# Coding for Pediatric Preventive Care 2012

99401

99383

99391

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prevention and health promotion
for infants, children, adolescents,
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99411

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# Coding for Pediatric Preventive Care 2012

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.

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# 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.
- The 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 a trivial illness, abnormality, or problem encountered in the process of performing the preventive medicine service that does not require additional work and the 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.

## 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) | **V20.3** | Newborn check under 8 days old |
| **99382** | Early childhood (age 1–4 years) | **V20.3** | Newborn check 8 to 28 days old |
| **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 | **V20.2** | Routine infant or child health check |
| | | **V20.2** | Routine infant or child health check |
| | | **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.

## 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) | **V20.3** | Newborn check under 8 days old |
| **99392** | Early childhood (age 1–4 years) | **V20.3** | Newborn check 8 to 28 days old |
| **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 | **V20.2** | Routine infant or child health check |
| | | **V20.2** | Routine infant or child health check |
| | | **V70.0** | Routine general medical examination at a health care facility |

# 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.
- The 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. They 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** Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes

**99403** Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 45 minutes

**99404** Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 60 minutes

## Behavior Change Interventions, Individual

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

**99407** Smoking and tobacco use cessation counseling visit; 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** Alcohol or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 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** Preventive medicine counseling or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 60 minutes

### *ICD-9-CM* Codes for Counseling Risk Factor Reduction and Behavior Change Interventions

- The diagnosis code(s) reported for the 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
  - **V15.85** Underimmunization status
  - **V15.89** Other specific personal history presenting as hazards to health (eg, tobacco use)
  - **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

# Other Preventive Medicine Services

## Pelvic Examination

- The 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 indicates 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.

## *ICD-9-CM* Codes

**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

## Health Risk Assessment

### *CPT* Code

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

NOTE: This code should 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.

### *ICD-9-CM* Code

**V79.8** Special screening for other specified mental disorders and developmental handicaps

## 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 provided by a physician 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** Telephone E/M service provided by a physician 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; 11 to 20 minutes of medical discussion

**99443** Telephone E/M service provided by a physician 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; 21 to 30 minutes of medical discussion

## Online Medical Evaluation

### *CPT* Code

**99444** Online E/M service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

## *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** 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; 30 minutes or more

- The care plan oversight (CPO) codes are *reported once per calendar month.*
- The 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 (either 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 codes, 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.

# Screening Codes

## 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** | Ocular photoscreening with interpretation and report, bilateral | **V20.2** | Routine infant or child health check |

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

- To report code **99173,** you must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (eg, Snellen chart).
- Code **99174** is reported for ocular photoscreening for esotropia, exotropia, an isometropia, cataracts, ptosis, hyperopia, and myopia.
- When acuity is measured as part of a general ophthalmologic service or an E/M service of the eye (ie, 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 may 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).

## 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 may 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).

## Developmental Screening

| *CPT* Codes | | *ICD-9-CM* Codes | |
|---|---|---|---|
| **96110** | Developmental testing; limited, with interpretation and report | **V79.3** | Special screening for developmental handicaps in early childhood |

- Used to report administration of 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 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.
- When multiple developmental screenings are scored and interpreted on the same day, they can all be coded for by reporting **96110** with units or multiple line items with modifier **59** (distinct procedural services) appended to the subsequent **96110** codes reported.

NOTE: Since *CPT* does not provide a more specific code for behavioral or emotional screening using a standardized tool, report **96110** for these screens.

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.* Minneapolis, MN: Behavior Science Systems, Inc. http://www.childdevrev.com. Accessed July 14, 2010
- Wetherby AM, Prizant BM. *Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP).* Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
- Kaufman AS, Kaufman NL. KBIT-2: *Kaufman Brief Intelligence Test.* 2nd ed. Upper Saddle River, NJ: Pearson School Publishing; 2007
- Conners CK. *Conners Rating Scales-Revised (CRS-R) Technical Manual.* North Tonawanda, NY: Multi Health Systems; 2000
- Glascoe FP. *Parents' Evaluation of Developmental Status.* Nashville, TN: Ellsworth & Vandermeer Press LLC; 2006
- Jellinek M, Murphy M. Pediatric Symptom Checklist. http://www2.massgeneral.org/allpsych/psc/psc_home.htm. Accessed July 14, 2010

- Wolraich ML. NICHQ Vanderbilt Assessment Scales. In: American Academy of Pediatrics, National Initiative for Children's Healthcare Quality, North Carolina Center for Children's Healthcare Improvement. *Caring for Children With ADHD: A Resource Toolkit for Clinicians.* Elk Grove Village, IL: American Academy of Pediatrics; 2005

# Immunizations

## Immunization Administration

Report a *CPT* code for each component administered as well as for each vaccine product given during a patient encounter. Also report the appropriate *ICD-9-CM* code linked to both the component and vaccine product.

### Pediatric Immunization Administration Codes

**90460** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

**+90461** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component
Use **90461** in conjunction with **90460.**

NOTE: New in *CPT 2012,* the term "qualified health care professional" has been defined. 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 their 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.

NOTE: A *component* refers to an antigen in a vaccine that prevents disease(s) caused by one organism.

## Non–Age-Specific Immunization Administration Codes

**90471** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

Do not report **90471** in conjunction with **90473.**

**+90472** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

Use **90472** in conjunction with **90471** or **90473.**

**90473** Immunization administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

Do not report **90473** in conjunction with **90471.**

**+90474** Immunization administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

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

The pediatric component-based immunization administration codes **(90460–90461)** are reported only when *both* of the following requirements are met:

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

If *both* of these requirements are not met, report a non–age-specific, non-component–based immunization administration code(s) **(90471–90474)** instead.

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** code during a single office encounter. Code **90461** is considered an *add-on* code (hence the + symbol next to it) to **90460.** This means that the provider will use **90461** in addition to **90460** if more than one component is contained within a single vaccine administered.

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 **90471** and **90473,** respectively. This means that the provider will use **90472** or **90474** in addition to **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.

The following examples may help illustrate their correct use.

**Example**

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 (**VIS**s) and discussing the risks and benefits of immunizations with her parents, the physician administers the vaccines.

How do you go about selecting the appropriate code(s) for this service?

**Step 1:** Select the appropriate E/M code.

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

**Step 2:** Select the 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

**90660** Influenza virus vaccine, live, for intranasal use

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

- Is the patient 18 years or younger?
- If the patient is 18 years or younger, did the physician or other qualified health care professional do the face-to-face vaccine

counseling, discussing the specific risks and benefits of the vaccine(s)?

If the answer to both questions is "yes," you will select a code from the component-based pediatric immunization administration code family **(90460, 90461).** If the answer to one of the questions is "no," you will select a code from the non–age-specific immunization administration code family **(90471–90474).**

In this example, the answer to both questions is "yes," therefore, the following immunization administration codes will be reported:

**90460** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

**+90461** each additional vaccine/toxoid component

**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. *Current Procedural Terminology* 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 immunization administration *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.

The diagnosis codes for the 3 vaccines and the 3 immunization administration codes used in this example are as follows:

| ***CPT* Codes** | | ***ICD-9-CM* Codes** |
|---|---|---|
| **90633** | Hepatitis A vaccine | **V20.2** |
| **90460** | Immunization administration (IA) (1-component hepatitis A vaccine) | **V20.2** |
| **90700** | DTaP vaccine | **V20.2** |
| **90460** | IA (first component of DTaP vaccine) | **V20.2** |
| **90461** | IA (second component of DTaP vaccine) | **V20.2** |
| **90461** | IA (third component of DTaP vaccine) | **V20.2** |
| **90660** | Influenza virus vaccine, live | **V20.2** |
| **90460** | IA (one-component influenza vaccine) | **V20.2** |

**Alternative Coding**

| ***CPT* Codes** | | ***ICD-9-CM* Codes** |
|---|---|---|
| **90633** | Hepatitis A vaccine | **V20.2** |
| **90700** | DTaP vaccine | **V20.2** |
| **90660** | Influenza virus vaccine, live | **V20.2** |
| **90460 (x3)** | IA (First component hepatitis A, DTaP, influenza vaccines) | **V20.2** |
| **90461 (x2)** | IA (second and third components of DTaP vaccine) | **V20.2** |
| **90461** | IA (third component of DTaP vaccine) | **V20.2** |

NOTE: Since the immunizations were 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). The E/M code used in the example **(99393)** would also be linked to *ICD-9-CM* code **V20.2.** 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/child encounter

NOTE: Some payers will require the use of the alternative coding and can only adjudicate the claims appropriately when the **90460/90461** codes are reported with units and not as separate line items.

As described previously, the physician will independently code for each vaccine administered based on each vaccine's given number of components. If, for example, 3 vaccines are given, you will look at each of the 3 vaccines independently to

determine the number of components in each one. Since the influenza vaccine and the hepatitis A vaccine each contain only one component, you will report code **90460** once for each. However, since the DTaP vaccine contains 3 distinct components (diphtheria, tetanus, pertussis), you would report code **90460** for the first component (diphtheria), plus code **90461** twice to account for each of the additional 2 components (tetanus and pertussis).

**Example**

A 1-year-old established patient is unable to receive her immunizations at her routine scheduled well examination due to an illness. She is rescheduled to come back in 2 weeks. Upon return, the physician sees the patient and determines that she is healthy. The physician orders her first measles, mumps, rubella (MMR) vaccine; her first hepatitis A vaccine; and her first varicella vaccine. The physician distributes the **VIS**s and discusses the risks and benefits of immunizations with her parents. The nurse administers the vaccines.

How do you go about selecting the appropriate code(s) for this service?

**Step 1:** Select the appropriate E/M code.

**99392** Preventive medicine service, established patient, age 1 to 4 years

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

**90707** MMR, live for subcutaneous use

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

**90716** Varicella virus vaccine, live, for subcutaneous use

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

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

If the answer to both questions is "yes," you will select a code from the component-based pediatric immunization administration code family **(90460, 90461).** If the answer to one of the questions is "no," you will select a code from the non–age-specific immunization administration code family **(90471–90474).**

In this example, the answer to both questions is "yes," therefore, the following immunization administration codes will be reported:

**90460**

**+90461**

**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. *Current Procedural Terminology* 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 immunization administration *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.

The diagnosis codes for the 3 vaccines and the 3 immunization administration codes used in this example are as follows:

| ***CPT* Codes** | | ***ICD-9-CM* Codes** |
|---|---|---|
| **90707** | MMR vaccine | **V06.4** |
| **90460** | IA (first component of MMR vaccine) | **V06.4** |
| **90461** | IA (second component of MMR vaccine) | **V06.4** |
| **90461** | IA (third component of MMR vaccine) | **V06.4** |
| **90633** | Hepatitis A vaccine | **V05.3** |
| **90460** | IA (one-component hepatitis A vaccine) | **V05.3** |
| **90660** | Varicella virus vaccine | **V05.4** |
| **90460** | IA (one-component varicella vaccine) | **V05.4** |
| **Alternative Reporting** | | |
| **90707** | MMR vaccine | **V06.4** |
| **90633** | Hepatitis A vaccine | **V05.3** |
| **90660** | Varicella virus vaccine | **V05.4** |
| **90460 (x3)** | IA (first component of MMR, hepatitis A and varicella vaccines) | **V06.4** |
| | | **V05.3** |
| | | **V05.4** |
| **90461 (x2)** | IA (second and third component of MMR vaccine) | **V06.4** |

NOTE: Since the immunizations were administered during a nonroutine well-child visit, each individual *ICD-9-CM* code for the vaccines should be linked to the individual vaccine product and administration code(s). The E/M code used in the example **(9921x)** would be linked to the appropriate *ICD-9-CM* code to describe the follow-up encounter. Modifier **25** should be appended to the appropriate **9921x** code.

As described previously, the physician will independently code for each vaccine administered based on each vaccine's given number of components. If, for example, 3 vaccines are given, you will look at each of the 3 vaccines independently to determine the number of components in each one. Since the varicella vaccine and the hepatitis A vaccine each contain only one component, you will report code **90460** once for

each. However, since the MMR vaccine contains 3 distinct components (measles, mumps, rubella), you would report code **90460** for the first component (measles), plus code **90461** twice to account for each of the additional 2 components (mumps and rubella).

**Example**

An established patient who just turned 19 presents to your office for his yearly checkup and catch-up vaccines not previously given. He is due for a tetanus, diphtheria, and acellular pertussis (Tdap); meningococcal conjugate vaccine (MCV); and his yearly influenza. This patient will also be entering college and living in a dorm. The physician counsels and orders the vaccines. The patient is given the Tdap and MCV by injection and the influenza vaccine intranasally.

How do you go about selecting the appropriate code(s) for this service?

**Step 1:** Select the appropriate E/M code.

**99395** Preventive medicine service, established patient, age18–39 years

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

**90715** Tdap when administered to 7 years or older, for intramuscular use

**90734** Meningococcal vaccine (tetravalent) for intramuscular use

**90660** Influenza virus vaccine, live, for intranasal use

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

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

If the answer to both questions is "yes," you will select a code from the component-based pediatric immunization administration code family **(90460, 90461).** If the answer to one of the questions is "no," you will select a code from the non–age-specific immunization administration code family **(90471–90474).**

In this example, the answer to one question is "no" (patient is 19 years old), therefore, the following immunization administration codes will be reported:

**90471** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

**+90472** each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

**+90474** Immunization administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

**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. *Current Procedural Terminology* 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 immunization administration *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. The diagnosis codes for the 3 vaccines and the 3 immunization administration codes used in this example are as follows:

| ***CPT* Codes** | | ***ICD-9-CM* Codes** |
|---|---|---|
| **90715** | Tdap vaccine | **V06.5** |
| **90471** | IA (Tdap vaccine) | **V06.5** |
| **90734** | Meningococcal vaccine | **V03.89** |
| **90472** | IA (meningococcal vaccine) | **V03.89** |
| **90660** | Influenza virus vaccine, live | **V04.81** |
| **90474** | IA (influenza vaccine) | **V04.81** |

NOTE: The E/M code used in the example **(99395)** would be linked to its own *ICD-9-CM* code (**V70.0,** routine general medical examination). The vaccine product code(s) and administration code(s) will not be linked to the **V70.0** as with the **V20.2** because *ICD-9-CM* guidelines do not allow for this reporting.

As described previously, the physician will code for the administration of each immunization. If, for example, 3 injectable immunizations are given during a single visit, the physician will report 1 first administration code and 2 "each additional" administration codes. It is imperative that the add-on codes **(90472, 90474)** are not used without the codes for the first immunization administration **(90471, 90473).**

## 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 a vaccine or defer it, 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 this as part of your *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** Immune compromised state

**V64.04** Allergy to vaccine or component

**V64.05** Caregiver refusal

**V64.06** Patient refusal

**V64.08** Patient has disease being vaccinated against

### Example

A 1-year-old presents for his routine well-child examination. He is scheduled to receive his first MMR vaccine, his first hepatitis A vaccine, and his first varicella vaccine. Since he has a documented case of varicella when he was 9 months old, the varicella vaccine is not given. However, you want to report that

the varicella was reviewed but not given because of previous disease.

**Report**

**V05.4** Need for prophylactic vaccination against varicella

**V64.08** Vaccination not carried out due to patient had disease being vaccinated against

## Commonly Administered Pediatric Vaccines/Toxoids and Immune Globulins[a,b]

*REMEMBER: Report with therapeutic injection code **96372** when you administer a Synagis.*

| CPT Code | Immune Globulin | Manufacturer | Brand | ICD-9-CM Code |
|---|---|---|---|---|
| **90378** | Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each | MedImmune | Synagis | **V04.82** |

***REMEMBER:** Report with immunization administration code(s) **(90460–90461, 90471–90474).***

| CPT Code | Vaccine | Manufacturer | Brand | ICD-9-CM Code |
|---|---|---|---|---|
| **90633** | Hepatitis A vaccine, pediatric/adolescent dosage, 2-dose, for intramuscular (IM)use | GlaxoSmithKline<br>Merck | HAVRIX<br>VAQTA | **V05.3** |
| **90634** | Hepatitis A vaccine, pediatric/adolescent dosage, 3-dose, for IM use | GlaxoSmithKline | HAVRIX | **V05.3** |
| **90644** | Meningococcal conjugate vaccine, serogroups C & Y and *Haemophilus influenzae type* b vaccine, (Hib-MenCY-TT), 4-dose schedule, when administered to children 2–15 months of age, for IM use | ⚡<br>GlaxoSmithKline | ⚡<br>MenHibRix | **V06.8** |
| **90647** | *Haemophilus influenzae* type b vaccine (Hib), PRP-OMP conjugate, 3-dose, for IM use | Merck | PedvaxHIB | **V03.81** |
| **90648** | *Haemophilus influenzae* type b vaccine (Hib), PRP-T conjugate, 4-dose, for IM use | sanofi pasteur<br>GlaxoSmithKline | ActHIB<br>HIBERIX | **V03.81** |
| **90649** | Human papillomavirus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3-dose schedule, for IM use | Merck | GARDASIL | **V04.89** |
| **90650** | Human papillomavirus (HPV) vaccine, types 16 and 18, bivalent, 3-dose schedule, for IM use | GlaxoSmithKline | CERVARIX | **V04.89** |
| **90655** | Influenza virus vaccine, split virus, preservative-free, for children 6 to 35 months of age, for IM use | sanofi pasteur | Fluzone No Preservative Pediatric | **V04.81** |
| **90656** | Influenza virus vaccine, split virus, preservative-free, when administered to 3 years and older, for intramuscular use | sanofi pasteur<br><br>Chiron<br>GlaxoSmithKline | Fluzone No Preservative<br>Fluvirin<br>FLUARIX | **V04.81** |

*(continued from previous page)*

| *CPT* Code | Vaccine | Manufacturer | Brand | *ICD-9-CM* Code |
|---|---|---|---|---|
| **90657** | Influenza virus vaccine, split virus, 6 to 35 months' dosage, for intramuscular use | sanofi pasteur | Fluzone | **V04.81** |
| **90658** | Influenza virus vaccine, split virus, 3 years and older dosage, for intramuscular use | sanofi pasteur<br>Novartis | Fluzone<br>Fluvirin | **V04.81** |
| **90660** | Influenza virus vaccine, live, intranasal use | MedImmune | FluMist | **V04.81** |
| **90661** | Influenza virus vaccine, derived from cell cultures, subunit, preservative- and antibiotic-free, for IM use | ⚡ | ⚡ | **V04.81** |
| **90670** | Pneumococcal conjugate vaccine, 13-valent, for IM use | Pfizer | PREVNAR13 | **V03.82** |
| **90680** | Rotavirus vaccine, pentavalent, 3-dose schedule, live, for oral use | Merck | RotaTeq | **V04.89** |
| **90681** | Rotavirus vaccine, human, attenuated, 2-dose schedule, live, for oral use | GlaxoSmithKline | ROTARIX | **V04.89** |
| **90696** | Diphtheria, tetanus toxoids, and acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for IM use | GlaxoSmithKline | KINRIX | **V06.3** |
| **90698** | Diphtheria, tetanus toxoids, acellular pertussis vaccine, *Haemophilus influenzae* type b, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use | sanofi pasteur | Pentacel | **V06.8** |
| **90700** | Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than 7 years, for IM use | sanofi pasteur<br>sanofi pasteur<br>GlaxoSmithKline | DAPTACEL<br>Tripedia<br>INFANRIX | **V06.1** |
| **90702** | Diphtheria and tetanus toxoids (DT), adsorbed when administered to younger than 7 years, for IM use | sanofi pasteur | Diphtheria and Tetanus Toxoids Adsorbed | **V06.5** |
| **90707** | Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use | Merck | M-M-R II | **V06.4** |
| **90710** | Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use | Merck | ProQuad | **V06.8** |
| **90713** | Poliovirus vaccine (IPV), inactivated, for subcutaneous or intramuscular use | sanofi pasteur | IPOL | **V04.0** |
| **90714** | Tetanus and diphtheria toxoids (Td) adsorbed, preservative-free, when administered to 7 years or older, for IM use | sanofi pasteur | DECAVAC | **V06.5** |
| **90715** | Tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for IM use | sanofi pasteur<br>GlaxoSmithKline | ADACEL<br>BOOSTRIX | **V06.1** |
| **90716** | Varicella virus vaccine, live, for subcutaneous use | Merck | Varivax | **V05.4** |

*(continued from previous page)*

| *CPT* Code | Vaccine | Manufacturer | Brand | *ICD-9-CM* Code |
|---|---|---|---|---|
| **90718** | Tetanus and diphtheria toxoids (Td) adsorbed when administered to 7 years or older, for IM use | sanofi pasteur | Tetanus and Diphtheria Toxoids | **V06.5** |
| **90721** | Diphtheria, tetanus toxoids, and acellular pertussis vaccine and *Haemophilus influenzae* type b vaccine (DTaP-Hib) | sanofi pasteur | TriHIBit | **V06.8** |
| **90723** | Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine (DTaP-Hep B-IPV), for IM use | GlaxoSmithKline | PEDIARIX | **V06.8** |
| **90732** | Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or IM use | Merck | PNEUMOVAX 23 | **V03.82** |
| **90733** | Meningococcal polysaccharide vaccine, for subcutaneous use | sanofi pasteur | Menomune | **V03.89** |
| **90734** | Meningococcal conjugate vaccine, serogroups A, C, Y, and W-135 (tetravalent), for intramuscular use | sanofi pasteur<br>Novartis | Menactra<br>Menveo | **V03.89** |
| **90740** | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3-dose, for intramuscular use | Merck | RECOMBIVAX HB | **V05.3** |
| **90743** | Hepatitis B vaccine, adolescent, 2-dose, for intramuscular use | Merck | RECOMBIVAX HB | **V05.3** |
| **90744** | Hepatitis B, pediatric/adolescent dosage, 3-dose, for intramuscular use | Merck<br>GlaxoSmithKline | RECOMBIVAX HB<br>ENERGIX-B | **V05.3** |
| **90746** | Hepatitis B vaccine, adult dosage, for intramuscular use | Merck<br>GlaxoSmithKline | RECOMBIVAX HB<br>ENERGIX-B | **V05.3** |
| **90747** | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4-dose, for intramuscular use | GlaxoSmithKline | ENERGIX-B | **V05.3** |
| **90748** | Hepatitis B and Hib (Hep B-Hib), for intramuscular use | Merck | COMVAX | **V06.8** |

⚡ Vaccine pending FDA approval [http://www.ama-assn.org/ama/pub/category/10902.html]

[a] *International Classification of Diseases, Ninth Revision, Clinical Modification* guidelines indicate that immunizations administered as part of a routine well-baby or well-child check should be reported with code **V20.2.** The codes listed above can be reported in addition to the **V20.2** code if specific payers request them. Immunizations administered in encounters **other than those for a routine well-baby or well-child check** should be reported only with the codes listed above.

[b] Brand names are furnished for identification purposes only. No endorsement of the manufacturers or products is implied.

# Healthcare Common Procedure Coding System Codes

- Healthcare Common Procedure Coding System 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: (1) blood is drawn in the office and the specimen is sent to an outside laboratory for analysis or (2) 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.

## Model 1: Blood is drawn in the office and the 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 to be used for routine venipuncture)

**36415** Collection of venous blood by venipuncture

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

#### *ICD-9-CM* Codes

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

## Model 2: 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 to be used for routine venipuncture)

**36415** Collection of venous blood by venipuncture

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

#### *ICD-9-CM* Codes

Link to *ICD-9-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, HDL cholesterol

**84478** Triglycerides

### *ICD-9-CM* Codes

**V77.91** Screening for lipid disorders

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

## Hematocrit/Hemoglobin

### *CPT* Codes

**85014** Blood count; hematocrit

**85018** Blood count; hemoglobin

### *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].)

## Lead Screening

### *CPT* Code

**83655** Lead

### *ICD-9-CM* Code

**V82.5** Special screening for chemical poisoning and other contamination

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

## Newborn Metabolic Screening

### HCPCS Code

(NOTE: See "Healthcare Common Procedure Coding SystemCodes" on page 33 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; and thyroxine, total)

### *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 phenylketonuria

**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].)

## Papanicolaou Smear

### HCPCS Code

(NOTE: See "Healthcare Common Procedure Coding System Codes" on page 33 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 **(99381–99395).**

### *ICD-9-CM* Codes

**V15.89** Other specified personal history presenting hazards to health (for high-risk patients only)

**V76.2** Special screening, 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].)

## Tuberculosis Testing (Mantoux/Purified Protein Derivative)

### Administration of Purified Protein Derivative Test

| *CPT* Codes | | *ICD-9-CM* Codes | |
|---|---|---|---|
| **86580** | Skin test; tuberculosis, intradermal | **V74.1** | Special screening examination for pulmonary tuberculosis |

### Reading of Purified Protein Derivative Test

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

| CPT Code | | ICD-9-CM Code | |
|---|---|---|---|
| **99211** | Office or other outpatient services (nurse visit) | **V74.1** | Special screening examination for pulmonary tuberculosis (if test is negative) |
| | | or | |
| | | **795.51** | Nonspecific reaction to tuberculin skin test without active tuberculosis (if test is positive) |

## Sexually Transmitted Infection Screening

### *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*

### *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].)

## Urinalysis

Urinalysis, by dipstick or table reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, or any number of these constituents.

### *CPT* Codes

**81000** Nonautomated, with microscopy

**81001** Automated, with microscopy

**81002** Nonautomated, without microscopy

**81003** Automated, without microscopy

### *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].)

# 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** | Encounter for routine child health examination *with abnormal findings* |
| | | **Z00.129** | Encounter for routine child health examination *without abnormal findings* |
| **V70.0** | Routine general medical exam at a health care facility | **Z00.00** | Encounter for general adult medical examination *without abnormal findings* |
| | | **Z00.01** | Encounter for general adult medical examination *with abnormal findings* |
| **V72.11** | Encounter for hearing exam following failed hearing screen | **Z01.110** | Encounter for hearing exam following failed hearing screening |
| **V72.19** | Other exam of ears and hearing | **Z01.11** | Encounter for examination of ears and hearing without abnormal findings |
| | | **Z01.118** | 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 lipoid 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** | Encounter for screening for nutritional disorder |
| | | **Z13.228** | Encounter for screening for other metabolic disorder |
| | | **Z13.29** | 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 |

*(continued from previous page)*

| ***ICD-9-CM*** | | ***ICD-10-CM*** | |
|---|---|---|---|
| **Code** | **Descriptor** | **Code[a]** | **Descriptor** |
| **V74.1** | Special screening exam for pulmonary tuberculosis | **Z11.1** | Encounter for screening for respiratory tuberculosis |

[a]*International Classification of Diseases, Tenth Revision, Clinical Modification* 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.

# Additional Pediatric Practice Management Resources From the American Academy of Pediatrics

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