Coding for Pediatric Preventive Care 2012

99401

99383

99391

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99411

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Coding for Pediatric Preventive Care 2012

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

Following are the *Current Procedural Terminology* (*CPT*©), Healthcare Common Procedure Coding System (HCPCS) Level II, and *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes most commonly reported by pediatricians in providing preventive care services. It is strongly recommended that the pediatrician, not the staff, select the appropriate code(s) to report.

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Preventive Medicine Service Codes

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

- The comprehensive nature of the preventive medicine service codes reflects an age- and gender-appropriate history and physical examination and is not synonymous with the comprehensive examination required for some other E/M codes (eg, **99204, 99205, 99215**).
- Immunizations and ancillary studies involving laboratory, radiology, or other procedures, or screening tests (eg, vision and hearing screening) identified with a specific *CPT* code, are reported separately from the preventive medicine service code.

Preventive Medicine Services: New Patients

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

***CPT* Codes**		***ICD-9-CM* Codes**	
99381	Infant (younger than 1 year)	**V20.3**	Newborn check under 8 days old
99382	Early childhood (age 1–4 years)	**V20.3**	Newborn check 8 to 28 days old
99383	Late childhood (age 5–11 years)	**V20.2**	Routine infant or child health check
99384	Adolescent (age 12–17 years)	**V20.2**	Routine infant or child health check
99385	18 years or older	**V20.2**	Routine infant or child health check
		V20.2	Routine infant or child health check
		V70.0	Routine general medical examination at a health care facility

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

Preventive Medicine Services: Established Patients

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

***CPT* Codes**		***ICD-9-CM* Codes**	
99391	Infant (younger than 1 year)	**V20.3**	Newborn check under 8 days old
99392	Early childhood (age 1–4 years)	**V20.3**	Newborn check 8 to 28 days old
99393	Late childhood (age 5–11 years)	**V20.2**	Routine infant or child health check
99394	Adolescent (age 12–17 years)	**V20.2**	Routine infant or child health check
99395	18 years or older	**V20.2**	Routine infant or child health check
		V20.2	Routine infant or child health check
		V70.0	Routine general medical examination at a health care facility

Counseling, Risk Factor Reduction, and Behavior Change Intervention Codes

- Used to report services provided for the purpose of promoting health and preventing illness or injury. They are distinct from other E/M services that may be reported separately when performed.
- The counseling will vary with age and address such issues as family dynamics, diet and exercise, sexual practices, injury prevention, dental health, and diagnostic or laboratory test results available at the time of the encounter.
- Codes are time-based, where the appropriate code is selected based on the approximate time spent providing the service.

- Extent of counseling or risk factor reduction intervention must be documented in the patient chart to qualify the service based on time.
- Counseling or interventions are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. They cannot be reported with patients who have symptoms or established illness.
- For counseling individual patients with symptoms or established illness, report an office or other outpatient service code **(99201–99215)** instead.
- For counseling groups of patients with symptoms or established illness, report **99078** (physician educational services rendered to patients in a group setting) instead.

Preventive Medicine, Individual Counseling

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

99402 Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes

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

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

Behavior Change Interventions, Individual

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

99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

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

99409 Alcohol or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes

Preventive Medicine, Group Counseling

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

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

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

- The diagnosis code(s) reported for the counseling risk factor reduction and behavior change intervention codes will vary depending on the reason for the encounter.

- Remember that the patient cannot have symptoms or established illness; therefore, the diagnosis code(s) reported cannot reflect symptom(s) or illness(es).
- Examples of some possible diagnosis codes include
  - **V15.85** Underimmunization status
  - **V15.89** Other specific personal history presenting as hazards to health (eg, tobacco use)
  - **V25.09** Encounter for contraceptive management; general counseling and advice; other
  - **V65.3** Dietary surveillance and counseling
  - **V65.40** Counseling not otherwise specified
  - **V65.41** Exercise counseling
  - **V65.42** Counseling on substance use and abuse
  - **V65.43** Counseling on injury prevention
  - **V65.49** Other specified counseling

Other Preventive Medicine Services

Pelvic Examination

- The preventive medicine service codes (**99381–99385** and **99391–99395**) include a pelvic examination as part of the age- and gender-appropriate examination.
- However, if the patient is having a problem, the physician can report an office or other outpatient E/M service code **(99212–99215)** for the visit and attach modifier **25**, which indicates that the problem-oriented pelvic visit is a separately identifiable E/M service by the same physician on the same date of service.

- Link *ICD-9-CM* code **V20.2** to the preventive medicine service code, but link a different diagnosis code (eg, **623.5** [vaginal discharge], **625.3** [dysmenorrhea]) to the office or other outpatient E/M service code.
- Anticipatory or periodic contraceptive management is not a "problem" and, therefore, is included in the preventive medicine service code; however, if contraception creates a problem (eg, breakthrough bleeding, vomiting), the service can be reported separately with an office or other outpatient service code.

ICD-9-CM Codes

V25.40 Surveillance of previously prescribed contraceptive methods; contraceptive surveillance, unspecified

V25.41 Surveillance of previously prescribed contraceptive methods; contraceptive pill

V25.42 Surveillance of previously prescribed contraceptive methods; intrauterine contraceptive device

V25.43 Surveillance of previously prescribed contraceptive methods; implantable subdermal contraceptive

V25.49 Surveillance of previously prescribed contraceptive methods; other contraceptive method

V72.31 Routine gynecologic examination

V72.32 Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear

Health Risk Assessment

CPT Code

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

NOTE: This code should be reported for a postpartum screening administered to a mother as part of a routine newborn check, but can be billed under the baby's name. Link to *ICD-9-CM* code **V20.2** for a normal screen.

ICD-9-CM Code

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

Unlisted Preventive Medicine Service

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

Case Management or Care Plan Oversight Services

Telephone Services

CPT Codes

99441 Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within

the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion

99442 Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11 to 20 minutes of medical discussion

99443 Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21 to 30 minutes of medical discussion

Online Medical Evaluation

CPT Code

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

CPT Codes

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

99340 Individual physician supervision of a patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian), or key caregiver(s) involved in patient's care; integration of

new information into medical treatment plan; or adjustment of medical therapy; within a calendar month; 30 minutes or more

- The care plan oversight (CPO) codes are *reported once per calendar month.*
- The telephone service codes are reported for each physician telephone call made or received from a patient or parent, excluding those that occur 7 days after or 24 hours before a face-to-face visit.
- The online medical evaluation code is reported only once for the same episode of care during a 7-day period, although multiple physicians can report their exchanges with the same patient.
- If the online medical evaluation refers to an E/M service previously performed and reported by a physician within the previous 7 days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, the service is considered covered by the previous E/M service or procedure.
- For the online medical evaluation codes, a reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter.
- The CPO codes include telephone calls and online medical evaluations; therefore, if you include time spent on a telephone call or an online medical evaluation toward your monthly CPO billing, you cannot also separately report that service.

Screening Codes

Vision Screening

CPT Codes		*ICD-9-CM* Codes	
99173	Screening test of visual acuity, quantitative, bilateral	**V20.2**	Routine infant or child health check
99174	Ocular photoscreening with interpretation and report, bilateral	**V20.2**	Routine infant or child health check

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

- To report code **99173,** you must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (eg, Snellen chart).
- Code **99174** is reported for ocular photoscreening for esotropia, exotropia, an isometropia, cataracts, ptosis, hyperopia, and myopia.
- When acuity is measured as part of a general ophthalmologic service or an E/M service of the eye (ie, for an eye-related problem or symptom), it is considered part of the diagnostic examination of the office or other outpatient service code **(99201–99215)** and is not reported separately.
- Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).
- Failed vision screenings may result in a follow-up office visit (eg, **99212–99215**), linked to the diagnosis code for the reason for the failure (eg, **367.1** [myopia]); when a specific code cannot be identified, report **368.8** (other specified visual disturbance).

Hearing Screening

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

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

- Requires use of calibrated electronic equipment; tests using other methods (eg, whispered voice, tuning fork) are not reported separately.
- Includes testing of both ears; append modifier **52** when a test is applied to only one ear.
- Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).
- Failed hearing screenings may result in a follow-up office visit (eg, **99212–99215**), linked to the diagnosis code for the reason for the failure; when a specific code cannot be identified, report **389.8** (other specified forms of hearing loss).

Developmental Screening

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

- Used to report administration of developmental screening instruments of a limited nature.
- Often reported when performed in the context of preventive medicine services, but may also be reported when screening is performed with other E/M services such as acute illness or follow-up office visits.
- Clinical staff (eg, registered nurse) typically administers and scores the completed instrument while the physician incorporates the interpretation component into the accompanying E/M service.
- When a limited screening test is performed along with any E/M service (eg, preventive medicine service), both services should be reported and modifier **25** (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.
- When multiple developmental screenings are scored and interpreted on the same day, they can all be coded for by reporting **96110** with units or multiple line items with modifier **59** (distinct procedural services) appended to the subsequent **96110** codes reported.

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

Examples of **96110** instruments include, but are not limited to,

- Bricker D, Squires J, Mounts L. *Ages & Stages Questionnaire (ASQ).* 2nd ed. Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 1999 and Squires J, Bricker D, Twombly E. *Ages &*

Stages Questionnaires: Social-Emotional (ASQ:SE). Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002

- Australian Scale for Asperger's Syndrome. In: Attwood T. *Asperger's Syndrome: A Guide for Parents and Professionals.* London, England: Jessica Kingsley Publishers; 1997
- Reynolds CR, Kamphaus RW. BASC-2: *Behavior Assessment Scale for Children.* 2nd ed. Upper Saddle River, NJ: Pearson School Publishing; 2004
- Gioia GA, Isquith PK, Guy SC, Kenworthy L. *Behavioral Rating Inventory of Executive Functioning (BRIEF).* Lutz, FL: Psychological Assessment Resources, Inc; 2000
- Ireton H. *Child Development Review.* Minneapolis, MN: Behavior Science Systems, Inc. http://www.childdevrev.com. Accessed July 14, 2010
- Wetherby AM, Prizant BM. *Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP).* Baltimore, MD: Paul H. Brookes Publishing Co, Inc; 2002
- Kaufman AS, Kaufman NL. KBIT-2: *Kaufman Brief Intelligence Test.* 2nd ed. Upper Saddle River, NJ: Pearson School Publishing; 2007
- Conners CK. *Conners Rating Scales-Revised (CRS-R) Technical Manual.* North Tonawanda, NY: Multi Health Systems; 2000
- Glascoe FP. *Parents' Evaluation of Developmental Status.* Nashville, TN: Ellsworth & Vandermeer Press LLC; 2006
- Jellinek M, Murphy M. Pediatric Symptom Checklist. http://www2.massgeneral.org/allpsych/psc/psc_home.htm. Accessed July 14, 2010

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

Immunizations

Immunization Administration

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

Pediatric Immunization Administration Codes

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

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

NOTE: New in *CPT 2012,* the term "qualified health care professional" has been defined. A "qualified health care professional" is an individual who by education, training,

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

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

Non–Age-Specific Immunization Administration Codes

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

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

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

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

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

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

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

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

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

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

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

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

Codes **90471** and **90473** are used to code for the first immunization given during a single office visit. Codes **90472** and **90474** are considered add-on codes (hence the + symbol next to them) to **90471** and **90473,** respectively. This means that the provider will use **90472** or **90474** in addition to **90471** or **90473** if more than one vaccine is administered during a visit.

Note that there can only be one first administration during a given visit.

The following examples may help illustrate their correct use.

Example

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

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

Step 1: Select the appropriate E/M code.

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

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

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

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

90660 Influenza virus vaccine, live, for intranasal use

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

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

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

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

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

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

+90461 each additional vaccine/toxoid component

Step 4: Select the appropriate *ICD-9-CM* diagnosis code(s). Diagnosis codes are used along with *CPT* codes to reflect the outcome of a visit. *Current Procedural Terminology* codes tell a carrier what was done and *ICD-9-CM* codes tell a carrier why it was done.

The vaccine product *CPT* code and its corresponding immunization administration *CPT* code are always linked to the same *ICD-9-CM* code. This is because the vaccine product and the work that goes into administering that product are intended to provide prophylactic vaccination against a certain type of disease.

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

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

Alternative Coding

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

NOTE: Since the immunizations were administered during a routine well-child visit, *ICD-9-CM* code **V20.2** should be linked to the individual vaccine product and administration code(s). The E/M code used in the example **(99393)** would also be linked to *ICD-9-CM* code **V20.2.** This is due to *ICD-9-CM* guidelines that allow for the linkage of age-appropriate vaccines to be reported under **V20.2** during a routine well-baby/child encounter

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

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

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

Example

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

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

Step 1: Select the appropriate E/M code.

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

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

90707 MMR, live for subcutaneous use

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

90716 Varicella virus vaccine, live, for subcutaneous use

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

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

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

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

90460

+90461

Step 4: Select the appropriate *ICD-9-CM* diagnosis code(s). Diagnosis codes are used along with *CPT* codes to reflect the outcome of a visit. *Current Procedural Terminology* codes tell a carrier what was done and *ICD-9-CM* codes tell a carrier why it was done.

The vaccine product *CPT* code and its corresponding immunization administration *CPT* code are always linked to the same *ICD-9-CM* code. This is because the vaccine product and the work that goes into administering that product are intended to provide prophylactic vaccination against a certain type of disease.

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

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

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

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

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

Example

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

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

Step 1: Select the appropriate E/M code.

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

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

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

90734 Meningococcal vaccine (tetravalent) for intramuscular use

90660 Influenza virus vaccine, live, for intranasal use

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

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

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

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

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

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

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

Step 4: Select the appropriate *ICD-9-CM* diagnosis code(s). Diagnosis codes are used along with *CPT* codes to reflect the outcome of a visit. *Current Procedural Terminology* codes tell a

carrier what was done and *ICD-9-CM* codes tell a carrier why it was done.

The vaccine product *CPT* code and its corresponding immunization administration *CPT* code are always linked to the same *ICD-9-CM* code. This is because the vaccine product and the work that goes into administering that product are intended to provide prophylactic vaccination against a certain type of disease. The diagnosis codes for the 3 vaccines and the 3 immunization administration codes used in this example are as follows:

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

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

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

How to Code When Immunizations Are Not Administered

- There are many reasons why immunizations are not given during routine preventive medicine services. Parents may refuse a vaccine or defer it, a patient may be ill at the time and it is counteractive to administer, or the patient may already have had the disease or be immune.
- Due to tracking purposes and quality measures, it is important to report this as part of your *ICD-9-CM* codes. The following *ICD-9-CM* codes were created to report why a vaccine(s) is not given.

Vaccination not carried out due to

V64.00 Unspecified reason

V64.01 Acute illness

V64.02 Chronic illness or condition

V64.03 Immune compromised state

V64.04 Allergy to vaccine or component

V64.05 Caregiver refusal

V64.06 Patient refusal

V64.08 Patient has disease being vaccinated against

Example

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

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

Report

V05.4 Need for prophylactic vaccination against varicella

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

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

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

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

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

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

(continued from previous page)

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

(continued from previous page)

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

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

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

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

Healthcare Common Procedure Coding System Codes

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

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

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

S0610 Annual gynecologic examination; new patient

S0612 Annual gynecologic examination; established patient

S0613 Annual gynecologic examination, clinical breast examination without pelvic examination

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

S9444 Parenting classes, nonphysician provider, per session

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

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

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

S9451 Exercise classes, nonphysician provider, per session

S9452 Nutrition classes, nonphysician provider, per session

S9454 Stress management classes, nonphysician provider, per session

Laboratory Codes

There are 2 different practice models surrounding the conducting of laboratory tests: (1) blood is drawn in the office and the specimen is sent to an outside laboratory for analysis or (2) laboratory tests are performed in the physician's practice.

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

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

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

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

Venipuncture

CPT Codes

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

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

36415 Collection of venous blood by venipuncture

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

ICD-9-CM Codes

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

Model 2: Laboratory tests are performed in the physician's practice.

Venipuncture

CPT Codes

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

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

36415 Collection of venous blood by venipuncture

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

ICD-9-CM Codes

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

Cholesterol Screening

CPT Codes

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

82465 Cholesterol, serum, total

83718 Lipoprotein, direct measurement, HDL cholesterol

84478 Triglycerides

ICD-9-CM Codes

V77.91 Screening for lipid disorders

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

Hematocrit/Hemoglobin

CPT Codes

85014 Blood count; hematocrit

85018 Blood count; hemoglobin

ICD-9-CM Codes

V78.0 Special screening for iron deficiency anemia

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

Lead Screening

CPT Code

83655 Lead

ICD-9-CM Code

V82.5 Special screening for chemical poisoning and other contamination

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

Newborn Metabolic Screening

HCPCS Code

(NOTE: See "Healthcare Common Procedure Coding SystemCodes" on page 33 for explanation of HCPCS codes.)

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

ICD-9-CM Codes

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

V77.0 Special screening for thyroid disorders

V77.3 Special screening for phenylketonuria

V77.4 Special screening for galactosemia

V77.7 Special screening for other inborn errors of metabolism

V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders

V78.0 Special screening for iron deficiency anemia

V78.1 Special screening for other and unspecified deficiency anemia

V78.2 Special screening for sickle cell disease or trait

V78.3 Special screening for other hemoglobinopathies

V78.8 Special screening for other disorders of blood and blood-forming organs

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

Papanicolaou Smear

HCPCS Code

(NOTE: See "Healthcare Common Procedure Coding System Codes" on page 33 for explanation of HCPCS codes.)

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

CPT Code

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

ICD-9-CM Codes

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

V76.2 Special screening, malignant neoplasms, cervix

V76.47 Special screening, malignant neoplasms, vagina

V76.49 Special screening, malignant neoplasms, other sites (for patients without a uterus or cervix)

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

Tuberculosis Testing (Mantoux/Purified Protein Derivative)

Administration of Purified Protein Derivative Test

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

Reading of Purified Protein Derivative Test

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

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

Sexually Transmitted Infection Screening

CPT Codes

86631 Antibody; chlamydia

86632 Antibody; chlamydia, IgM

86701 Antibody; HIV-1

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

87081 Culture, presumptive, pathogenic organisms, screening only

87110 Culture, chlamydia, any source

87205 Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types

87210 Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)

87270 Infectious agent antigen detection by immunofluorescent technique; *Chlamydia trachomatis*

87320 Infectious agent detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; *C trachomatis*

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

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

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

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

87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

87801 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe technique

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

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

ICD-9-CM Codes

V73.88 Special screening examination for other specified chlamydial diseases

V74.5 Special screening examination for bacterial and spirochetal diseases; venereal disease

V75.9 Special screening examination for unspecified infectious disease

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

Urinalysis

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

CPT Codes

81000 Nonautomated, with microscopy

81001 Automated, with microscopy

81002 Nonautomated, without microscopy

81003 Automated, without microscopy

ICD-9-CM Codes

V77.1 Special screening for diabetes mellitus

V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders

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

Common Preventive Medicine *ICD-9-CM* Codes and the *ICD-10-CM* "Crosswalk"

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

(continued from previous page)

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

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

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