s) conducted. Examples include

V77.0 Special screening for thyroid disorders
V77.3 Special screening for PKU
V77.4 Special screening for galactosemia
V77.7 Special screening for other inborn errors of metabolism
V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders
V78.0 Special screening for iron deficiency anemia
V78.1 Special screening for other and unspecified deficiency anemia
V78.2 Special screening for sickle cell disease or trait
V78.3 Special screening for other hemoglobinopathies
V78.8 Special screening for other disorders of blood and blood-forming organs
V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].)

[C]Papanicolaou Smear

[D]HCPCS Code

(Note: See "Healthcare Common Procedure Coding System Codes" on pages 28 and 29 for explanation of HCPCS codes.)

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

[D]*CPT* Code

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

[D]*ICD-9-CM* Codes

V15.89 Other specified personal history presenting as hazards to health (for high-risk patients only)
V76.2 Special screening for malignant neoplasms; cervix
V76.47 Special screening, malignant neoplasms, vagina
V76.49 Special screening, malignant neoplasms, other sites (for patients without a uterus or cervix)
V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].)

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

[D]Administration of PPD Test

CPT Code
86580 Skin test; tuberculosis, intradermal

ICD-9-CM Code
V74.1 Special screening examination for pulmonary tuberculosis

NOTE: **There is no separate administration code for the PPD test. Do not report one.[DESIGNER: PLEASE PLACE THIS TEXT IN A BOX TO HIGHLIGHT.]**

[D]Reading of PPD Test

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

CPT Code
99211 Office or other outpatient services (nurse visit)

ICD-9-CM Code
V74.1 Special screening examination for pulmonary tuberculosis *(if test is negative)*
or
795.5 Nonspecific reaction to tuberculin skin test without active tuberculosis *(if test is positive)*

[C]Sexually Transmitted Infection Screening

[D]*CPT* Codes

86631 Antibody; chlamydia
86632 Antibody; chlamydia, IgM
86701 Antibody; HIV-1
86703 Antibody; HIV-1 and HIV-2; single assay
87081 Culture, presumptive, pathogenic organisms, screening only
87110 Culture, chlamydia, any source
87205 Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types

87210 Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87270 Infectious agent antigen detection by immunofluorescent technique; *Chlamydia trachomatis*
87320 Infectious agent detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; *C trachomatis*
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
87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; 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*

[D]*ICD-9-CM* Codes
V73.88 Special screening examination for other specified chlamydial diseases
V74.5 Special screening examination for bacterial and spirochetal diseases; venereal disease
V75.9 Special screening examination for unspecified infectious disease
V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].)

[C]Urinalysis
For urinalysis by dipstick or table reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, or any number of these constituents, code as follows:

[D]*CPT* Codes
81000 Nonautomated, with microscopy
81001 Automated, with microscopy
81002 Nonautomated, without microscopy
81003 Automated, without microscopy

[D]*ICD-9-CM* Codes
V77.1 Special screening for diabetes mellitus
V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders
V72.6 Laboratory examination (NOTE: Reported secondary to code[s] for screening[s].

[A]Common Preventive Medicine *ICD-9-CM* Codes and the *ICD-10-CM* Crosswalk

ICD-9-CM Code	Descriptor	*ICD-10-CM* Code[a]	Descriptor
V20.31	Newborn check under 8 days old	**Z00.110**	Newborn check under 8 days old
V20.32	Newborn check 8 to 28 days old	**Z00.111**	Newborn check 8 to 28 days old
V20.2	Routine infant or child health check	**Z00.121** **Z00.129**	Encounter for routine child health examination *with abnormal findings* Encounter for routine child health examination *without abnormal findings*
V70.0	Routine general medical examination at a health care facility	**Z00.00** **Z00.01**	Encounter for general adult medical examination *without abnormal findings* Encounter for general adult medical examination *with abnormal findings*
V72.11	Encounter for hearing examination following failed hearing screen	**Z01.110**	Encounter for hearing examination following failed hearing screening
V72.19	Other examination of ears and hearing	**Z01.11** **Z01.118**	Encounter for examination of ears and hearing *without abnormal findings* Encounter for examination of ears and hearing *with other abnormal findings*
V77.1	Special screening for diabetes mellitus	**Z13.1**	Encounter for screening for diabetes mellitus
V77.91	Screening for lipid disorders	**Z13.220**	Encounter for screening for lipoid disorders
V77.99	Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders	**Z13.21** **Z13.228** **Z13.29**	Encounter for screening for nutritional disorder Encounter for screening for other metabolic disorder Encounter for screening for other suspected endocrine disorder
V79.8	Special screening for other specified mental disorders and developmental handicaps	**Z13.4**	Encounter for screening for certain developmental disorders in childhood *(excludes routine screening)*
V03–V06.9	Need for prophylactic vaccination and inoculation	**Z23**	Encounter for immunization
V15.83	Underimmunized status	**Z28.3**	Underimmunized status
V74.1	Special screening examination for pulmonary tuberculosis	**Z11.1**	Encounter for screening for respiratory tuberculosis

[a]*International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* codes do not become effective until October 1, 2013. Use of these codes prior to that date will result in a carrier denial. Please do not implement these codes until they are effective.