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Immunization Coding for Obstetrician–Gynecologists



The American College of
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WOMEN'S HEALTH CARE PHYSICIANS
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All diagnosis codes referred to in *Immunization Coding for Obstetrician–Gynecologists* were excerpted from the *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)*, October 2018 revision, published by the United States Government under the auspices of the ICD-10-CM Coordination and Maintenance Committee.

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Introduction

Immunizations are recommended as part of comprehensive care for women. Under the Patient Protection and Affordable Care Act (ACA), vaccines recommended by the Advisory Committee on Immunization Practices are required to be provided with no cost sharing (ie, no co-pay) for children, adolescents, and adults. Check the list of vaccines covered (<https://www.healthcare.gov/coverage/preventive-care-benefits/>) for more information about the ACA. The American College of Obstetricians and Gynecologists (ACOG) and its Immunization, Infectious Disease, and Public Health Preparedness Expert Work Group recognized a need for a coding guide solely focused on immunization. Correct coding helps ensure that a practice receives payment for the vaccines given to patients. Proper coding means being sure that the code selected from the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) is appropriate as follows:

- The code represents the most accurate description of “what” was performed and “why” it was performed consistent with coding conventions and guidelines.
- The code is supported by documentation in the medical record.

The *Current Procedural Terminology* (CPT) coding guidelines state that the code selected must be the most accurate description of the service provided and be consistent with coding conventions and guidelines. Individuals responsible for coding should carefully review their coding books, including any coding guidelines, notes, instructions, or other explanatory statements. These may be printed under subsections, headings, subheadings, or before and after codes. The physician also should understand the bundling and unbundling rules used by CPT, commercial payers, and the Centers for Medicare & Medicaid Services. It is vital that coding reference materials be kept up to date. Coding guidelines change, and new codes are implemented every year. Medicare bundling rules, however, are revised every quarter. Failure to keep your coding knowledge up to date can result in improper billing and missed reimbursement opportunities.



Reimbursement for Vaccinations

To ensure that a practice will receive adequate payment for vaccines provided in the office-based setting, a clinical practice must investigate whether their third-party payers cover these services, and if so, whether payment is allowed for vaccine drugs and administration.

Medicare

Medicare Part B currently covers preventive vaccine costs for three conditions:

1. Influenza (once per influenza season). Use CPT codes 90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90688, 90689, or 90756 or Q codes Q2034, Q2035, Q2036, Q2037, or Q2038. They may be linked to ICD-10 diagnosis code Z23 (Encounter for immunization). Payment is 100% of the Medicare allowable reimbursement.
2. Pneumococcal conjugate and pneumococcal polysaccharide (once per lifetime, only report one in a single visit). Use CPT codes 90670 or 90732 respectively, linked to diagnosis code Z23. Payment is 100% of the Medicare allowable reimbursement.
3. Hepatitis B (for those in medium-risk to high-risk categories). Use CPT codes 90739–90747 linked to diagnosis code Z23. The Part B deductible and coinsurance are waived.

Medicare typically pays for only one influenza vaccination per year. If more than one vaccination is medically necessary (eg, multiple doses are required), then Medicare will pay for those additional vaccinations. If a patient receives the influenza vaccine and a pneumococcal pneumonia virus vaccine during the same visit, use diagnosis code Z23.

The pneumococcal vaccine is paid once per patient in most cases. However, Medicare will reimburse for revaccination if the patient is considered to be at the highest level of risk of a serious pneumococcal infection and for patients likely to have a rapid decrease in pneumococcal antibody levels. At least 5 years must have passed since the most recent dose of this vaccine.

Note: ICD-10-CM contains a single code for immunizations (Z23—Encounter for immunization). The CPT or Healthcare Common Procedure Coding System (HCPCS) codes linked to diagnosis code Z23 will identify the specific immunizations administered.

Hepatitis B vaccinations are reimbursed only for Medicare beneficiaries considered to be at highest risk and those most likely to have rapid decreases in antibody levels. Medicare defines the highest-risk patients as those with functional or anatomic asplenia, human immunodeficiency virus (HIV) infection, leukemia, lymphoma, Hodgkin disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression.

Medicare Part B does not cover other immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition (eg, tetanus or exposure to rabies). The ICD-10-CM diagnosis code attached to the vaccine must define the disease or condition.

The prescription drug plan Medicare Part D, however, does cover other preventive vaccines. If the patient has Medicare Part D coverage, it is likely that she has preventive coverage for most vaccines. Travel vaccine coverage will depend on the Part D plan. In states that license pharmacists to provide vaccines, physicians can ask the patient to purchase the covered vaccine at the pharmacy and bring it into the office for administration. Alternatively, the physician can supply the vaccine, administer it in the office, and ask the patient for full payment at the time of the service. The patient can then be given a claim form to submit to her Part D plan for reimbursement.

Medicaid

Medicaid reimburses for routine immunizations for covered individuals younger than 21 years. For these individuals, there are two different programs that provide these services:

1. Patients aged 19–20 years receive routine immunizations as part of the Early and Periodic Screening, Diagnostic, and Treatment program. Physicians can bill Medicaid for the vaccines and the administration as a fee for service. This public program for low-income and medically indigent individuals is administered on a state-by-state basis. Thus, the extent of immunization coverage for adults varies state by state.
2. Patients 18 years or younger receive vaccinations through the state's Vaccines for Children (VFC) program. This program is described in the next section.

Vaccines for Children Program

When the Centers for Disease Control and Prevention (CDC) investigated the U.S. measles epidemic of 1989–1991, it found that more than one half of the children who had measles had not been immunized, even though many had seen a health care provider. In response, Congress created the VFC program in 1993.

The VFC program provides free vaccines to doctors who serve eligible children. It is administered at the national level by the CDC through the National Immunization Program. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Eligible children are those who meet the following criteria:

- Are eligible for Medicaid
- Are 18 years or younger

- Have no health insurance
- Are Native American or Alaska Native
- Have health insurance but no immunization coverage. In these cases, these children must go to a federally qualified health center or rural health clinic to receive their immunizations.

Vaccinations are provided for the following diseases:

- Diphtheria
- *Haemophilus influenzae* type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus
- Influenza
- Measles
- Meningococcal disease
- Mumps
- Pertussis (whooping cough)
- Pneumococcal disease
- Polio
- Rotavirus
- Rubella
- Tetanus
- Varicella

Any physician or physician practice can become a VFC provider. First, contact a state or territory VFC program coordinator. A Provider Enrollment Package will be mailed to the health care provider. After submission of this packet, the office will have a site visit. During this visit, a representative from the program will review the administrative requirements of the program and the proper storage and handling of vaccines with physicians and staff.

Because VFC vaccines are provided free of charge to the practice, an office cannot charge the patient for the vaccine product. However, an administrative fee can be charged. Each state sets a maximum fee that physicians can charge for administering a VFC vaccine. If the patient has no health insurance, a VFC health care provider cannot refuse to administer a recommended vaccine because a patient is unable to pay the administration fee. However, the obstetrician–gynecologist or other health care provider can accept whatever the patient can afford to pay. The administration fee for Medicaid patients is billed to the Medicaid plan. For more information on the VFC program, visit the CDC website, www.cdc.gov/vaccines/programs/vfc/index.html.

Commercial Plans

Patients can be enrolled in a variety of private or employer-provided commercial health insurance programs. Coverage for immunizations will vary from plan to plan. Some plans may offer no coverage for preventive medicine services. For patients covered by these plans, it is important to inform them that they will have to bear the costs of immunizations “out of pocket.” For patients who have coverage, it is very important to track payments to verify that the reimbursement received covers the cost of the vaccine product and other associated costs. Clinical practices must contact their patients’ insurance plans to verify coverage for preventive and medically indicated vaccines and their administration.

Third-party payers may or may not reimburse for vaccinations provided at the time of a covered evaluation and management (E/M) service. Some third-party payers will disallow the vaccine administration codes at the time of an E/M service unless the E/M service is documented as separate and significant. (See the section “Coding Examples” for additional information on when it is appropriate to bill an E/M service with vaccine administration.)

The Initial Reproductive Health Visit

The American College of Obstetricians and Gynecologists recommends that a girl’s first visit to her obstetrician–gynecologist take place between the ages of 13 years and 15 years. This visit is designed to provide health guidance, appropriate screening, and preventive health services. It is an excellent opportunity to discuss ongoing immunization status as well as the new recommendations for the human papillomavirus (HPV) vaccine; tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine; and meningococcal vaccine. The CPT code 99384 (Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent [age 12–17 years]) is used for a preventive visit for a new patient aged 12–17 years. The CPT code 99394 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent [age 12–17 years]) is used for a preventive visit for an established patient in the same age range.

It may be appropriate to offer and administer indicated vaccines during these initial reproductive health visits. If these services are performed, the physician also should code for the appropriate vaccine administration code(s) and the appropriate vaccine product code(s) as well as the preventive service.



Coding for Vaccinations

ICD-10-CM Diagnosis Codes for Vaccination Services

The diagnosis codes for an encounter for vaccinations are found in the Z code category (Factors Influencing Health Status and Contact With Health Services) of ICD-10-CM. If a patient is being seen for a specific disease or symptom, report the code for the disease or symptom as well as a code for the vaccination.

Diagnosis codes used for vaccinations are categorized as follows:

- Individuals with potential health hazards related to communicable diseases, including patients who have been exposed to or had contact with someone with a communicable disease
- Encounters for inoculations and vaccinations, including prophylactic administration of vaccines
- Encounters during which a planned immunization was not carried out

The diagnosis codes most likely to be reported when vaccinations are administered to individuals with potential health hazards related to communicable diseases are listed as follows (excludes: carrier of infectious disease [Z22.*], diagnosed current infectious or parasitic disease [Z22], and personal history of infectious and parasitic diseases [Z86.1-*]):

- Z20 Contact with and (suspected) exposure to communicable diseases
- Z20.1 Tuberculosis
- Z20.3 Rabies
- Z20.4 Rubella
- Z20.82 Contact with and (suspected) exposure to other viral communicable diseases
- Z20.820 Varicella
- Z20.828 Other viral communicable diseases
- Z20.81-* Other bacterial communicable diseases

*Note that a hyphen (-) indicates that an additional character is required to complete this code.

- Z20.811 Meningococcus
- Z20.9 Unspecified communicable diseases
- Z23 Encounter for immunization
- Z51.89 Encounter for other specified aftercare (Includes: isolation)
- Z41.8 Encounter for other procedures for purposes other than remedying health state (Includes administration of Immune sera [gamma globulin] RhoGAM, antivenin, and tetanus antitoxin)

Immunization not carried out and underimmunization status:

- Z28 Immunization not carried out and underimmunization status
- Z28.0 Immunization not carried out because of contraindication
- Z28.01 Immunization not carried out because of acute illness of patient
- Z28.02 Immunization not carried out because of chronic illness or condition of patient
- Z28.03 Immunization not carried out because of immune-compromised state of patient
- Z28.04 Immunization not carried out because of patient allergy to vaccine or component
- Z28.09 Immunization not carried out because of other contraindication
- Z28.1 Immunization not carried out because of patient decision for reasons of belief or group pressure
- Z28.20 Immunization not carried out because of patient decision for unspecified reason
- Z28.21 Immunization not carried out because of patient refusal
- Z28.29 Immunization not carried out because of patient decision for other reason
- Z28.81 Immunization not carried out due to patient having had the disease
- Z28.82 Immunization not carried out because of caregiver refusal
Excludes 1: Immunization not carried out because of caregiver refusal because of religious belief (Z28.1)
- Z28.83 Immunization not carried out due to unavailability of vaccine can be reported
- Z28.89 Immunization not carried out for other reason

Current Procedural Terminology and Medicare Coding for Vaccinations

Vaccination Procedures

A vaccination procedure has two components: 1) the administration of the vaccine and 2) the vaccine product (drug) itself. The administration may be performed by the obstetrician–gynecologist or other health care provider. When the vaccine drug and the administration are provided by the physician office, report a code for the vaccine and a code for administration of the vaccine.

Codes for Administration of the Vaccine

The administration codes specify the method and route of administration (see Table 1 for CPT codes). Medicare and CPT use the same set of codes to report administration of most vaccines.

Table 1. Current Procedural Terminology Codes for Vaccine Administration (Single or Combination Vaccine/Toxoid)

Code	Method	Route of Administration	Type of Service	Reporting Rules
90460	Any route	Percutaneous, intradermal, subcutaneous, or intramuscular	Primary	Report for each vaccine administered. Physician also provides counseling. Patient is 18 years or younger.
90461	Any route	Percutaneous, intradermal, subcutaneous, or intramuscular	Each additional	Report for each additional component in a vaccine in conjunction with 90460. Physician also provides counseling. Patient is 18 years or younger.
90471	Injection	Percutaneous, intradermal, subcutaneous, or intramuscular	Primary	Report only one primary vaccine administration per encounter.
+90472	Injection	Percutaneous, intradermal, subcutaneous, or intramuscular	Each additional	Report for secondary or subsequent vaccine administration. Report only with code 90460, 90471, or 90473.
90473	Intranasal	Intranasal or oral	Primary	Report only one primary vaccine administration per encounter. Do not report 90473 with 90471.
+90474	Intranasal or oral	Intranasal or oral	Each additional	Report for secondary or subsequent vaccine administration. Report only with code 90460, 90471, or 90473.

Medicare requires special HCPCS codes for the administration of influenza, pneumococcal, or hepatitis B vaccines (see Table 2). Note that some commercial carriers also accept these HCPCS codes. A summary of these codes follows.

Table 2. Medicare's Healthcare Common Procedure Coding System Codes for Vaccine Administration

Code	Vaccine	Specific Method	Type of Service
G0008	Influenza	Injection	Primary
G0009	Pneumococcal	Injection	Primary
G0010	Hepatitis B	Injection	Primary

The G codes are temporary codes used to identify professional health care services that would be reported using a CPT code if one existed or to provide more information. Report the G code for administration and the applicable CPT code for the vaccine.

There are no specific HCPCS codes for administration of other vaccines. In these cases, Medicare accepts the appropriate CPT code for the vaccine administration.

Codes for the Vaccine Drug Product

Current Procedural Terminology and Medicare use CPT codes 90476–90749 to report the vaccine drugs (see Table 3, Table 4, Table 5, Table 6, and Table 7). Beginning in 2006, CPT has included a symbol in front of a code number to indicate that this vaccine was not approved by the U.S. Food and Drug Administration at the time the CPT book was published. After the vaccine has Food and Drug Administration approval, the code is considered active. The changes in vaccine status are posted at <https://www.ama-assn.org/practice-management/find-coding-resources>.

Table 3, Table 4, Table 5, Table 6, and Table 7 summarize coding for vaccines and their administration under CPT and Medicare rules, assuming that patients who are 18 years or younger are not being immunized. If patients younger than 18 years are being immunized and provided with physician counseling, then codes 90460 and 90461 would be used instead of codes 90471 and 90472 for injectable vaccines, and codes 90460 and 90461 would be used instead of codes 90473 and 90474 for intranasal or oral vaccines.

The following are administration codes:

- 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.)
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
- +90474 Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

Table 3. Vaccines Commonly Administered to Adolescents and Adults (Report an Administration Code and a Vaccine Code)*

Vaccine	Code for Vaccine Product	Administration Codes	
		CPT	Medicare
Hepatitis A vaccine (HepA), adult dosage, for intramuscular use	90632	90471–90472	90471–90472
Hepatitis A vaccine (HepA), pediatric/adolescent dosage, two-dose schedule, for intramuscular use	90633	90460–90472	90471–90472
Hepatitis A vaccine (HepA), pediatric/adolescent dosage, three-dose schedule, for intramuscular use	90634	90460–90472	90471–90472
Hepatitis B vaccine (HepB), adolescent, two-dose schedule, for intramuscular use	90743	90460–90472	G0010
Hepatitis B vaccine (HepB), pediatric/adolescent dosage, three-dose schedule, for intramuscular use	90744	90460–90472	G0010
Hepatitis B vaccine (HepB), adult dosage, three-dose schedule, for intramuscular use	90746	90471–90472	G0010
Hepatitis B vaccine (HepB), adult dosage, two-dose schedule, for intramuscular use	90739	90471–90472	G0010
Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, three-dose schedule, for intramuscular use	90740	90471–90472	G0010
Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, four-dose schedule, for intramuscular use	90747	90471–90472	G0010
Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	90636	90471–90472	90471–90472
Human papillomavirus vaccine types 6, 11, 16, 18 (quadrivalent); three-dose schedule, for intramuscular use	90649	90460–90472	90471–90472
Human papillomavirus vaccine types 16, 18 (bivalent); three-dose schedule, for intramuscular use	90650	90460–90472	90471–90472
Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), two-dose or three-dose schedule, for intramuscular use	90651	90460–90472	90471–90472
Meningococcal polysaccharide vaccine, serogroups A, C, Y, W-135, quadrivalent (MPSV4), for subcutaneous use	90733	90460–90472	90471–90472
Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MCV4 or MenACWY), for intramuscular use	90734	90460–90472	90471–90472

(continued)

**Table 3. Vaccines Commonly Administered to Adolescents and Adults
(Report an Administration Code and a Vaccine Code) (continued)**

Vaccine	Code for Vaccine Product	Administration Codes	
		CPT	Medicare
Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	90670	90460–90472	G0009
Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	90732	90460–90472	90471-90472
Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use	90714	90460–90472	90471-90472
Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	90715	90460–90472	90471-90472
Varicella virus vaccine (VAR), live, for subcutaneous use	90716	90460–90472	90460–90472
Varicella-zoster immune globulin, human, for intramuscular use	90396	90460–90472	96372
Zoster (shingles) vaccine (HZV), live, for subcutaneous injection	90736	90471–90472	90471–90472
Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use	90750	90471–90472	90471–90472

*Note: Influenza codes are outlined in Table 4.

Abbreviation: CPT, Current Procedural Terminology.

Table 4. Coding for Influenza Vaccines

Vaccine (Description)	Code for Vaccine Product	Administration Code
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	90630	90460–90472
Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	90653	90460–90472
Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	90654	90460–90472
Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	90655	90460–90472
Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	90656	90460–90472
Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	90657	90460–90472
Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	90658	90460–90472
Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	90661	90460–90472
Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	90662	90460–90472
Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	90672	90473–90474
Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	90673	90460–90472
Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	90674	90460–90472
Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	90682	90460–90472
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL, for intramuscular use	90685	90460–90472

(continued)

Table 4. Coding for Influenza Vaccines (continued)

Vaccine (Description)	Code for Vaccine Product	Administration Code
Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	90686	90460–90472
Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	90687	90460–90472
Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use	90689	90460–90472
Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use	90756	90460–90472

Table 5. Medicare Coding for Influenza Vaccines

Vaccine	Code for Vaccine Product	Administration Code (CPT and Medicare)
Influenza virus vaccine, split virus, for intramuscular use (Agriflu)	Q2034	G0008
Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)	Q2035	G0008
Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)	Q2036	G0008
Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)	Q2037	G0008
Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)	Q2038	G0008
Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)	Q2039	G0008

Table 6. Vaccines Commonly Administered to Children (Report an Administration Code and a Vaccine Code)*

Vaccine	Code for Vaccine Product	Administration Code (CPT and Medicare)
Diphtheria and tetanus toxoids and acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	90696	90460–90472
Diphtheria and tetanus toxoids and acellular pertussis vaccine, inactivated poliovirus vaccine, <i>Haemophilus influenzae</i> b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	90697	90460–90472
Diphtheria, tetanus toxoids, acellular pertussis vaccine, <i>Haemophilus influenzae</i> type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use	90698	90460–90472
Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	90723	90460–90472
Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use	90700	90460–90472
Diphtheria and tetanus toxoids adsorbed (DT) when administered to individuals younger than 7 years, for intramuscular use	90702	90460-90472
Hepatitis B and <i>Haemophilus influenzae</i> type b vaccine (Hib-HepB), for intramuscular use	90748	90460–90472
<i>Haemophilus influenzae</i> type b vaccine (Hib), PRP-OMP conjugate, three-dose schedule, for intramuscular use	90647	90460–90472
<i>Haemophilus influenzae</i> type b vaccine (Hib), PRP-T conjugate, four-dose schedule, for intramuscular use	90648	90460–90472
Measles–mumps–rubella virus vaccine (MMR), live, for subcutaneous use	90707	90471–90472
Measles–mumps–rubella and varicella vaccine (MMRV), live, for subcutaneous use	90710	90460–90472
Poliovirus vaccine, inactivate (IPV), for subcutaneous or intramuscular use	90713	90460–90472
Rotavirus vaccine, pentavalent (RV5), three-dose schedule, live, for oral use	90680	90460–90461
Varicella virus vaccine (VAR), live, for subcutaneous use	90716	90460–90472

Abbreviation: CPT, Current Procedural Terminology.

*Note: Influenza codes are outlined in Table 4.

**Table 7. Vaccines Commonly Administered for Travel
(Report an Administration Code and a Vaccine Code)**

Vaccine	Code for Vaccine Product	Administration Code
Rabies vaccine, for intramuscular use	90675	90460–90472
Typhoid vaccine, live, oral	90690	90460–90461
Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use	90691	90460–90472
Yellow fever vaccine, live, for subcutaneous use	90717	90460–90472



Coding Case Examples

Case 1

A 65-year-old woman comes in for her annual check-up. She also requests a flu vaccine. The patient has Medicare. The appropriate physical examination is performed, and a Pap test specimen is collected because of her risk factors.

Comment:

Medicare allows coverage for a pelvic examination every 2 years, but for certain high-risk patients it is covered annually. Collection of a Pap specimen is also a reimbursable service at the time of these encounters. Other services (eg, vaccines) also may be performed during these encounters and should be coded and billed separately. Medicare requires specific HCPCS codes for these services. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination
- Z01.419 Encounter for gynecologic examination (general) (routine) without abnormal findings
- Q0091 Collection of screening Pap smear
- Z01.419 Encounter for gynecologic examination (general) (routine) without abnormal findings
- 90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
- Z23 Encounter for immunization
- G0008 Influenza vaccine administration
- Z23 Encounter for immunization

Case 2

A 15-year-old new patient is brought to the office by her mother. The patient and her mother want to talk about a variety of topics, including reproductive health, birth control options, and vaccinations. The appropriate history is obtained. A physical examination limited to the head, chest, abdomen, and extremities is performed. Questions

are answered, and the appropriate counseling is given. The physician then administers an influenza vaccine, a Tdap vaccine, and the first of the series of three HPV vaccines.

Comment:

This encounter is an example of the initial reproductive health visit recommended by ACOG. This encounter should be coded using the preventive medicine codes. The comprehensive nature of preventive medicine codes reflects an age-appropriate and gender-appropriate history or examination, or both, and is not synonymous with the comprehensive examination required in other E/M codes. There are no CPT guidelines stating what is included in a preventive visit, and it will vary with the needs of each patient. In this case, a pelvic examination and breast examination were not necessary. Nevertheless, this encounter is reported as a preventive visit. Other services may be provided at the time of these types of encounters and should be coded and billed separately. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 99384 Initial comprehensive preventive medicine adolescent (12–17 years)
- Z01.419 Encounter for gynecologic examination (general) (routine) without abnormal findings
- 90651 Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2-dose or 3-dose schedule, for intramuscular use
- Z23 Encounter for immunization
- 90460 Vaccine administration
- Z23 Encounter for immunization
- 90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
- Z23 Encounter for immunization
- 90460 Vaccine administration
- Z23 Encounter for immunization
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
- Z23 Encounter for immunization
- 90460 Vaccine administration
- +90461 Additional vaccine component
- +90461 Additional vaccine component

Case 3

A 34-year-old established patient requests assistance in obtaining a hepatitis B vaccine. Her insurance plan requires her to obtain the vaccine product from her local pharmacy. She brings the appropriately stored vaccine to the office. The office nurse sees the patient, checks her blood pressure, obtains appropriate informed consent documents, and administers the hepatitis B vaccine.

Comment:

This example describes a situation in which the only service provided in the office is the vaccine administration. The services provided by the nurse are integral to the vaccine administration code. A separate E/M service was not provided in this situation. Because the patient brought the vaccine product with her, it is not appropriate to bill for the vaccine product. The appropriate procedure code and ICD-10-CM linkage are listed as follows:

- Z23 Encounter for immunization
- 90471 Vaccine administration

NOTE: Some third-party payers deny payment for the vaccine administration codes (90471 and +90472) provided on the same day as a separate and distinct E/M service. It is important to track and appeal such denials because they are in conflict with CPT coding guidelines and standard payment conventions.

Case 4

A 21-year-old established patient comes in for her wellness examination. She has questions about the HPV vaccine. In addition to the usual age-appropriate history, counseling, comprehensive physical examination, and Pap test, the patient is given information regarding the requested vaccine. Her questions are answered, and she requests that the first of the series of three vaccinations be given.

Comment:

This example illustrates the additional counseling that will be necessary as new vaccinations become available. The additional work involved with this counseling is integral to the preventive medicine visit and not reported separately. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 99395 Periodic comprehensive preventive medicine 18–39 years
- Z01.419 Encounter for gynecologic examination (general) (routine) without abnormal findings
- 90651 Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2- or 3-dose schedule, for intramuscular use
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization

Case 5

The 21-year-old established patient referenced in Case 4 returns to the clinic in 2 months for the second of her series of three HPV vaccines. She also reports dysuria. The office nurse checks her blood pressure, completes the appropriate vaccine informed consent documents, and orders a urinalysis. The urinalysis result is normal. The nurse administers the HPV vaccine, documents the encounter in the medical record, and asks the

patient to make a follow-up appointment with her physician to further assess her report of dysuria.

Comment:

This example illustrates an encounter in which the nurse provides a separate E/M service distinct from the vaccine administration service. Some vaccines require a multidose regimen. It is appropriate to use the same vaccine product code for each of the three injections. Modifier 25 is appended to the E/M encounter to signify the distinct and separate service. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 99211–25 Office outpatient visit (nursing encounter)
- R30.0 Dysuria
- 81000 Urinalysis
- R30.0 Dysuria
- 90651 Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2- or 3-dose schedule, for intramuscular use
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization

Case 6

A 28-year-old new patient presents with primary dysmenorrhea. She also requests an influenza vaccine. A detailed history is taken, and a detailed physical examination is performed. The medical decision making is of low complexity. The patient is given information regarding the influenza vaccine and the vaccine is administered by the office nurse.

Comment:

Patients sometimes will request vaccine services at the time of a problem-oriented visit. It is appropriate to code and bill for the vaccine administration and vaccine product as well as for the E/M service. If counseling is extensive and accounts for more than 50% of the total time spent with the patient, it may be appropriate to code based on time rather than the usual key components of history, physical examination, and medical decision making. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 99203–25 Office outpatient visit new patient
- N94.4 Primary dysmenorrhea
- 90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL, for intramuscular use
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization

Case 7

A 25-year-old nulligravid patient is receiving prenatal care in the office. At 12 weeks of gestation, an influenza vaccination is administered.

Comment:

Pregnant patients will request, and in some instances require, vaccinations during their pregnancies. Vaccination services performed during pregnancy should be billed separately at the time of the service. If a patient has any additional conditions that might put her at high risk of influenza, report a secondary code for the high-risk condition. This process will facilitate payment from plans that only cover vaccinations for patients identified as high-risk patients. A separate E/M service should not be reported because the office visit is part of the global obstetric package. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 90656 Preservative-free influenza vaccine (trivalent) (drug), for intramuscular use
- Or
- 90686 Influenza vaccine (quadrivalent), for intramuscular use
- Or
- 90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z3A.12 12 weeks of gestation (optional)

Case 8

The patient referenced in Case 7 comes in for a routine appointment at 28 weeks of gestation. She is Rh negative and is given antenatal Rho(D) immune globulin. She also receives her Tdap vaccination.

Comment:

It is appropriate to code and bill for the Rho(D) immune globulin administration outside of the global obstetric package. Some payers may require the use of special HCPCS codes (“J” codes) to identify the Rho(D) immune globulin product. Also, note that the CPT codes for administration of Rho(D) immune globulin are different than those used for administration of vaccines. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 90384 Rho(D) immune globulin (RhIg), full dose (drug), for intramuscular use
- Or
- J2790 Injection, Rho(D) immune globulin, human, full dose, 300 micrograms (1,500 international units)

- 96372 Injection (therapeutic, prophylactic, or diagnostic), for subcutaneous or intramuscular use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester
- Z3A.28 28 weeks of gestation (optional)

Case 9

The patient referenced in Case 7 and Case 8 is now 6 weeks in the postpartum period. On her antenatal screening, her rubella titer result was negative. She is given a measles–mumps–rubella (MMR) vaccination.

Comment:

The postpartum visit often will require vaccination services. These services should be coded and billed outside the global obstetric package. A separate E/M service should not be reported because the 6-week postpartum visit is part of the global obstetric package. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 90707 Measles–mumps–rubella virus vaccine (MMR), live, for subcutaneous use
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z39.2 Encounter for routine postpartum follow-up



Coding Resources

The American College of Obstetricians and Gynecologists has developed the following resources to assist physicians with selecting the correct codes and interacting with third-party payers. In addition to these publications, coding workshops, and coding webcasts, a website for questions and information is provided at www.acog.org. Publications listed can be ordered through ACOG's Publications and Educational Materials catalog online at <http://sales.acog.org> or by phone from the distribution center (1-800-762-2264).

Ob/Gyn Coding Manual: Components of Correct Procedural Coding, with flash drive, (<http://sales.acog.org/>)—This 500+ page book provides important information to assist physicians in correct coding for surgical procedures commonly performed by obstetrician–gynecologists.

Each code is listed with services that are part of the procedure's global surgical package, information about whether Medicare will reimburse for an assistant or cosurgeon for the procedure, and other coding hints. In addition, the book contains information about the included and excluded services according to Medicare's Correct Coding Initiative and ACOG's Committee on Health Economics and Coding to note when these opinions differ. This information may be useful in preparing appeals to third-party payers, and it is made simpler with the included flash drive. Also included are sections on reproductive medicine, modifiers, relative value units, and bundling issues. This book and flash drive are revised annually.

Other coding resources include the following:

- *Healthcare Common Procedure Coding System (HCPCS)*—A coding system established in 1978 as a way to standardize identification of medical services, supplies, and equipment. There are two sets of codes. The first level, or Level I, of the HCPCS comprises CPT, a numeric coding system maintained by the American Medical Association. The second level, or Level II, is a code set for medical services not included in Level I, such as durable medical equipment, prosthetics, orthotics, and supplies.
- American Medical Association's *Current Procedural Terminology (CPT)*—The most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. It was developed by the American Medical Association in 1966. Each year, an annual publication is prepared that makes changes corresponding with significant updates in medical technology and practice.

- *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)*— Based on the World Health Organization’s Tenth Revision, *International Classification of Diseases (ICD-10)*. The ICD-10-CM is the official system of assigning codes to diagnoses and procedures associated with hospital use in the United States. The ICD-10 is used to code and classify mortality data from death certificates. The ICD-10 was implemented in the United States on October 1, 2015.

Note: Obstetrician–gynecologists and their staff should always use the term “coding” rather than “reimbursement” regarding services rendered. Coding is the action undertaken to secure reimbursement. The intent is to report the services provided using the correct codes; the appropriate reimbursement will follow. If the claim is inappropriately denied, the physician has support for his or her appeal when correct codes were reported.

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center.

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