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.
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Infant (younger than 1 year)</td>
</tr>
<tr>
<td>99392</td>
<td>Early childhood (age 1–4 years)</td>
</tr>
<tr>
<td>99393</td>
<td>Late childhood (age 5–11 years)</td>
</tr>
<tr>
<td>99394</td>
<td>Adolescent (age 12–17 years)</td>
</tr>
<tr>
<td>99395</td>
<td>18 years or older</td>
</tr>
</tbody>
</table>

[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
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

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99173</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>99174</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Codes</th>
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</tr>
</thead>
<tbody>
<tr>
<td>92551</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>92552</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>92567</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>96110</td>
<td>V79.3 Special screening for developmental handicaps in early childhood</td>
</tr>
</tbody>
</table>

- 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

[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 \textbf{90460} and \textbf{90461} are reported regardless of route of administration.

Pediatric IA codes \textbf{(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. \textit{(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) \textbf{(90471–90474)} instead.

\textbf{[C]Nonage-Specific Immunization Administration Codes}

Report a \textit{CPT} and an \textit{ICD-9-CM} code for each vaccine administration as well as for each vaccine product given during a patient encounter.

\begin{itemize}
  \item \textbf{90471} IA (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
  \begin{itemize}
    \item Do not report \textbf{90471} in conjunction with \textbf{90473}.
    \item +\textbf{90472} each additional vaccine (single or combination vaccine/toxoid) (List separately to code for primary procedure.)
    \item Use \textbf{90472} in conjunction with \textbf{90460}, \textbf{90471}, or \textbf{90473}.
  \end{itemize}
  \item \textbf{90473} IA (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)
  \begin{itemize}
    \item Do not report \textbf{90473} in conjunction with \textbf{90471}.
    \item +\textbf{90474} each additional vaccine (single or combination vaccine/toxoid) (List separately to code for primary procedure.)
    \item Use \textbf{90474} in conjunction with \textbf{90460}, \textbf{90471}, or \textbf{90473}.
  \end{itemize}
\end{itemize}

Codes \textbf{90471} and \textbf{90473} are used to code for the first immunization given during a single office visit. Codes \textbf{90472} and \textbf{90474} are considered \textit{add-on} codes (hence the + symbol next to them) to \textbf{90460}, \textbf{90471}, and \textbf{90473}. This means that the provider will use \textbf{90472} or \textbf{90474} in addition to \textbf{90460}, \textbf{90471}, or \textbf{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 \textbf{90460} (and \textbf{90461} when applicable) for those counseled on and defer to codes \textbf{90472} or \textbf{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):

\textbf{[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

<table>
<thead>
<tr>
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<th>Description</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99393</td>
<td>Preventive medicine service, established patient, 5–11 years</td>
<td>V20.2</td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A vaccine product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90460</td>
<td>Pediatric IA (hepatitis A vaccine), first component</td>
<td>V20.2</td>
</tr>
<tr>
<td>90700</td>
<td>DTaP vaccine product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90460</td>
<td>Pediatric IA (DTaP vaccine), first component</td>
<td>V20.2</td>
</tr>
<tr>
<td>90461 (x2)</td>
<td>Pediatric IA (DTaP vaccine), each additional component</td>
<td>V20.2</td>
</tr>
<tr>
<td>90672</td>
<td>Influenza virus vaccine, quadrivalent, live product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90460</td>
<td>Pediatric IA (influenza vaccine), first component</td>
<td>V20.2</td>
</tr>
</tbody>
</table>

### Alternative Coding

<table>
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<th>CPT Codes</th>
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<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90633</td>
<td>Hepatitis A vaccine product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90700</td>
<td>DTaP vaccine product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90672</td>
<td>Influenza virus vaccine, quadrivalent, live product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90460 (x3)</td>
<td>Pediatric IA (hepatitis A, DTaP, influenza vaccines), first component</td>
<td>V20.2</td>
</tr>
<tr>
<td>90461 (x2)</td>
<td>Pediatric IA (DTaP vaccine), second and third components</td>
<td>V20.2</td>
</tr>
</tbody>
</table>

**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.

#### 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.

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</thead>
<tbody>
<tr>
<td>99391</td>
<td>Preventive medicine service, established patient, &lt;1 year</td>
<td>V20.2</td>
</tr>
<tr>
<td>90698</td>
<td>DTaP-Hib-IPV (Pentacel) product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal product</td>
<td>V20.2</td>
</tr>
<tr>
<td>90680</td>
<td>Rotavirus vaccine</td>
<td>V20.2</td>
</tr>
<tr>
<td>90460 (x3)</td>
<td>Pediatric IA (Pentacel, pneumococcal, rotavirus), first component</td>
<td>V20.2</td>
</tr>
<tr>
<td>90461 (x4)</td>
<td>Pediatric IA (Pentacel), each additional component</td>
<td>V20.2</td>
</tr>
</tbody>
</table>

**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
| Preventive medicine service, established patient, 18–39 years | V70.0 and V70.3 |
| Tdap product | V06.1 |
| IA, first injection | V06.1 |
| Meningococcal (MCV4) product | V03.89 |
| IA, each additional injection | V03.89 |
| Influenza virus vaccine, quadrivalent, live product | V04.81 |
| 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
| Preventive medicine service, established patient, 12–17 years | V20.2 and V70.3 |
| Meningococcal (MCV4) product | V03.89 |
| Pediatric IA (meningococcal), first component | V03.89 |
| Tdap product | V06.1 |
| IA, each additional injection (Tdap) | V06.1 |
| Influenza virus vaccine, quadrivalent, live product | V04.81 |
| 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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Preventive medicine service, established patient, &lt;1 year</td>
<td>V20.2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90700</td>
<td>DTaP product</td>
<td>V06.1</td>
</tr>
<tr>
<td>90670</td>
<td>Pneumococcal product</td>
<td>V03.82</td>
</tr>
<tr>
<td>90744</td>
<td>Hepatitis B vaccine product</td>
<td>V05.3</td>
</tr>
<tr>
<td>90471</td>
<td>IA (DTaP), first vaccine</td>
<td>V06.1</td>
</tr>
<tr>
<td>90472 (x2)</td>
<td>IA (pneumococcal, hepatitis B), each additional component</td>
<td>V03.82 and V05.3</td>
</tr>
</tbody>
</table>

**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](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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V64.00</td>
<td>Unspecified reason</td>
</tr>
<tr>
<td>V64.01</td>
<td>Acute illness</td>
</tr>
<tr>
<td>V64.02</td>
<td>Chronic illness or condition</td>
</tr>
<tr>
<td>V64.03</td>
<td>Immunocompromised state</td>
</tr>
<tr>
<td>V64.04</td>
<td>Allergy to vaccine or component</td>
</tr>
<tr>
<td>V64.05</td>
<td>Caregiver refusal</td>
</tr>
<tr>
<td>V64.06</td>
<td>Patient refusal</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>86580</td>
<td>V74.1</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>CPT Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>V74.1</td>
</tr>
</tbody>
</table>

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].)
### Common Preventive Medicine ICD-9-CM Codes and the ICD-10-CM Crosswalk

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

*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.