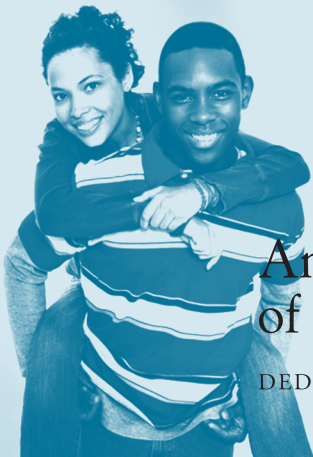


Coding for Pediatric Preventive Care, 2018



Bright Futures™

prevention and health promotion
for infants, children, adolescents,
and their families™



**American Academy
of Pediatrics**



DEDICATED TO THE HEALTH OF ALL CHILDREN®

Coding for Pediatric Preventive Care, 2018

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 or billing sheet.

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

Symbol Description

- A bullet at the beginning of a code means it is a new code for the current year.
- + A plus sign means the code is an add-on code.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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The Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, also known as the “Periodicity Schedule,” is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The following services and codes coincide with this schedule. For more details on the Periodicity Schedule see www.aap.org/periodicityschedule.

Preventive Medicine Service Codes

- ❖ Services included under these codes include measurements (length/height, head circumference, weight, BMI, Blood Pressure), age and gender appropriate exam and history (initial or interval).
- ❖ To report the appropriate preventive medicine service code, first determine if the patient qualifies as new or established (defined in the next 2 sections), and then select the appropriate code within the new or established code family according to patient age.
- ❖ Preventive medicine service codes are not time-based; therefore, time spent during the visit is not relevant in selecting the appropriate preventive medicine services code.
- ❖ If an illness or abnormality is encountered, or a preexisting problem is addressed, in the process of performing the preventive medicine service, and if the illness, abnormality, or problem *is significant enough to require additional work* to perform the key components of a problem-oriented evaluation and management (E/M) service (history, physical examination, medical decision-making, or a combination of those), the appropriate office or other outpatient service code (**99201–99215**) should be reported in addition to the

preventive medicine service code. Modifier **25** should be appended to the office or other outpatient service code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.

- ❖ An *insignificant or trivial illness*, abnormality, or problem encountered in the process of performing the preventive medicine service that does not require additional work and performance of the key components of a problem-oriented E/M service should not be reported.
- ❖ The comprehensive nature of the preventive medicine service codes reflects an age- and gender-appropriate history and physical examination and is not synonymous with the comprehensive examination required for some other E/M codes (eg, **99204, 99205, 99215**).
- ❖ Immunizations and ancillary studies involving laboratory, radiology, or other procedures, or screening tests (eg, vision, developmental, and hearing screening) identified with a specific CPT® code, are reported separately from the preventive medicine service code.

PREVENTIVE MEDICINE SERVICES: NEW PATIENTS

- ❖ Initial comprehensive preventive medicine E/M of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.
- ❖ A new patient is defined as one who has not received any professional face-to-face services rendered by physicians

and other qualified health care professionals who may report E/M services and reported by a specific *CPT*[®] code(s) from a physician/other qualified health care professional, or another physician/other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years.

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

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

Counseling, Risk Factor Reduction, and Behavior Change Intervention Codes

- ❖ Used to report services provided for the purpose of promoting health and preventing illness or injury.
- ❖ They are distinct from other E/M services that may be reported separately when performed. However, one exception is you cannot report counseling codes (**99401–99404**) in addition to preventive medicine service codes (**99381–99385** and **99391–99395**).
- ❖ Counseling will vary with age and address such issues as family dynamics, diet and exercise, sexual practices, injury prevention, dental health, and diagnostic or laboratory test results available at the time of the encounter.

- ❖ Codes are time-based, where the appropriate code is selected according to the approximate time spent providing the service. Codes may be reported when the midpoint for that time has passed. For example, once 8 minutes are documented, one may report **99401**.
- ❖ Extent of counseling or risk factor reduction intervention must be documented in the patient chart to qualify the service based on time.
- ❖ Counseling or interventions are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.
- ❖ Cannot be reported with patients who have symptoms or established illness.
- ❖ For counseling individual patients with symptoms or established illness, report an office or other outpatient service code (**99201–99215**) instead.
- ❖ For counseling groups of patients with symptoms or established illness, report **99078** (physician educational services rendered to patients in a group setting) instead.

PREVENTIVE MEDICINE, COUNSELING

CPT® Codes

- | | |
|--------------|---|
| 99401 | Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 15 minutes |
| 99402 | approximately 30 minutes |
| 99403 | approximately 45 minutes |
| 99404 | approximately 60 minutes |

CPT® Codes

- 99411** Preventive medicine counseling or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 30 minutes
- 99412** approximately 60 minutes

ICD-10-CM Codes for Preventive Counseling

- ❖ The diagnosis codes reported for preventive counseling will vary depending on the reason for the encounter.
- ❖ Remember that the patient cannot have symptoms or established illness; therefore, the diagnosis codes reported cannot reflect symptoms or illnesses.

❖ Examples of some possible diagnosis codes include

- Z28.3** Underimmunized status
- Z71.3** Dietary surveillance and counseling
- Z71.82** Exercise counseling
- Z71.89** Other specified counseling
- Z71.9** Counseling, unspecified

BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

CPT® Codes

- ❖ 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**).

❖ Codes (**99406–99409**) may be reported in addition to the preventive medicine service codes.

- 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

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

- F10.10** Alcohol abuse, uncomplicated
- F11.10** Opioid abuse, uncomplicated
- F12.10** Cannabis abuse, uncomplicated
- F13.10** Sedative, hypnotic or anxiolytic abuse, uncomplicated
- F13.90** Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
- F15.90** Other stimulant use, unspecified, uncomplicated
- F16.90** Hallucinogen use, unspecified, uncomplicated
- Z71.41** Alcohol abuse counseling and surveillance of alcoholic
- Z71.42** Counseling for family member/partner/friend of alcoholic
- Z71.51** Drug abuse counseling and surveillance of drug abuser
- Z71.52** Counseling for family member/partner/friend of drug abuser

- Z71.6** Tobacco abuse counseling
- Z87.891** Personal history of nicotine dependence
- Z91.89** Other specified personal risk factors, presenting as hazards to health not elsewhere classified

Other Preventive Medicine Services

ORAL HEALTH

CPT® Codes

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

Refer to page 17 for definition of other qualified health care professional.

ICD-10-CM Codes

Z00.121

Z00.129

Z29.3 Encounter for prophylactic fluoride administration

- **Z91.841** Risk for dental caries, low
- **Z91.842** Risk for dental caries, moderate
- **Z91.843** Risk for dental caries, high
- **Z91.849** Unspecified risk for dental caries

PELVIC EXAMINATION

- ❖ Preventive medicine service codes (**99381–99385** and **99391–99395**) include a pelvic examination as part of the age- and gender-appropriate examination.

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

ICD-10-CM Codes

- Z01.411** Gynecological exam *with abnormal findings*
- Z01.419** Gynecological exam *without abnormal findings*
- Z11.51** Screening for human papillomavirus (HPV)
- Z12.72** Screening for malignant neoplasm of vagina
- Z30.011** Initial prescription of contraceptive pills
- Z30.012** Prescription of emergency contraception
- Z30.013** Initial prescription of injectable contraceptive
- Z30.014** Initial prescription of intrauterine contraceptive device (IUD)

- Z30.015** Encounter for initial prescription of vaginal ring hormonal contraceptive
- Z30.016** Encounter for initial prescription of transdermal patch hormonal contraceptive device
- Z30.017** Encounter for initial prescription of implantable subdermal contraceptive
- Z30.018** Encounter for initial prescription of other contraceptives
- Z30.02** Counseling and instruction in natural family planning to avoid pregnancy
- Z30.09** General counseling and advice on contraception
- Z30.40** Surveillance of contraceptives, unspecified
- Z30.41** Surveillance of contraceptive pills
- Z30.42** Surveillance of injectable contraceptive
- Z30.430** Insertion of IUD
- Z30.431** Routine checking of IUD
- Z30.432** Removal of IUD
- Z30.433** Removal and reinsertion of IUD
- Z30.44** Encounter for surveillance of vaginal ring hormonal contraceptive device
- Z30.45** Encounter for surveillance of transdermal patch hormonal contraceptive device
- Z30.46** Encounter for surveillance of implantable subdermal contraceptive
- Z30.49** Surveillance of other contraceptives

HEALTH RISK ASSESSMENTS

CPT® Codes

- 96160** Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
- 96161** Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

NOTE: Code **96161** can be reported for a postpartum screening administered to a mother as part of a routine newborn check but billed under the baby's name. Link to *ICD-10-CM* code **Z00.121** or **Z00.129** for normal screening results during a routine well-baby examination.

Used to report administration of standardized health risk assessment instruments on the patient (**96160**) or a primary caregiver (eg, parent) on behalf of the patient (**96161**). Code **96161** requires that the questions and answers relate to the primary caregiver's health and behaviors, not the patient's.

UNLISTED PREVENTIVE MEDICINE SERVICE

CPT® Code

- 99429** Unlisted preventive medicine service

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

Screening Codes

VISION SCREENING

CPT[®] Codes

- 99173** Screening test of visual acuity quantitative, bilateral
- 99174** Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with remote-analysis and report
- 99177** Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with on-site analysis

ICD-10-CM Codes

- Z00.121** Routine child health exam *with abnormal findings*
- Z00.129** Routine child health exam *without abnormal findings*

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

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

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

HEARING SCREENING

CPT® Codes

| | |
|--------------|--|
| 92551 | Screening test, pure tone, air only |
| 92552 | Pure tone audiometry (threshold), air only |
| 92567 | Tympanometry (impedance testing) |

ICD-10-CM Codes

| | |
|----------------|--|
| Z00.121 | Routine child health exam <i>with abnormal findings</i> |
| Z00.129 | Routine child health exam <i>without abnormal findings</i> |

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

- ❖ Requires use of calibrated electronic equipment; tests using other methods (eg, whispered voice, tuning fork) are not reported separately.
- ❖ Includes testing of both ears; append modifier **52** when a test is applied to only one ear.
- ❖ Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).

- ❖ Failed hearing screenings will most likely result in a follow-up office visit (eg, **99212–99215**). Code **Z01.110** (encounter for hearing exam following failed hearing screening) is reported when a specific disorder cannot be identified or when the follow-up hearing screening findings are normal. You can also report **Z01.118** (encounter for exam of ears and hearing with other abnormal findings) and include the code for the abnormal findings (eg, **R94.120** [abnormal auditory function study]).

DEVELOPMENTAL SCREENING AND EMOTIONAL/BEHAVIORAL ASSESSMENT

CPT® Codes

| | |
|--------------|--|
| 96110 | Developmental screening, per instrument, scoring and documentation |
| 96127 | Brief emotional/behavioral assessment (eg, depression inventory) with scoring and documentation, per standardized instrument |

ICD-10-CM Codes

| | |
|---------------|--|
| Z13.4- | Encounter for screening for certain developmental disorders in childhood (excludes developmental screening during a routine well child exam) |
| Z13.89 | Encounter for screening for other disorder (eg, depression) |

- ❖ Used to report administration of **standardized** developmental screening instruments (**96110**) or behavioral/emotional assessments (**96127**).
- ❖ The *ICD-10-CM* code **Z13.4-** is not to be used for routine developmental screening performed during a routine well-child exam. The *ICD-10-CM* code **Z13.89** is not necessary to report in addition to a well-child exam.
- ❖ Often reported when performed in the context of preventive medicine services but may also be reported when screening or assessment is performed with other E/M services (eg, acute illness or follow-up office visits).

- ❖ Clinical staff (eg, registered nurse) typically administers and scores the completed instrument, while the physician incorporates the interpretation component into the accompanying E/M service.
- ❖ When a standardized screening or assessment is administered along with any E/M service (eg, preventive medicine service), both services should be reported, and modifier **25** (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) may need to be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.
- ❖ Examples of both **96110** and **96127** instruments can be found online at <https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Private/Developmental-Screening-and-Testing.aspx>.

Immunizations

IMMUNIZATION ADMINISTRATION

Pediatric Immunization Administration Codes

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

+90461 each additional vaccine or toxoid component administered

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

- ❖ *Component* refers to all antigens in a vaccine that prevent diseases caused by 1 organism. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine, as defined previously.
- ❖ A *qualified health care professional* is an individual who by education, training, licensure/regulation, facility credentialing (when applicable), and payer policy is able to perform a professional service within his or her scope of practice and to 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 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 **90460** more than once 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 1 component is contained within a single vaccine administered. The CPT® codes **90460** and **90461** are reported regardless of route of administration.
- ❖ Pediatric immunization administration (IA) codes (**90460–90461**) are reported only when *both* of the following requirements are met:

1. The patient must be 18 years or younger.
2. The physician or other qualified health care professional must perform face-to-face vaccine counseling associated with the administration.

NOTE: The clinical staff can do the actual administration of the vaccine.

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

Non–age-specific Immunization Administration Codes

- ❖ Report a *CPT*® for both the administration and product and an *ICD-10-CM* code for each vaccine administered during a patient encounter.

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

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

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

Use **90472** in conjunction with **90460**, **90471**, or **90473**.

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

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

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

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

- ❖ Codes **90471** and **90473** are used to code for the first immunization given during a single office visit. Codes **90472** and **90474** are considered *add-on* codes (hence the + symbol next to them) to **90460**, **90471**, and **90473**. This means that the provider will use **90472** or **90474** in addition to **90460**, **90471**, or **90473** if more than 1 vaccine is administered during a visit. There can be only 1 first administration during a given visit. (See vignettes 3, 4, and 5 on pages 23–26.)
- ❖ If during a single encounter for a patient 18 years or younger, a physician or other qualified health care professional only counsels on some of the vaccines, report code **90460** (and **90461** when applicable) for those counseled on and defer to codes **90472** or **90474**, as appropriate, for those that are not counseled on.
- ❖ The following vignettes may help illustrate the correct use of the administration codes:

NOTE: The coding vignettes are for teaching purposes and do not necessarily follow every payer's reporting requirements.

Vignette 1

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

How are the appropriate codes for this service selected?

Step 1: Select appropriate E/M code.

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

Step 2: Select appropriate vaccine product codes.

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

90686 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for IM use

Step 3: Select appropriate IA codes 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 vaccines?

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

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

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

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

Step 4: Select the appropriate ICD-10-CM diagnosis codes.

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

The vaccine product CPT code and its corresponding IA CPT code are always linked to the same ICD-10-CM code.

This is because the vaccine product and work that goes into administering that product are intended to provide prophylactic vaccination against a certain type of disease.

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

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

| CPT® Codes | | ICD-10-CM Codes |
|-------------------|---|------------------------|
| 99393 25 | Preventive medicine service, established patient, 5–11 years | Z00.129 |
| 90633 | Hepatitis A vaccine product | Z23 |
| 90460 | Pediatric IA (hepatitis A vaccine), first component | Z23 |
| 90700 | DTaP vaccine product | Z23 |
| 90460 | Pediatric IA (DTaP vaccine), first component | Z23 |
| 90461 (x2) | Pediatric IA (DTaP vaccine), each additional component | Z23 |
| 90686 | Influenza virus vaccine, quadrivalent, preservative free, 0.5 mL dosage | Z23 |
| 90460 | Pediatric IA (influenza vaccine), first component | Z23 |

Alternative Coding

| CPT® Codes | | ICD-10-CM Codes |
|-------------------|---|------------------------|
| 99393 25 | Preventive medicine service, established patient, 5–11 years | Z00.129 |
| 90633 | Hepatitis A vaccine product | Z23 |
| 90700 | DTaP vaccine product | Z23 |
| 90686 | Influenza virus vaccine, quadrivalent, preservative free, 0.5 mL dosage | Z23 |
| 90460 (×3) | Pediatric IA (hepatitis A, DTaP, influenza vaccines), first component | Z23 |
| 90461 (×2) | Pediatric IA (DTaP vaccine), second and third components | Z23 |

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

Rationale

Because the patient is younger than 18 years and there is physician counseling, pediatric IA codes are reported (**90460** and **90461**). Each vaccine administered will be reported with its own **90460** (hepatitis A, DTaP, and 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-inactivated poliovirus (Pentacel), pneumococcal, and rotavirus. The physician counsels the parents on all of them, and the nurse administers them all.

| CPT® Codes | | ICD-10-CM Codes |
|-------------------|---|------------------------|
| 99391 25 | Preventive medicine service, established patient, <1 year | Z00.129 |
| 90698 | DTaP-Hib-IPV (Pentacel) product | Z23 |
| 90670 | Pneumococcal product | Z23 |
| 90680 | Rotavirus vaccine, oral use | Z23 |
| 90460 (×3) | Pediatric IA (Pentacel, pneumococcal, rotavirus), first component | Z23 |
| 90461 (×4) | Pediatric IA (Pentacel), each additional component | Z23 |

Rationale

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

Vignette 3

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

| CPT® Codes | | ICD-10-CM Codes |
|-------------------|---|------------------------|
| 99395 25 | Preventive medicine service, established patient, 18–39 years | Z02.0 |
| 90715 | Tdap product | Z23 |
| 90471 | IA, first injection | Z23 |
| 90734 | Meningococcal (MCV4) product | Z23 |
| 90472 (×2) | IA, each additional injection | Z23 |
| 90686 | Influenza virus vaccine, quadrivalent, preservative free, 0.5 mL dosage | Z23 |

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.

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 dormitory). The patient is healthy and due for a Tdap booster, meningococcal vaccine, first human papillomavirus (HPV, 9-valent) vaccine, and influenza vaccine. The physician counsels the patient only on the meningococcal and HPV vaccines, and the nurse administers each. The patient is asked to return in 4 to 6 weeks for her second HPV vaccine.

| CPT® Codes (First Visit Only) | | ICD-10-CM Codes (First Visit Only) |
|--|---|---|
| 99394 25 | Preventive medicine service, established patient, 12–17 years | Z00.00 and Z02.0 |
| 90734 | Meningococcal (MCV4) product | Z23 |
| 90651 | HPV (9-valent) product | Z23 |
| 90460 (×2) | Pediatric IA (meningococcal and HPV) first component | Z23 |
| 90715 | Tdap product | Z23 |
| 90472 (×2) | IA, each additional injection (Tdap) | Z23 |
| 90686 | Influenza virus vaccine, quadrivalent, preservative free, 0.5 mL dosage | Z23 |

Rationale

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

first vaccine code is already reported with code **90460**, so the additional IA code **90472** has to be reported. While *ICD-10-CM* does not provide official ages for the “adult” *ICD-10-CM* codes (**Z00.00** and **Z00.01**) in lieu of the well-child examination codes, many payers use age 17 years as the cutoff. Refer to specific payer policy for details.

Vignette 5

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

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

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

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

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

Rationale

If counseling occurs outside 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 only the nurse, 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 *only for vaccines*, an E/M service is not reported. The *ICD-10-CM* code will be reported for *with abnormal findings* (**Z00.121**) because an abnormality was identified during the encounter.

For more information on IA codes, refer to the Coding at the AAP Web site (www.aap.org/coding) and its page dedicated to vaccine coding.

HOW TO CODE WHEN IMMUNIZATIONS ARE NOT ADMINISTERED

ICD-CM-10 Codes

- ❖ For many reasons, 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.
- ❖ Because of tracking purposes and quality measures, it is important to report non-administration as part of the *ICD-10-CM* codes. The following *ICD-10-CM* codes were created to report why a vaccine is not given:

Vaccination not carried out due to

- Z28.01** Acute illness
- Z28.02** Chronic illness or condition
- Z28.03** Immunocompromised state
- Z28.04** Allergy to vaccine or component
- Z28.1** Religious reasons
- Z28.20** Unspecified reason
- Z28.21** Patient refusal
- Z28.81** Patient has disease being vaccinated against
- Z28.82** Caregiver refusal
- Z28.89** Other reason

Vignette

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

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

- Z23** Encounter for immunization
- Z28.81** Vaccination not carried out due to patient had disease being vaccinated against

Vaccines for Children Program

The rules for reporting vaccines for patients who qualify for the Vaccines for Children (VFC) program vary greatly. Some states require that the product code be submitted, while others require the IA codes. Some require the use of modifiers, while others do not. Currently, the VFC program does not recognize

component-based vaccine counseling; therefore, you will not be paid for CPT® code **90461**. The American Academy of Pediatrics continues to work on changing this so pediatric providers can be properly compensated for giving multiple-component vaccines.

| Commonly Administered Pediatric Vaccines | | | | |
|---|---|--------------|---|---------------------------|
| Product Code | Separately report the administration with codes 90460–90461 or 90471–90474 . | Manufacturer | Brand | No. of Vaccine Components |
| 90702 | Diphtheria and tetanus toxoids (DT), adsorbed when administered to younger than seven years, for IM use | SP | Diphtheria and Tetanus Toxoids Adsorbed | 2 |
| 90700 | Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to <7 years, for IM use | SP GSK | DAPTACEL INFANRIX | 3 |
| 90696 | Diphtheria, tetanus toxoids, and acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4-6 years of age, for IM use | GSK SP | KINRIX Quadacel | 4 |
| 90723 | Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and inactivated poliovirus vaccine (DTaP-Hep B-IPV), for IM use | GSK | PEDIARIX | 5 |
| 90698 | Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for IM use | SP | Pentacel | 5 |
| 90633 | Hepatitis A vaccine (Hep A), pediatric/adolescent dosage, 2 dose, for IM use | GSK Merck | HAVRIX VAQTA | 1 |
| 90740 | Hepatitis B vaccine (Hep B), dialysis or immunosuppressed patient dosage, 3 dose, for IM use | Merck | RECOMBIVAX HB | 1 |
| 90743 | Hepatitis B vaccine (Hep B), adolescent, 2 dose, for IM use | Merck | RECOMBIVAX HB | 1 |
| 90744 | Hepatitis B vaccine (Hep B), pediatric/adolescent dosage, 3 dose, for IM use | Merck GSK | RECOMBIVAX HB ENERGIX-B | 1 |
| 90746 | Hepatitis B vaccine (Hep B), adult dosage, for IM use | Merck GSK | RECOMBIVAX HB ENERGIX-B | 1 |
| 90747 | Hepatitis B vaccine (Hep B), dialysis or immunosuppressed patient dosage, 4 dose, for IM use | GSK | ENERGIX-B | 1 |
| 90748 | Hepatitis B and Hib (Hep B-Hib), for IM use | Merck | COMVAX | 2 |
| 90647 | Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate, 3 dose, for IM use | Merck | PedvaxHIB | 1 |
| 90648 | Hemophilus influenza B vaccine (Hib), PRP-T conjugate, 4 dose, for IM use | SP GSK | ActHIB HIBERIX | 1 |
| 90651 | Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 2 or 3 dose schedule, for IM use | Merck | GARDASIL 9 | 1 |
| 90630 | Influenza virus vaccine, quad (IIV4), split virus, preservative free, for intradermal use | SP | Fluzone Intradermal Quad | 1 |
| 90672 | Influenza virus vaccine, quad (LAIV), live, intranasal use | MedImmune | Flumist Quad | 1 |
| 90674 | Influenza virus vaccine, quad (cdIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, IM (Do not use for multi-dose – report 90749) | Seqirus | Flucelvax | 1 |

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| Product Code | Separately report the administration with codes 90460-90461 or 90471-90474. | Manufacturer | Brand | No. of Vaccine Components |
|----------------|--|-----------------------------|---|---------------------------|
| 90682 | Influenza virus vaccine, quad (RIV4), derived from recombinant DNA, HA protein only, preservative and antibiotic free, IM use | Protein Sciences | Flublok | 1 |
| 90685 | Influenza virus vaccine, quad (IIV4), split virus, preservative free, 0.25ml dose, for IM use | SP | Fluzone Quad | 1 |
| 90686 | Influenza virus vaccine, quad (IIV4), split virus, preservative free, 0.5ml dosage, for IM use | Seqirus SP GSK GSK | Afluria FLUARIX Quad Fluzone Quad FLULAVAL | 1 |
| 90687 | Influenza virus vaccine, quad (IIV4), split virus, 0.25ml dosage, for IM use | SP | Fluzone Quad | 1 |
| 90688 | Influenza virus vaccine, quad (IIV4), split virus, 0.5ml dosage, for IM use | SP GSK | Fluzone Quad FLULAVAL | 1 |
| 90756 or 90749 | Influenza virus vaccine, quad(ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for IM use | Seqirus | Flucelexv Quad | 1 |
| 90656 | Influenza virus vaccine, tri (IIV3), split virus, preservative free, 0.5ml dosage, for IM use | Seqirus Novatis | AFLURIA Fluvirin | 1 |
| 90658 | Influenza virus vaccine, tri (IIV3), split virus, 0.5ml dosage, for IM use | Seqirus Novartis | AFLURIA Fluvirin | 1 |
| 90673 | Influenza virus vaccine, tri (RIV3), derived from recombinant DNA, HA protein only, preservative and antibiotic free, IM use | Protein Sciences | Flublok | 1 |
| 90707 | Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use | Merck | M-M-R II | 3 |
| 90710 | Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use | Merck | ProQuad | 4 |
| 90620 | Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for IM use | Novartis | Bexsero | 1 |
| 90621 | Meningococcal recombinant lipoprotein vaccine, serogroup B, 2 or 3 dose schedule, for IM use | Pfizer | Trumenba | 1 |
| 90644 | Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (MenCY-Hib), 4-dose schedule, (children 6 weeks-18 months of age), for IM use | GSK | MenHibrix | 2 |
| 90733 | Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quad (MenACWY or MPSV4), for subcutaneous use | SP | Menomune | 1 |
| 90734 | Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 quad (MenACWY or MCV4), for IM use | SP Novartis | Menactra Menveo | 1 |
| 90670 | Pneumococcal conjugate vaccine, 13 valent (PCV13), for IM use | Pfizer | PREVNAR 13 | 1 |
| 90732 | Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or IM use | Merck | PNEUMOVAX 23 | 1 |
| 90713 | Poliovirus vaccine (IPV), inactivated, for subcutaneous or IM use | SP | IPOL | 1 |
| 90680 | Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use | Merck | RotaTeq | 1 |

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| Product Code | Separately report the administration with codes 90460–90461 or 90471–90474. | Manufacturer | Brand | No. of Vaccine Components |
|--------------|--|-----------------------|--------------------------------|---------------------------|
| 90681 | Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use | GSK | ROTARIX | 1 |
| 90714 | Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to seven years or older, for IM use | MBL SP | Td (adult) adsorbed TENIVAC | 2 |
| 90715 | Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for IM use | SP GSK | ADACEL BOOSTRIX | 3 |
| 90716 | Varicella virus vaccine (VAR), live, for subcutaneous use | Merck | VARIVAX | 1 |
| 90749 | Unlisted vaccine or toxoid | Please See CPT Manual | | |

Developed and maintained by the American Academy of Pediatrics. Updated periodically at https://www.aap.org/en-us/Documents/coding_vaccine_coding_table.pdf. For reporting purposes only.

Laboratory

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

MODEL 1: BLOOD IS DRAWN IN OFFICE AND SPECIMEN IS SENT TO AN OUTSIDE LABORATORY FOR ANALYSIS.

CPT® Code

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

Venipuncture CPT® Codes

- 36406** Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture
- 36410** Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture)
- 36415** Collection of venous blood by venipuncture
- 36416** Collection of capillary blood specimen (eg, finger, heel, ear stick)

Venipuncture ICD-10-CM Codes

Link to *ICD-10-CM* codes for the well-child examination or for specific screening tests.

MODEL 2: BLOOD IS DRAWN AND LABORATORY TESTS ARE PERFORMED IN THE PHYSICIAN'S PRACTICE.

Venipuncture CPT® Codes

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

- 36410** Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture)
- 36415** Collection of venous blood by venipuncture
- 36416** Collection of capillary blood specimen (eg, finger, heel, ear stick)

Venipuncture ICD-10-CM Codes

Link to *ICD-10-CM* codes for the well-child examination or for specific screening tests.

Bilirubin CPT® Codes

- 82247** Bilirubin, total
- 88720** Bilirubin, total, transcutaneous

Bilirubin ICD-10-CM Code

- Z13.228** Encounter for screening for other metabolic disorder

Dyslipidemia Screening CPT® Codes

- 80061** Lipid panel (includes total cholesterol, high-density lipoprotein [HDL] cholesterol, and triglycerides)
- 82465** Cholesterol, serum, total
- 83718** Lipoprotein, direct measurement, high-density cholesterol (HDL cholesterol)
- 84478** Triglycerides

Dyslipidemia Screening ICD-10-CM Code

- Z13.220** Encounter for screening for lipid disorders

Anemia Screening CPT® Code

- 85018** Blood count; hemoglobin

Anemia Screening ICD-10-CM Code

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

Lead Screening CPT® Code

83655 Lead

Lead Screening ICD-10-CM Code

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

Newborn Metabolic Screening HCPCS Code

NOTE: See Healthcare Common Procedure Coding System Codes section on page 36 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)

NOTE: Only report the **S3620** if you are billing for the actual running of the lab or test kit. Otherwise only report the appropriate blood collection code (eg, **36416**)

Newborn Metabolic Screening ICD-10-CM Codes

Report the diagnosis codes for the state-specific newborn screening tests conducted. Examples include

- Z13.0** Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (eg, anemia, sickle cell)
- Z13.21** Encounter for screening for nutritional disorder
- Z13.228** Encounter for screening for other metabolic disorders (eg, PKU, galactosemia)
- Z13.29** Encounter for screening for other suspected endocrine disorder (eg, thyroid)

Papanicolaou Smear HCPCS Code

NOTE: See Healthcare Common Procedure Coding System Codes on page 36 for explanation of HCPCS codes.

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

Papanicolaou Smear CPT® Code

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

Papanicolaou Smear ICD-10-CM Codes

- Z12.4** Encounter for screening for malignant neoplasm of cervix (excludes HPV)
- Z12.72** Encounter for screening for malignant neoplasm of vagina
- Z12.79** Encounter for screening for malignant neoplasm of other genitourinary organs

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

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

Administration of PPD Test

CPT® Code

ICD-10-CM Code

86580 Skin test; tuberculosis, intradermal

Z11.1 Encounter for screening for respiratory tuberculosis

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

Reading of PPD Test

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

CPT® Code

ICD-10-CM Codes

99211 Office or other outpatient services (nurse visit or negative outcome)

Z11.1 Encounter for screening for respiratory tuberculosis (*if test is negative*)

99212-99215 Office or outpatient services (physician service for positive encounter)

R76.11 Nonspecific reaction to tuberculin skin tuberculosis (*if test is positive*)

Sexually Transmitted Infection and HIV Screening

CPT® Codes

86701 Antibody; HIV-1

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

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

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

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

- 87591** Infectious agent detection by nucleic acid (DNA or RNA); *N gonorrhoeae*, amplified probe technique
- 87810** Infectious agent detection by immunoassay with direct optical observation; *C trachomatis*
- 87850** Infectious agent detection by immunoassay with direct optical observation; *N gonorrhoeae*

Sexually Transmitted Infection and HIV Screening

ICD-10-CM Codes

- Z11.3** Encounter for screening for infections with a predominantly sexual mode of transmission (excludes HPV and HIV)
- Z11.8** Encounter for screening for other infectious and parasitic diseases (eg, chlamydia)

Healthcare Common Procedure Coding System Codes

- ❖ The 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

Commonly Reported ICD-10-CM Codes for Preventive Services

| ICD-10-CM | | |
|--|--|---|
| Code | Descriptor | Special Coding Conventions |
| Encounter and Examination Codes | | |
| Z00.110 | Newborn check under 8 days old | Outpatient codes only |
| Z00.111 | Newborn check 8 to 28 days old | Outpatient codes only |
| Z00.121 | Routine child health examination <i>with abnormal findings</i> | First-listed ICD-10-CM code only. Includes routine screening when performed at same encounter. |
| Z00.129 | <i>without abnormal findings</i> | |
| Z00.00 | General adult medical examination <i>without abnormal findings</i> | First-listed ICD-10-CM code only. Typically used for patients 18 years and older (payer policy). |
| Z00.01 | <i>with abnormal findings</i> | |
| Z02.0 | Examination for admission to educational institution | Not required in addition to a Z00 code |
| Z02.4 | Examination for driving license | |
| Z02.5 | Examination for participation in sport | |
| Z01.00 | Examination of eyes and vision <i>without abnormal findings</i> | First-listed ICD-10-CM code only. Do not report as a secondary code or in addition to a Z00 code. |
| Z01.01 | <i>with abnormal findings</i> | |
| Z01.110 | Hearing examination following failed hearing screening | First-listed ICD-10-CM code only. Do not report as a secondary code or in addition to a Z00 code. |
| Z01.10 | Encounter for examination of ears and hearing <i>without abnormal findings</i> | First-listed ICD-10-CM code only. Do not report as a secondary code or in addition to a Z00 code. |
| Z01.118 | <i>with other abnormal findings</i> | |
| Z23 | Immunizations | This is the only code in ICD-10-CM for vaccines. Link to both the product and administration CPT® codes. |
| Z29.3 | Encounter for prophylactic fluoride administration | |
| Screening Codes | | |
| Z11.1 | Respiratory tuberculosis | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z11.3 | Infections with a predominantly sexual mode of transmission (<i>excludes</i> HPV and HIV) | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z12.4 | Encounter for screening for malignant neoplasm of cervix (<i>excludes</i> HPV) | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z12.79 | Malignant neoplasm of other genitourinary organs | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z12.89 | Malignant neoplasms of other sites | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.29 | Other suspected endocrine disorder | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.1 | Diabetes mellitus | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |

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ICD-10-CM

| Code | Descriptor | Special Coding Conventions |
|---|---|--|
| Screening Codes | | |
| Z13.228 | Other metabolic disorders (eg, inborn errors of metabolism, galactosemia, PKU) | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.220 | Lipid disorders | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.21 Z13.228 Z13.29 | Nutritional disorder Other metabolic disorder Other suspected endocrine disorder | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.0 | Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (eg, anemia, sickle cell) | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.89 | Other disorders (eg, depression) | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Z13.4 | Developmental disorders in childhood (<i>excludes routine screening</i>) (eg, autism) | Do not report in addition to a Z00.12- code; it is already included. |
| Z13.88 | Disorder due to exposure to contaminants (eg, lead) | A screening code is not necessary if the screening is inherent to a routine examination. But can be reported. |
| Performance Measure Codes | | |
| Z68.51 | Body mass index (BMI) pediatric, < 5th percentile for age | |
| Z68.52 | Body mass index (BMI) pediatric, 5th percentile to < 85th percentile for age | |
| Z68.53 | Body mass index (BMI) pediatric, 85th percentile to < 95th percentile for age | |
| Z68.54 | Body mass index (BMI) pediatric, ≥ 95th percentile for age | |
| Z71.3 | Dietary counseling and surveillance | |
| Z71.82 | Exercise counseling | |
| Underimmunized Status and Vaccines Not Given | | |
| Z28.3 | Underimmunized status | A status code is informative and may affect the course of treatment and its outcome. Report when this is the case. |
| Z28.01 | <i>Vaccine not given: Acute illness</i> | |
| Z28.04 | Allergy to vaccine or components | |
| Z28.82 | Caregiver refusal | |
| Z28.02 | Chronic illness or condition | |
| Z28.03 | Immune compromised state | |
| Z28.21 | Patient refusal | |
| Z28.81 | Pt had disease being vaccinated for | |
| Z28.1 | Religious reasons | |
| Z28.89 | Other reason | |
| Z28.20 | Unspecified reason | |

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