Coding for Pediatric Preventive Care, 2019

99401

99383

99391

99441

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, 2019

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.

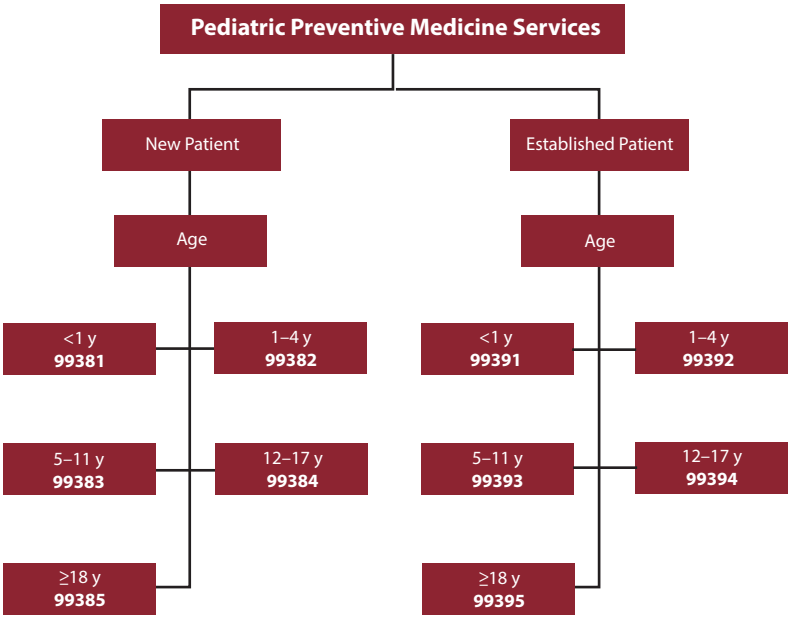
Symbol Description

- • 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 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, body mass index, blood pressure) and age- and gender-appropriate examination and history (initial or interval).



- 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 discovered, 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, counseling/care coordination, 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. Append modifier **25** to the office or other outpatient service code (eg, **99392** and **99213 25**).
- An *insignificant or trivial illness,* abnormality, or problem encountered in the process of performing the preventive medicine service should not be separately 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, hearing) identified with a specific *CPT*® code, are reported and paid for 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 *with abnormal findings* or
		Z00.129	Routine child health exam *without abnormal findings*
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 *without abnormal findings*
		Z00.01	General adult medical exam *with abnormal findings*

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-10-CM* Codes**	
99391	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 *with abnormal findings* **or**
		Z00.129	Routine child health exam *without abnormal findings*
99392	Early childhood (age 1–4 years)	**Z00.121** **Z00.129**	
99393	Late childhood (age 5–11 years)		
99394	Adolescent (age 12–17 years)		
99395	18 years or older	**Z00.00**	General adult medical exam *without abnormal findings*
		Z00.01	General adult medical exam *with abnormal findings*

PREVENTIVE MEDICINE SERVICES: WITH AND WITHOUT ABNORMAL FINDINGS

The use of an *ICD-10-CM* code for *with abnormal findings* (eg, **Z00.121**) does not mean that an additional E/M service must be used. Abnormal findings can be trivial issues that do not require additional work, but the condition is still documented. Examples of abnormal findings include abnormal screening results, new acute problem, or unstable or worsening chronic condition.

A stable chronic condition (whether addressed or not) would *not* warrant the use of an "abnormal finding" code.

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
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 (Also include an additional code, eg, **Z28.82** [caregiver refusal].)
Z71.3 Dietary surveillance and counseling
Z71.82 Exercise counseling
Z71.89 Other specified counseling
Z71.9 Counseling, unspecified

BEHAVIOR CHANGE INTERVENTIONS, INDIVIDUAL

- Used only when counseling a patient on smoking cessation (**99406**, **99407**).
- If counseling a patient's parent or guardian on smoking cessation, do not report these codes (**99406**, **99407**) under the patient; instead, refer to preventive medicine counseling codes (**99401–99404**) if the patient is not currently experiencing adverse effects (eg, illness), or include under the problem-related E/M service (**99201–99215**).
- 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
Z71.51	Drug abuse counseling and surveillance 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® Code

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

Refer to pages 17 and 18 for definition of *qualified health care professional*.

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 examination 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.

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 (eg, CRAFFT)

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. Do *not* report *ICD-10-CM* code **Z13.31** or **Z13.32** under the baby, as those are *only for the maternal record*.

❖ 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		*ICD-10-CM* Codes	
99173	Screening test of visual acuity quantitative, bilateral	**Z00.121**	Routine child health exam *with abnormal findings*
99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with remote-analysis and report	**Z00.129**	Routine child health exam *without abnormal findings*
99177	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral, with on-site analysis		

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**		***ICD-10-CM* Codes**	
92551	Screening test, pure tone, air only	**Z00.121**	Routine child health exam *with abnormal findings*
92552	Pure tone audiometry (threshold), air only	**Z00.129**	Routine child health exam *without abnormal findings*
92567	Tympanometry (impedance testing)		

- 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.

- For newborn hearing screenings for young patients, including those patients who are nonverbal or have developmental delays, other hearing assessment methods may be more appropriate (refer to *CPT* codes **92558** and **92585–92588**).
- Codes **Z01.10** (encounter for examination of ears and hearing without abnormal findings) and **Z01.118** (encounter for examination 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 examination at which a hearing screening is performed.
- Failed hearing screenings will most likely result in a follow-up office visit (eg, **99212–99215**). Code **Z01.110** (encounter for hearing examination 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 examination of ears and hearing with other abnormal findings) and include the code for the abnormal findings (eg, **R94.120** [abnormal auditory function study]).

DEVELOPMENTAL/AUTISM SCREENING AND EMOTIONAL/BEHAVIORAL ASSESSMENT

***CPT*® Codes**		***ICD-10-CM* Codes**	
96110	Developmental screening, per instrument, scoring and documentation	• **Z13.41**	Encounter for autism screening
96127	Brief emotional/behavioral assessment (eg, depression inventory) with scoring and documentation, per standardized instrument	• **Z13.42**	Encounter for screening for global developmental delays (milestones)
		• **Z13.31**	Encounter for screening for depression

- Used to report administration of **standardized** developmental/autism screening instruments (**96110**) or behavioral/emotional assessments (**96127**).
- 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/Documents/coding_factsheet_developmentalscreeningtestingandEmotionalBehvioraassessment.pdf.

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. *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®* code 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 only 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.

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 examinations.

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 (×2)	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)**
99395 25	Preventive medicine service, established patient, 12–17 years	**Z00.0** 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 (×2)	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-baby 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 website (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 had disease being vaccinated against
Z28.82 Caregiver refusal
• **Z28.83** Vaccine was unavailable (eg, manufacturer delay)
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 AAP continues to work on changing this so pediatric providers can be properly compensated for giving multiple-component vaccines. Also be sure to check with your individual state Medicaid plan for varying rules, including, but not limted to, being able to report code **99211** in addition to IA codes for vaccine-only encounters. Be sure to get these rules in writing.

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 Quadracel	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
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 (ccIIV4), 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
90682	Influenza virus vaccine, quad (RIV4), derived from recombinant DNA, HA protein only, preservative and antibiotic free, IM use	Seqirus	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 GSK SP GSK	Afluria FLUARIX Quad Fluzone Quad FLULAVAL	1

Product Code	Separately report the administration with codes **90460–90461** or **90471–90474**.	Manufacturer	Brand	No. of Vaccine Components
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	Seqirus SP GSK	Afluria Fluzone Quad FLULAVAL	1
90756	Influenza virus vaccine, quad (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for IM use	Seqirus	Afluria Flucelvax 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	Afluria	1
90673	Influenza virus vaccine, tri (RIV3), derived from recombinant DNA, HA protein only, preservative and antibiotic free, IM use	Seqirus	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	GSK	Bexsero	1
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 2 or 3 dose schedule, for IM use	Pfizer	Trumenba	1
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 quad (MenACWY or MCV4) , for IM use	SP GSK	Menactra Menveo	1
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for IM use	Pfizer	PREVNAR 13	
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 IMuse	SP	IPOL	1
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use	Merck	RotaTeq	1
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 to 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 35 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 code **S3620** if you are billing for the actual running of the laboratory test 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 35 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® Codes		*ICD-10-CM* Codes	
99211	Office or other outpatient services (negative PPD 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 **Z00.129**	Routine child health examination *with abnormal findings* *without abnormal findings*	First-listed *ICD-10-CM* code only. Includes routine screening when performed at same encounter.
Z00.00 **Z00.01**	General adult medical examination *without abnormal findings* *with abnormal findings*	First-listed *ICD-10-CM* code only. Typically used for patients 18 years and older (payer policy).
Z02.0 **Z02.4** **Z02.5**	Examination for admission to educational institution Examination for driving license Examination for participation in sport	Not required in addition to a **Z00** code
Z01.00 **Z01.01**	Examination of eyes and vision *without abnormal findings* *with abnormal findings*	First-listed *ICD-10-CM* code only. Do not report as a secondary code or in addition to a **Z00** code.
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 **Z01.118**	Encounter for examination of ears and hearing *without abnormal findings* *with other abnormal findings*	First-listed *ICD-10-CM* code only. Do not report as a secondary code or in addition to a **Z00** code.
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 A screening code is not necessary if the screening is inherent to a routine examination, but it can be reported.		
Z11.1	Respiratory tuberculosis	
Z11.3	Infections with a predominantly sexual mode of transmission (*excludes* HPV and HIV)	
Z12.4	Encounter for screening for malignant neoplasm of cervix (*excludes* HPV)	
Z12.79 **Z12.89**	Malignant neoplasm of other genitourinary organs Malignant neoplasms of other sites	
Z13.29	Other suspected endocrine disorder	
Z13.1	Diabetes mellitus	
Z13.228	Other metabolic disorders (eg, inborn errors of metabolism, galactosemia, PKU)	
Z13.220	Lipid disorders	

(*continued on next page*)

(*continued from previous page*)

ICD-10-CM Code	Descriptor	Special Coding Conventions
Screening Codes (*continued*)		
A screening code is not necessary if the screening is inherent to a routine examination, but it can be reported.		
Z13.21	Nutritional disorder	
Z13.228	Other metabolic disorder	
Z13.29	Other suspected endocrine disorder	
Z13.0	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (eg, anemia, sickle cell)	
Z13.31	Encounter for screening for depression	
Z13.89	Other disorders	
Z13.41	Encounter for autism screening	
Z13.42	Encounter for screening for global developmental delays (milestones)	
Z13.88	Disorder due to exposure to contaminants (eg, lead)	
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	*Vaccine not given:* Acute illness	
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	
•Z28.83	Vaccine was unavailable (eg, manufacturer delay)	
Z28.20	Unspecified reason	

Healthcare Effectiveness Data and Information Set Measures Related to Pediatric Preventive Care

Measure Topic	Measure	Coding Options
Child and Adolescent Well-Care Visits: Well-Child Visits in the First 15 Months of Life (W15)	At least 6 well-child examinations by 15 months of age	*ICD-10-CM:* **Z00.110**, **Z00.111**, **Z00.121**, **Z00.129** *CPT:* **99381**, **99382**, **99391**, **99392**
Child and Adolescent Well-Care Visits: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	One or more comprehensive well-child visits with a PCP (per year)	*ICD-10-CM:* **Z00.121**, **Z00.129** *CPT:* **99382**, **99392**
Child and Adolescent Well-Care Visits: Adolescent Well-Care Visits (AWC)	At least one annual comprehensive well-care encounter (per year) for adolescents and young adults aged 12–21 years	*ICD-10-CM:* **Z00.00**, **Z00.01**, **Z00.121**, **Z00.129** *CPT:* **99384**, **99385**, **99394**, **99395**

Measure Topic	Measure	Coding Options
Lead Screening in Children (LSC)	By age 2 years, have had one or more capillary or venous lead blood tests for lead poisoning	*CPT:* **83655**
Chlamydia Screening in Women (CHL)	Sexually active women aged 16–24 years who received at least one chlamydia test each year	*CPT:* **87110**, **87270**, **87320**, **87490–87492**, **87810**
Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA)	**By age 2 y, have** DTaP (4 doses) IPV (3 doses) MMR (1 dose) Hib (3 doses) Hep B (3 doses) Varicella (1 dose) Pneumococcal (4 doses) Hep A (1 dose) Rotavirus (2–3 doses) Influenza (2 doses) **By 13th birthday, have** Meningococcal (1 dose) (Ages 11–13 y) Tdap (1 dose) (Ages 10–13 y) HPV (males/females) (2–3 doses) (Ages 9–13 y)	Varies; refer to the Commonly Administered Pediatric Vaccines table on pages 28 and 29 for specific vaccine codes.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)	For those aged 3–17 years who had an outpatient visit with a PCP during the measurement year and had evidence of BMI percentile documentation and counseling for nutrition and/or physical activity	*ICD-10-CM:* **Z68.51–Z68.54**,[a] **Z71.3**, **Z02.5**, **Z71.82** *CPT:* **3000F**[a]

Abbreviations: BMI, body mass index; *CPT, Current Procedural Terminology;* DTaP, diphtheria, tetanus, acellular pertussis; Hep A, hepatitis A; Hep B, hepatitis B; Hib, *Haemophilus influenzae* type b; HPV, human papillomavirus; *ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification;* IPV, inactivated poliovirus; MMR, measles, mumps, rubella; PCP, primary care practitioner; Tdap, tetanus, diphtheria, acellular pertussis.
[a] Body mass index codes should only be reported when there is a related condition (eg, obesity). Payers needs to accept **3000F** in lieu of BMI *ICD-10-CM* codes for the BMI measure unless the patient has a related condition.

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