AAP Coding Hotline:

AAP's Division of Health Care Finance and Practice maintains a FaxBack Coding Hotline. National AAP Members can call 1-800-433-9016, ext 4022. Leave your name and fax number. A form will be faxed to you for your questions and responses should return to you via fax within 1 week. You may also email your questions to aapcodinghotline@aap.org.

AAP Pediatric Coding Newsletter:

To view a sample issue, visit: http://coding.aap.org. If you would like to subscribe to the newsletter contact the AAP Bookstore at http://www.aap.org/bookstore or call toll-free 1-888-277-1770.

Coding and Billing Resources
Coding for Childhood Immunizations

Current Procedural Terminology (CPT®) 2015

International Classification of Diseases ICD-9-CM and ICD-10-CM 2015

HealthCare Common Procedure Coding System (HCPCS)

American Academy of Pediatrics (www.aap.org)

Practice Management for Immunization
http://www2.aap.org/immunization/pediatricians/practicemanagement.html

Using Average Wholesale Price (AWP) and Average Sales Price (ASP)
http://practice.aap.org/content.aspx?aid=1843

Pediatric Council Immunization Toolkit
http://www.aap.org/moc/reimburse/pcit/pcit.htm

AAP Coding Publications
AAP Pediatric Coding Newsletter™
Coding for Pediatrics 2015

Georgia Health Partnership - Department of Community Health (DCH)
(www.ghp.georgia.gov)

Health Check Manual

Georgia Chapter American Academy of Pediatrics (GAAAP)
(www.gaaap.org)

Vaccines for Children
Mike Chaney, VFC Coordinator
404-881-5094
MChaney@gaaap.org

Centers for Medicare and Medicaid Services (www.cms.hhs.gov)

Physicians Fee Schedule (www.cms.hhs.gov/PhysicianFeeSched/)

Centers for Disease Control http://www.cdc.gov/vaccines

Vaccine Price List
http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm

Calculating Vaccine Costs

Purchase price, taxes

Personnel costs associated with:
- Ordering/purchasing vaccines,
- Monitoring the storage of vaccines,
- Negotiating vaccine purchase contracts,
- Scheduling vaccine appointments,
- Patient calls related to vaccines,
- Entering vaccine into registry
- Billing/collections

Purchase price of refrigerator/freezer, alarm/temperature monitoring device, generators (depreciated)

Rent and utilities used for vaccine-related services

Electricity costs for vaccine storage refrigerator

Cost of sharps containers and disposal service

Annual insurance costs

Value of current inventory

Calculating Immunization Administration Costs

Physician salary dedicated to time spent with patient/parent

Staff salary spent in administering vaccine, distribution of VIS and answering questions.

Medical Supplies (non-sterile gloves, exam table paper, OSHA-compliant syringe with needle, CDC information sheet, alcohol swabs, band-aid) and medical equipment (exam table)

Total professional liability insurance

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The Business Case for Pricing Vaccines

Revised March 2012

One of the goals of the American Academy of Pediatrics (AAP), shared by the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), is to promote maximum immunization coverage for all infants, children, adolescents, and young adults. To achieve this goal, physicians must be paid for the full costs (direct and indirect) of vaccine product-related expenses and vaccine administration expenses as well as the margin for overall overhead expenses. Because the private physician practice is the backbone of the immunization delivery infrastructure, public and private sector payers must recognize that a pediatric practice is really a business entity and must run on sound, generally accepted business principles to remain viable. Vaccines are among the top overhead expenses for the pediatric practice. Therefore, payments must ensure recovery of the total direct and indirect practice expenses and a margin for both the vaccine product and the vaccine administration office costs and the time spent counseling families on the indications for and potential adverse effects of each vaccine product.

The number of vaccines continues to increase and the costs have become increasingly high, necessitating a more business-like approach to payment because of the increased potential for uncompensated costs. For most states, which are non-universal purchase, the direct and indirect expenses in maintaining the vaccine product must be accounted for in a compensation formula that incorporates these factors in the vaccine purchase as well as a margin to incentivize immunizations. For universal purchase states, this means having an acceptable immunization administration fee that also covers compensation for indirect vaccine acquisition and maintenance expenses as there are no direct vaccine purchase costs and no mechanism for paying indirect expenses.

Several studies published in the *Pediatrics* supplement, "Financing of Childhood and Adolescent Vaccines,"[1] underscore the need for appropriate payment to cover the total costs for immunizations. In one major study, a cross-sectional survey of private practices in 5 states (California, Georgia, Michigan, New York, and Texas) concluded that there is a wide variation in payment for vaccines and administration fees by payers, resulting in the "need for providers to seek opportunities to reduce costs and increase reimbursements."[2]

Vaccine Product-Related Expenses: ***This is separately reportable from the immunization administration.***

Some payers mistakenly try to maintain that inadequate vaccine payments can be made up by nominal immunization administration fees. ***However, these are two separate expenses, and both need to be appropriately covered by payers. The payment for vaccines is a legitimate expense that must cover the total direct and indirect expenses as listed below.***

1. ***Purchase price (acquisition cost) of the vaccine:*** This is the amount paid by the physician for the vaccine. Although discounts may exist, these are not available to all pediatric practices and may be time limited. An accurate and verifiable public source on the current manufacturer's price for vaccines can be accessed on the CDC vaccine price list for the private sector at: http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm The AAP believes that the CDC private payer vaccine price list should be used as a transparent methodologic basis for vaccine acquisition and invoice cost as part of the total cost of the vaccine.

2. ***Personnel costs for ordering and inventory:*** Medical office staff (clinical and administrative) time to monitor vaccine stock; place orders; negotiate costs, delivery, and payment terms; and ensure safe storage procedures (locks, alarms, temperature controls, etc)

3. ***Storage costs:*** Vaccines must be stored at very specific temperature ranges and, therefore, require special monitoring and storage equipment. The practice expense component of the total immunization administration code pays for part of the vaccine storage costs; however, there are certain expenses that are **not** included that must be compensated: freezer(s), freezer lock(s), freezer alarm system(s), and generators for continued electrical supply (all of which are depreciated).

4. ***Insurance against loss of the vaccine:*** Professional liability malpractice insurance does not cover vaccine product, so additional insurance coverage is needed by the practice.

5. ***Recovery of costs attributable to inventory shrinkage, wastage, and nonpayment:*** In the retail market, inventory shrinkage refers to the uncompensated loss of product due to theft, vendor error, and administrative error. Additionally, there is an estimated wastage/nonpayment of at least 5% (this should be accurately accounted for in each office). This includes drawing up the vaccine and having the patient/family reconsider and refuse, resulting in subsequent nonpayment, or a loss of dose that may occur in attempting to vaccinate an uncooperative/combative patient. This would also include collection costs in response to nonpayment by the patient or third-party payer.

6. ***Lost opportunity costs:*** This is the cost of maintaining a large vaccine inventory. Between $10,000 and $15,000 in inventory is maintained per pediatrician or other provider of vaccines. Every business with this level of money tied up in product inventory must receive an appropriate return on its investment, and so should every pediatric practice.

When the direct and indirect expenses are totaled for the vaccine product, estimates range from 17% to 28% depending on the practice. Therefore, payments for the vaccine should be at the level that covers the total vaccine expenses. So what would be appropriate payment for vaccine product expenses for the total direct and indirect costs? Payments must:

- Be free of any discounts and based on a transparent and verifiable data source, such as the CDC vaccine price list for the private sector, available at: http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm.
- Cover the vaccine product purchase price as well as all related office expenses as noted above and a return on the investment for the dollars invested in vaccine inventory.
- Be at least 125% of the current CDC vaccine price list for the private sector

Pediatric practices are the public health infrastructure for the nation's childhood immunization program. It is imperative to incentivize pediatricians to participate in immunization efforts by appropriate payment for vaccines.

References

[1.] Financing of Childhood and Adolescent Vaccines. *Pediatrics*. 2009;124(Suppl 5). Available at: http://pediatrics.aappublications.org/content/vol124/Supplement_5/)

[2.] Freed GL, Cowan AE, Gregory S, Clark SJ. Variation in provider vaccine purchase prices and payer reimbursement. *Pediatrics*. 2009;124(Suppl 5):S459-S465. Available at: http://pediatrics.aappublications.org/cgi/content/full/124/Supplement_5/S459

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The Business Case for Pricing Immunization Administration

One of the goals of the American Academy of Pediatrics (AAP), shared by the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) is to promote maximum immunization coverage for all infants, children, adolescents, and young adults. To achieve this goal, physicians must be paid for the full costs (direct and indirect) of vaccine product-related expenses and vaccine administration expenses as well as the margin for overall overhead expenses. Because the private physician practice is the backbone of the immunization delivery infrastructure, payers must recognize that a pediatric practice is really a business entity and must run on sound, generally accepted business principles to remain viable. Vaccines are among the top overhead expenses for the pediatric practice. Therefore, payments must ensure reimbursement for the total direct and indirect practice expenses and a margin for both the vaccine product and the vaccine administration office costs and the time spent counseling families on the indications for and potential side effects of each vaccine product.

Immunization Administration Expenses: ***This service is separately reportable from the vaccine product.***

Some payers mistakenly try to maintain that inadequate vaccine payments can be made up by nominal immunization administration fees. ***However, these are two separate expenses and both need to be appropriately covered by payers.***

Several studies published in the *Pediatrics* supplement, "Financing of Childhood and Adolescent Vaccines"[1], underscore the need for appropriate payment to cover the total costs for immunizations. In one study on variable costs for immunizations by pediatric practices in Colorado it was determined that the variable costs of vaccine administration exceeded reimbursement from some insurers and health plans.[2]

The Centers for Medicare and Medicaid Services (CMS) uses its Medicare Resource-Based Relative Value Scale (RBRVS), which assigns relative value units (RVUs) to services based on the resources utilized. The RVUs of a *Current Procedural Terminology* (CPT) code take into account the physician work, practice expenses, and professional insurance liability expenses associated with that service. For immunization administration, these components are detailed below.

1. Physician Work Component: The total value of physician work contained in the Medicare RBRVS physician fee schedule includes:

- Physician time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with the physician's concerns about the iatrogenic risk to the patient

2. Practice Expense Component: Medicare RBRVS uses both direct and indirect practice expenses to determine practice expense RVUs, including the resources used within the facility or physician's office (or patient's home) in providing the service. The practice expense component of the immunization administration fee includes: 1) clinical staff time (RN/LPN/MA blend, including time for vaccine registry input, refrigerator/freezer temperature log monitoring/documentation, and refrigerator/freezer alarm monitoring/documentation); 2) medical supplies (1 pair non-sterile gloves, 7 feet of exam table paper, 1 OSHA-compliant syringe with needle, 1 CDC information sheet, 2 alcohol swabs, 1 band-aid) and; 3) medical equipment (exam table, dedicated full size vaccine refrigerator with alarm/lock [commercial grade], and refrigerator/freezer vaccine temperature monitor/alarm).

3. Professional Liability Insurance Expense Component: The professional liability insurance RVUs assigned to a code are based on CMS historic malpractice claims data.

These three components are combined to create total RVUs (see Table below).

2012 Medicare Relative Value Units for Immunization Administration

CPT code and description	Physician Work RVUs	Practice Expense RVUs (Non-Facility)	Professional Insurance Liability RVUs	Total RVUs (Non-Facility)	Total RVUs x 2012 Medicare conversion factor ($34.0376) = Medicare Amount (Non-Facility)
90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component *	0.17	0.54	0.01	0.72	$24.51
90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component *	0.15	0.21	0.01	0.37	$12.59
90471 Immunization administration, one injection **	0.17	0.53	0.01	0.71	$24.17
90472 Immunization administration, each additional injection**	0.15	0.19	0.01	0.35	$11.91
90473 Immunization administration by intranasal/oral route, first administration**	0.17	0.47	0.01	0.65	$22.12
90474 Immunization administration by intranasal/oral route, each additional vaccine **	0.15	0.18	0.01	0.34	$11.57

** CPT codes 90460 and 90461 are reported for patients under 19 years of age and when counseling is performed on the patient by the physician or other qualified health care professional. It should also be noted that the following codes are reported per vaccine component rather than per injection/administration and make no distinction between routes of administration (i.e., injectable versus oral/intranasal).*
***These codes are reported for older patients (i.e., those 19 years and older) or if there is no counseling performed on the patient or the healthcare professional counseling does not meet state requirements for an "other qualified healthcare professional". It should also be noted that the following codes are reported per injection/administration and allow distinction between routes of administration (i.e., injectable versus oral/intranasal).*

As a separately reported service, payments for immunization administration need to

- Adequately cover those costs to the practice which are separate from the direct and indirect costs associated with the vaccine product
- Be at least 100% of the current Medicare Resource Based Relative Value Scale (RBRVS) physician fee schedule

Insurers understand business principles including the concept of return on investment and expect it in their business. There is no reason physicians should accept carrier refusal to pay separately and adequately for the vaccine product ***and*** the administration/counseling. Viable businesses pass on their increased costs to their purchasers to maintain profitability. The pediatric practice has a legitimate business case to make for separate and adequate payment for vaccines and immunization administration and carriers need to provide adequate payments to cover the total direct and indirect expenses for both the vaccine product and the administration.

Pediatric practices are the public health infrastructure for the nation's childhood immunization program. It is imperative to incentivize pediatricians to participate in immunization efforts by appropriate payment for immunization administration.

References

1. Financing of Childhood and Adolescent Vaccines; Pediatrics Supplement 2009 Available at: http://pediatrics.aappublications.org/content/vol124/Supplement_5/)
2. Judith E. Glazner, MS, Brenda Beaty, MSPH and Stephen Berman, MD Cost of Vaccine Administration Among Pediatric Practices Pediatrics 2009; 124:S492-S498 Available at: http://pediatrics.aappublications.org/cgi/content/abstract/124/Supplement_5/S492

Effective 8/30/2013

Commonly Administered Pediatric Vaccines

Vaccine	*Separately report the administration with Current Procedural Terminology (CPT®) codes 90460-90461 or 90471-90474 [Please see table below]*	Manufacturer	Brand	ICD-9-CM‡	Number of Vaccine Components
90633	Hepatitis A vaccine, pediatric/adolescent dosage, 2 dose, for intramuscular use	GlaxoSmithKline Merck	HAVRIX® VAQTA®	V05.3	1
90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (MenCY-Hib), 4-dose schedule, when administered to children 2-15 months of age, for intramuscular use	GlaxoSmithKline	MenHibrix™	V06.8	2
90647	Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate, 3 dose, for intramuscular use	Merck	PedvaxHIB®	V03.81	1
90648	Hemophilus influenza B vaccine (Hib), PRP-T conjugate, 4 dose, for intramuscular use	sanofi pasteur GlaxoSmithKline	ActHIB® HIBERIX®	V03.81	1
90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use	Merck	GARDASIL®	V04.89	1
90650	Human Papilloma virus (HPV) vaccine, types 16 and 18, bivalent, 3 dose schedule, for intramuscular use	GlaxoSmithKline	CERVARIX™	V04.89	1
90655	Influenza virus vaccine, trivalent, split virus, preservative free, for children 6-35 months of age, for intramuscular use	sanofi pasteur	Fluzone No Preservative Pediatric®	V04.81	1
90656	Influenza virus vaccine, trivalent, split virus, preservative free, when administered to 3 years of age and above, for intramuscular use	Merck sanofi pasteur Novatis GlaxoSmithKline	Afluria® Fluzone No Preservative® Fluvirin® FLUARIX™	V04.81	1
90657	Influenza virus vaccine, trivalent, split virus, 6–35 months dosage, for intramuscular use	sanofi pasteur	Fluzone®	V04.81	1
90658	Influenza virus vaccine, trivalent, split virus, 3 years and older dosage, for intramuscular use	Merck sanofi pasteur Novartis	Afluria® Fluzone® Fluvirin®	V04.81	1
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Pfizer	PREVNAR 13™	V03.82	1
90672	Influenza virus vaccine, quadrivalent, live, intranasal use	MedImmune	Flumist® Quadrivalent	V04.81	1
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	Merck	RotaTeq®	V04.89	1
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	GlaxoSmithKline	ROTARIX®	V04.89	1
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, for children 6-35 months of age, for intramuscular use	Sanofi Pasteur	Fluzone Quadrivalent	V04.81	1
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to 3 years of age and above, for intramuscular use	GlaxoSmithKline	FLUARIX Quadrivalent	V04.81	1
90687	Influenza virus vaccine, quadrivalent, split virus, 6–35 months dosage, for intramuscular use	″	″	V04.81	1
90688	Influenza virus vaccine, quadrivalent, split virus, 3 years and older dosage, for intramuscular use	GlaxoSmithKline	FLULAVAL	V04.81	1
90696	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	GlaxoSmithKline	KINRIX™	V06.3	4
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for intramuscular use	sanofi pasteur	Pentacel®	V06.8	5
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than seven years, for intramuscular use	sanofi pasteur sanofi pasteur GlaxoSmithKline	DAPTACEL® INFANRIX®	V06.1	3

Vaccine	*Separately report the administration with codes 90460-90461 or 90471-90474 [Please see table below]*	Manufacturer	Brand	ICD-9-CM‡	Number of Vaccine Components
90702	Diphtheria and tetanus toxoids (DT), adsorbed when administered to younger than seven years, for intramuscular use	sanofi pasteur	Diphtheria and Tetanus Toxoids Adsorbed	V06.5	2
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use	Merck	M-M-R II®	V06.4	3
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	Merck	ProQuad®	V06.8	4
90713	Poliovirus vaccine (IPV), inactivated, for subcutaneous or intramuscular use	sanofi pasteur	IPOL®	V04.0	1
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to seven years or older, for intramuscular use	sanofi pasteur	TENIVAC®	V06.5	2
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use	sanofi pasteur GlaxoSmithKline	ADACEL® BOOSTRIX®	V06.1	3
90716	Varicella virus vaccine, live, for subcutaneous use	Merck	VARIVAX®	V05.4	1
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine (DTaP-Hep B-IPV), for intramuscular use	GlaxoSmithKline	PEDIARIX®	V06.8	5
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use	Merck	PNEUMOVAX 23®	V03.82	1
90733	Meningococcal polysaccharide vaccine, for subcutaneous use	sanofi pasteur	Menomune®	V03.89	1
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use	sanofi pasteur Novartis	Menactra® Menveo®	V03.89	1
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 3 dose, for intramuscular use	Merck	RECOMBIVAX HB®	V05.3	1
90743	Hepatitis B vaccine, adolescent, 2 dose, for intramuscular use	Merck	RECOMBIVAX HB®	V05.3	1
90744	Hepatitis B, pediatric/adolescent dosage, 3 dose, for intramuscular use	Merck GlaxoSmithKline	RECOMBIVAX HB® ENERGIX-B®	V05.3	1
90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Merck GlaxoSmithKline	RECOMBIVAX HB® ENERGIX-B®	V05.3	1
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, 4 dose, for intramuscular use	GlaxoSmithKline	ENERGIX-B®	V05.3	1
90748	Hepatitis B and Hib (Hep B-Hib), for intramuscular use	Merck	COMVAX®	V06.8	2
90749	**Unlisted vaccine or toxoid**	**Please**	**See**	**ICD**	**Manual**

	Immunization Administration Codes
	Immunization Administration Through Age 18 With Counseling^
90460	Immunization administration 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 component administered
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered
	Immunization Administration
90471	Immunization administration, one vaccine
90472	Immunization administration, each additional vaccine
90473	Immunization administration by intranasal/oral route; one vaccine
90474	Immunization administration by intranasal/oral route; each additional vaccine

^CPT 2012 manual has defined an "**other qualified healthcare professional**" as one who is qualified by education and training, licensure/regulation, and facility privileging who performs a professional service within his/her scope of practice and independently reports that 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 healthcare professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.
Therefore based on these new restrictions, if clinical staff alone performs vaccine counseling, you must defer to codes **90471-90474.**

‡ ICD-9-CM guidelines indicate that immunizations administered as part of a routine well baby or child check should be reported with code V20.2. The codes listed above can be reported in addition to the V20.2 code if specific payers request them. Immunizations administered in encounters **other than those for a routine well baby or child check** should be reported only with the codes listed above.

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

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Frequently Asked Questions for the Pediatric Immunization Administration Codes

I heard that the pediatric immunization administration (IA) codes (90465–90468) were deleted starting in 2011. Is that true?
Yes, that is true. Starting January 1, 2011, codes **90465, 90466, 90467,** and **90468** were deleted from the *Current Procedural Terminology (CPT®)* nomenclature.

Were codes 90471–90474 deleted as well?
No, codes 90471–90474 were *not* deleted or revised in any way.

Were codes 90465–90468 replaced? If so, what are the replacement code numbers and descriptors?
Yes, codes **90465–90468** were replaced with codes **90460** and **90461.**

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

+90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure.)

Code **90460** is reported once for the first component of each vaccine or toxoid administered by any route. The reporting of code **90460** includes counseling for the first vaccine component. Code **90461** is additionally reported for the counseling associated with each additional component of any combination vaccine or toxoid.

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The **+** symbol next to code **90461** indicates that it is an add-on code, just like **90466** was an add-on code to **90465** and **90468** was an add-on code to **90467.** An add-on code (ie, **90461)** can only be reported in conjunction with the primary code (in this case, **90460).**

How does *CPT* define a vaccine *component?*

A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined above.

How many components are in the common pediatric vaccines and which pediatric IA codes would I report with each?

Please see the following chart:

Vaccine	No. of Vaccine Components	Immunization Administration Code(s) Reported	*ICD-9-CM* Code Reported When Vaccine Administered During a Non-preventive Medicine Visit[a]
HPV	1	**90460**	**V04.89**
Influenza	1	**90460**	**V04.81**
Meningococcal	1	**90460**	**V03.89**
Pneumococcal	1	**90460**	**V03.82**
Td	2	**90460, 90461**	**V06.5**
DTaP or Tdap	3	**90460, 90461, 90461**	**V06.1**
MMR	3	**90460, 90461, 90461**	**V06.4**
DTaP-Hib-IPV (Pentacel)	5	**90460, 90461, 90461, 90461, 90461**	**V06.8**
DTaP-HepB-IPV (Pediarix)	5	**90460, 90461, 90461, 90461, 90461**	**V06.8**
DTaP-IPV (Kinrix)	4	**90460, 90461, 90461, 90461**	**V06.3**
MMRV (ProQuad)	4	**90460, 90461, 90461, 90461**	**V06.8**
DTaP-Hib (TriHIBit)	4	**90460, 90461, 90461, 90461**	**V06.8**
HepB-Hib (Comvax)	2	**90460, 90461**	**V06.8**
Rotavirus	1	**90460**	**V04.89**
IPV	1	**90460**	**V04.0**
Hib	1	**90460**	**V03.81**

ICD-9-CM, International Classification of Diseases, Ninth Revision, Clinical Modification; HPV, human papillomavirus; Td, tetanus and diphtheria; DTaP, diphtheria, tetanus, and acellular pertussis; Tdap, tetanus, diphtheria, and acellular pertussis; MMR, measles, mumps, and rubella; Hib, *Haemophilus influenzae* type b; IPV, inactivated poliovirus; HepB, hepatitis B; MMRV, measles, mumps, rubella, and varicella.

[a]*ICD-9-CM* guidelines indicate that immunizations administered as part of a routine well-baby or well-child check should be reported with code **V20.2.** The codes listed in this chart can be reported in addition to **V20.2** if specific payers request them. Immunizations administered in encounters *other than those for a routine*

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well-baby or well-child check should be reported only with the codes listed in this chart. When ICD-10-CM is implemented, report Z23 for all vaccine encounters regardless of which vaccine is given.

We administer Prevnar 13 to our patients. Do we report this vaccine to have 13 components?
No, because the antigens contained in the Prevnar 13 vaccine only prevent disease caused by one organism (ie, pneumococcus).

If a vaccine provides protection against multiple diseases but is not available in the United States as single component individual products, can I still report codes 90460–90461?
Yes, the *CPT* definition of *component* is not dependent on the availability of the product as single components. The commercial availability of vaccine products is a dynamic process that may vary throughout the year, making this a difficult indicator to use.

How are the pediatric IA codes (90460–90461) different from the former pediatric IA codes (90465–90468)?
Please see the following chart:

	Current Codes	**Deleted Codes**
	90460–90461	**90465–90468**
Reported per	Component	Immunization (single or combination)
Age restriction	18 years and younger	Younger than 8 years
Counseling	Required by physician or other qualified health care professional[a]	Required by physician
Routes of administration	Use for all routes of administration.	Codes differ based on route of administration (eg, injectable versus intranasal).

[a]Note that *Current Procedural Terminology* now defines the term “other qualified health care professional” refer to the next question.

The IA codes specify that the counseling must be performed by a physician or “other qualified health care professional.” What determines who qualifies as an “other qualified health care professional”?
This guideline was revised and clarified in the 2012 *CPT* manual. A "physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that 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 healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.

To report *CPT* codes **90460–90461,** the physician or the qualified health care professional who is reporting the service must perform face-to-face counseling (and so document that the counseling was personally performed).

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Some vaccines are given in a series—an initial dose and then one or more booster doses over a period of time. Is it a correct assumption that counseling codes 90460 and 90461 are only appropriate prior to the initial dose, and that further counseling sessions prior to the booster doses would *not* be required, only a vaccine administration code? *If* additional counseling is reportable for subsequent booster doses, why?

The decision for counseling will depend on patient and parent questions and concerns and not on the initial versus booster dose. For certain vaccines in a series, such as the human papillomavirus vaccine given to adolescents, the adolescent may return for subsequent doses to be administered by clinical staff, in which case counseling is unlikely to be provided and IA code **90471** would be reported instead of **90460.**

However, if the patient or parent has new questions or concerns at the return visit and the physician or other qualified health care professional is asked to address these concerns, it would be appropriate to report IA code **90460.** For infants who are receiving 3 doses of diphtheria, tetanus, and acellular pertussis (DTaP) in the first year of life, it is common for parents to be anxious and have questions and concerns at each visit. Parents hear stories from friends or read new information on the Internet and want to make sure that vaccines are safe even though the child may have already had a dose.

Do codes 90460-90461 require that the physician or the qualified health care professional perform the *actual administration* of the vaccine? In other words, do they have to be the ones to physically inject the patient with the vaccine in order to report the codes?
No, the physician or the qualified health care professional does not have to perform the actual administration of the vaccine in order to report codes 90460-90461. The administration (whether it is an injection or an oral/intranasal administration) can be performed by the clinical staff per the physician's or the qualified health care professional's orders.

Can codes 90460–90461 be reported even when the vaccine counseling occurs on a different date of service from the actual administration?

Vignette A
A physician or other qualified health care professional counsels a patient or parent on all vaccines needed during the annual preventive medicine service visit. Because the parent refuses multiple vaccines on the same day, the patient is on an alternative vaccine schedule and some of the vaccines are given over a series of visits. These subsequent visits are for vaccines only and the physician or other qualified health care professional does not see the patient or parent. Can codes 90460–90461 be reported on each day that vaccine(s) is administered?

Vignette B

A physician or other qualified health care professional counsels a patient or parent on vaccines during an office visit. However, because the patient is ill, vaccine administration is deferred at the parent's request until the patient's illness has resolved. Therefore, the vaccines are administered on a different day than the vaccine counseling. Can codes 90460–90461 be reported?

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No. *CPT 2012* currently states that codes **90460–90461** are reported when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. Because the situations in these vignettes essentially split the actual administration from the vaccine counseling into separate dates of service, codes **90460–90461** cannot be reported. In these situations, continue to report IA using codes **90471–90474** because they do not have explicit counseling requirements as part of their descriptors.

What constitutes sufficient documentation for vaccine counseling with these codes? Do we have to document counseling for each separate vaccine component?

CPT guidelines indicate that you must provide documentation to support the reporting of a given service. As an example, documentation should list all vaccine components along with a notation such as "counseling for all components completed." The documentation format (eg, check box, handwritten, electronic template, etc) for this service should be the same as it is for other services. Physicians and other qualified health care professionals can choose whatever format meets their needs as long as it is reflective of the service provided and is documented by the reporting clinician. Documentation should support the service provided and is not meant to be onerous. At the same time, payers may have their own rules on use of "auto-populated" or "pre-populated" templates that may not reflect actual services provided.

Will there ever be an occasion, given the guidelines for reporting pediatric IA codes (90460–90461), for which we would need to report 90471–90474?

Yes, if you see older patients (ie, those 19 years and older), there is no counseling performed on the patient, or the health care professional counseling does not meet the new CPT definition for an *other qualified health care professional,* such as clinical staff (eg, LPNs, RNs).

How will we report a patient encounter in which 2 injectable, single component vaccines are administered, yet counseling is only provided on 1 of the 2 vaccines? Will we report 90460 for the first (ie, counseled) vaccine and 90472 for the second (ie, non-counseled) vaccine?

Yes. If counseling is performed for one single-component vaccine but not another, code **90472** (or **90474** if the second, non-counseled vaccine is administered orally or intranasally) is reported for the non-counseled additional vaccine.

In a single encounter, can I report code 90460 more than once?

Yes, it is possible and allowable. Keep in mind that each vaccine administered is its own entity. Therefore, for each individual vaccine administered, you will report code **90460** because every vaccine will have at minimum one vaccine component. Because **90460** represents the first vaccine component of each vaccine, if you report **90460** in multiple

units, you lose the ability to separately designate each vaccine administered during the course of a single patient encounter.

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Then, depending on the specific vaccine, code **90461** may be additionally reported if the vaccine is a multiple component vaccine.

For example, if you administer a measles, mumps, and rubella (MMR) vaccine and a varicella vaccine at the same encounter, you will report codes **90460, 90461,** and **90461** for the MMR vaccine and **90460** for the varicella vaccine.

Based on an example from the Centers for Disease Control and Prevention web site, it appears that 90460 might be reported up to 9 times on a single date of service, with up to 5 instances of 90461 being reported on the same date. Are there *any* circumstances in which a higher frequency of the use of either code might appropriately be reported?

When counseling is provided and the patient is 18 years or younger, the national routine childhood immunization schedule will drive the number of components needed and hence the number of IA codes reported.

For example, on the routine schedule, the maximum number of diseases covered (components) via immunization is at the 4-year-old visit during influenza season. At this age, with the recently added Prevnar 13 vaccine, the following disease protection is recommended: diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, varicella, influenza, and pneumococcus. If all 10 of these components were given separately (unlikely), code **90460** would be reported 10 times and code **90461** would not be reported at all. If some of the components were provided in a combination vaccine, code **90460** would be reported for the first component of that individual combination vaccine and code **90461** for each additional component within that individual combination vaccine.

In the best-case scenario using currently available combination vaccines, one would report code **90460** 5 times and **90461** 5 times using DTaP; measles, mumps, rubella, and varicella (MMRV); poliovirus; Prevnar; and influenza vaccines.

It is possible that a child will be behind on vaccines and more vaccines may be given than are typically found for a certain age on the routine schedule. Pediatricians have seen as many as 7 injections given on one date and some of these were combination vaccines. However, if one were to add these up in total over the child's lifetime, the number of components would not exceed the recommended number even though a larger quantity may be given on a single date. These catch-up visits would be the circumstance with which a higher frequency of IA codes may be used. Again, this represents a situation in which charges are lumped in one visit instead of spread out over many, but the total remains the same.

We have received multiple claim denials stating 90460 and/or 90461 is a "duplicate" service. How should we report the appropriate IA codes when a patient presents for her 2-month-old well-child check and given the DTaP-Hib-IPV (Pentacel®) vaccine, pneumococcal vaccine, and rotavirus vaccine in order to avoid denials?

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The limitations imposed by some claims processing systems may reject the multiple 90460 codes or multiple 90461 codes appearing on the same claim form as “duplicate claims.” The following is what some payers have indicated will work with their systems:

A patient presents for her 2-month-old well-child check and given the DTaP-Hib-IPV (Pentacel®) vaccine, pneumococcal vaccine, and rotavirus vaccine:

First Claim Form:

	CPT descriptor	CPT code	Units
Line 1	DTaP-Hib-IPV (Pentacel®) vaccine	90698	1
Line 2	Pneumococcal vaccine	90670	1
Line 3	Rotavirus vaccine	90680	1
Line 4	First component administration for each vaccine	90460	3
Line 5	Each additional component administration for each vaccine	90461	4

Second Claim Form:

	CPT descriptor	CPT code	Units
Line 1	Preventive medicine service <1 year	99391	1

Be sure to increase your charges according to the number of units report for the 90460 and 90461.

Can the IA codes (90460–90461) be reported in the neonatal intensive care unit setting where the independent physician is providing face-to-face counseling and dissemination of information about the vaccine components but the hospital-employed nursing staff is providing the supplies and administering the vaccine?
No. Because this situation essentially splits the actual administration (as performed by facility-employed nurses) from the vaccine counseling (as performed by the physician), codes **90460–90461** cannot be reported.

The pediatric IA codes **(90460–90461)** are no different from their predecessor pediatric IA codes **(90465–90468)** in this regard. Because the Medicare Resource-Based Relative Value Scale values for the IA codes include the work (counseling), practice expense (clinical staff time, medical supplies, and medical equipment), and professional liability insurance expense, all 3 of these components must originate from one source for the codes to be able to be reported. In this situation, the facility is incurring practice expense while the physician is doing the work of vaccine counseling. Therefore, the codes cannot be reported. Again, this restriction is no different from the restriction in place with the previous pediatric IA codes **(90465–90468).**

Can codes 90460–90461 be reported for vaccines administered in the continuity clinic setting even when only the resident-in-training (education-limited license) does the vaccine counseling?

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The IA service is unique. As such, the Physicians at Teaching Hospitals (PATH) guidelines do not specifically address this issue, and each academic center will need to determine the appropriate approach within its institution.

However, we can encourage each academic center to be compliant by

- Being aware of IA codes **90460–90461**
- Being aware of the lack of defined guidance for IA per se in the PATH guidelines
- Reaching out to local or regional public and private payers for specific guidance, as might be done with other services not addressed by the Centers for Medicare & Medicaid Services

What *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes should we report with the pediatric IA codes when vaccines are administered during a routine well-baby/infant/child check and at other encounters such as a follow-up?

Per *ICD-9-CM* guidelines, code **V20.2** encompasses all age-appropriate vaccines administered during a routine health check to patients through 17 years of age and therefore should be the only diagnosis code reported for any vaccine administered during a routine well-baby/infant/child check. For patients 18 years and older, report **V70.0** instead of **V20.2**. When vaccines are administered outside of a preventive medicine service, you must report the appropriate "need for prophylactic vaccination" ICD-9-CM code that corresponds to the vaccine. Please refer to the vaccine coding table for more information see link at the beginning of the document.

What *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* codes should we report with the pediatric IA codes when vaccines are administered during a routine well-baby/infant/child check and at other encounters such as a follow-up?

Report **Z23** *encounter for immunization* regardless of when a vaccine is given. Note that there are not vaccine specific *ICD-10-CM* codes for different vaccines like there is in *ICD-9-CM*.

I was surprised at the Medicare Resource-Based Relative Value Scale (RBRVS) practice expense values for code 90461, which is reported for each additional vaccine component and, therefore, does not represent much incremental practice expense beyond the first vaccine component.

The Centers for Medicare and Medicaid Services (CMS) did not accept the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values for the **90460**-**90461** codes and instead assigned what it felt to be a crosswalk to the former pediatric IA codes.

How do you charge vaccine administration fees for patients who qualify for the Vaccines for Children (VFC) program?

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The legislation that created the VFC program requires that the Secretary, Department of Health and Human Services, establish a limit on the amount of money that a provider can charge for the administration of vaccines to VFC-eligible children. The Final Rule released in November of 2012 set the current regional maximum fee per state. Therefore you may charge all VFC eligible patients for the administration of the vaccines but not the vaccines themselves. For those who qualify for Medicaid, you must defer to your Medicaid provider to determine how you can submit the *CPT* codes for payment. Some Medicaid plans require that you submit the *CPT* code for the product that you administered in order to be paid for the administration (which is not the most appropriate mode of submission), while most require that you submit the appropriate vaccine administration code (**90460, 90471-90474**) to be paid for the administration fee. Note that under VFC, you may not be paid "per component" or under *CPT* code **90461**, however, *CPT* code **90460** should be the administration code of choice when most appropriate. While there may be some confusion surrounding this, note that *CPT* code **90461** is the only code excluded from payment under VFC.

Do the IA codes require that we submit vaccine registry data electronically?

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No. While the vignette for all IA codes says, "…the immunization tracking number is entered into a computerized statewide registry," vignettes simply describe the typical patient and do not set requirements to report a code. Because the immunization registry reference is not included as part of the *CPT* code descriptor, use of an immunization registry is not required to appropriately report the IA codes.

American Academy of Pediatrics
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Coding for Pediatric Preventive Care

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

Following are the *Current Procedural Terminology (CPT®)*, Healthcare Common Procedure Coding System (HCPCS) Level II, and *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* and *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* codes most commonly reported by pediatricians in providing preventive care services. It is strongly recommended that the pediatrician, *not* the staff, select the appropriate code(s) to report.

[A]Preventive Medicine Service Codes

- To report the appropriate preventive medicine service code, first determine if the patient qualifies as new or established (defined in the next 2 sections), then select the appropriate code within the new or established code family based on patient age.
- Preventive medicine service codes are not time-based; therefore, time spent during the visit is not relevant in selecting the appropriate code.
- If an illness or abnormality is encountered or a preexisting problem is addressed in the process of performing the preventive medicine service, and if the illness, abnormality, or problem is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service (history, physical examination, medical decision-making), the appropriate office or other outpatient service code **(99201–99215)** should be reported in addition to the preventive medicine service code. Modifier **25** should be appended to the office or other outpatient service code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.
- An insignificant or trivial illness, abnormality, or problem encountered in the process of performing the preventive medicine service that does not require additional work and performance of the key components of a problem-oriented E/M service should *not* be reported.
- The comprehensive nature of the preventive medicine service codes reflects an age- and gender-appropriate history and physical examination and is *not* synonymous with the comprehensive examination required for some other E/M codes (eg, **99204, 99205, 99215).**
- Immunizations and ancillary studies involving laboratory, radiology, or other procedures, or screening tests (eg, vision and hearing screening) identified with a specific *CPT* code, are reported separately from the preventive medicine service code.

[B]Preventive Medicine Services: *New Patients*

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

CPT Codes		*ICD-9-CM* Codes*	
99381	Infant (younger than 1 year)	**V20.31**	Health supervision for newborn under 8 days old or
		V20.32	Health supervision for newborns 8 to 28 days old or
99382	Early childhood (age 1–4 years)	**V20.2**	Routine infant or child health check
99383	Late childhood (age 5–11 years)	**V20.2**	Routine infant or child health check
99384	Adolescent (age 12–17 years)	**V20.2**	Routine infant or child health check
99385	18 years or older	**V20.2**	Routine infant or child health check
		V70.0	Routine general medical examination at a health care facility

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

A new patient is one who has not received any professional face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

[B]Preventive Medicine Services: Established Patients

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

CPT Codes		*ICD-9-CM* Codes*	
99391	Infant (younger than 1 year)	**V20.31**	Health supervision for newborn under 8 days old or
		V20.32	Health supervision for newborns 8 to 28 days old or
		V20.2	Routine infant or child health check
99392	Early childhood (age 1–4 years)	**V20.2**	Routine infant or child health check
99393	Late childhood (age 5–11 years)	**V20.2**	Routine infant or child health check
99394	Adolescent (age 12–17 years)	**V20.2**	Routine infant or child health check
99395	18 years or older	**V70.0**	Routine general medical examination at a health care facility

[A]Counseling, Risk Factor Reduction, and Behavior Change Intervention Codes

- Used to report services provided for the purpose of promoting health and preventing illness or injury.
- They are distinct from other E/M services that may be reported separately when performed.
- Counseling will vary with age and address such issues as family dynamics, diet and exercise, sexual practices, injury prevention, dental health, and diagnostic or laboratory test results available at the time of the encounter.
- Codes are time-based, where the appropriate code is selected based on the approximate time spent providing the service.
- Extent of counseling or risk factor reduction intervention must be documented in the patient chart to qualify the service based on time.
- Counseling or interventions are used for persons *without* a specific illness for which the counseling might otherwise be used as part of treatment.
- Cannot be reported with patients who have symptoms or established illness.
- For counseling individual patients with symptoms or established illness, report an office or other outpatient service code **(99201–99215)** instead.
- For counseling groups of patients with symptoms or established illness, report **99078** (physician educational services rendered to patients in a group setting) instead.

[B]Preventive Medicine, Individual Counseling

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

[B]Behavior Change Interventions, Individual

- Used only when counseling a patient on smoking cessation **(99406–99407).**
- If counseling a patient's parent or guardian on smoking cessation, do not report these codes **(99406–99407)** under the patient; instead, refer to preventive medicine counseling codes **(99401–99404)** if

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

the patient is not currently experiencing adverse effects (eg, illness) or include under the problem-related E/M service **(99201–99215).**

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407 intensive, greater than 10 minutes
99408 Alcohol or substance (other than tobacco) abuse structured screening (eg, Alcohol Use Disorder Identification Test [AUDIT], Drug Abuse Screening Test [DAST]) and brief intervention (SBI) services; 15 to 30 minutes
99409 greater than 30 minutes

[B]Preventive Medicine, Group Counseling

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

[C]Diagnostic Codes for Counseling Risk Factor Reduction and Behavior Change Interventions

- The diagnosis code(s) reported for counseling risk factor reduction and behavior change intervention codes will vary depending on the reason for the encounter.
- Remember that the patient cannot have symptoms or established illness; therefore, the diagnosis code(s) reported cannot reflect symptom(s) or illness(es).
- Examples of some possible diagnosis codes include

ICD-9-CM Code	Description	ICD-10-CM Code	Description
V15.82	History of tobacco use	**Z87.891**	Personal history of nicotine dependence
V15.83	Underimmunized status (Lapsed immunization schedule)	**Z28.3**	Underimmunization status
V15.89	Other specific personal history presenting as hazards to health	**Z91.89**	Other specified personal risk factors, not elsewhere classified
V25.04	Counseling and instruction in natural family planning to avoid pregnancy	**Z30.02**	Counseling and instruction in natural family planning to avoid pregnancy
V25.09	Encounter for contraceptive management; general counseling and advice; other	**Z30.09**	Encounter for other general counseling and advice on contraception
V65.3	Dietary surveillance and counseling	**Z71.3**	Dietary surveillance and counseling
V65.40	Counseling not otherwise specified	**Z71.9**	Counseling, unspecified
V65.41	Exercise counseling	**None**	
V65.42	Counseling on substance use and abuse	**Z71.41** **Z71.42** **Z71.51** **Z71.52** **Z71.6**	Alcohol abuse counseling and surveillance of alcoholic Counseling for family member/partner/friend of alcoholic Drug abuse counseling and surveillance of drug abuser Counseling for family member/partner/friend of drug abuser Tobacco abuse counseling
V65.43	Counseling on injury prevention	**None**	
V65.49	Other specified counseling	**Z71.89**	Other specified counseling

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

[A]Other Preventive Medicine Services

[B]Pelvic Examination

- Preventive medicine service codes **(99381–99385** and **99391–99395)** include a pelvic examination as part of the age- and gender-appropriate examination.
- However, if the patient is having a problem, the physician can report an office or other outpatient E/M service code **(99212–99215)** for the visit and attach modifier **25,** which identifies that the problem-oriented pelvic visit is a separately identifiable E/M service by the same physician on the same date of service.
- Link *ICD-9-CM* code **V20.2** to the preventive medicine service code, but link a different diagnosis code (eg, *ICD-9-CM* code **623.5** [vaginal discharge] or *ICD-10-CM* code **N89.8**, **625.3** [dysmenorrhea] or *ICD-10-CM* code **N94.4** [primary dysmenorrhea], **N94.5** [secondary dysmenorrhea] or **N94.6** [unspecified dysmenorrhea]) to the office or other outpatient E/M service code.
- Anticipatory or periodic contraceptive management is not a "problem" and therefore is included in the preventive medicine service code; however, if contraception creates a problem (eg, breakthrough bleeding, vomiting), the service can be reported separately with an office or other outpatient service code.

[C]Diagnosis Codes

ICD-9-CM	Description	*ICD-10-CM*	Description
V25.01	Prescription of oral contraceptives	**Z30.011**	Encounter for initial prescription of contraceptive pills
V25.02	Initiation of other contraceptive measures	**Z30.013** **Z30.014**	Encounter for initial prescription of injectable contraceptive Encounter for initial prescription of intrauterine contraceptive device
V25.03	Encounter for emergency contraceptive counseling and prescription	**Z30.012**	Encounter for prescription of emergency contraception
V25.11	Encounter for insertion of intrauterine contraceptive device	**Z30.430**	Encounter for insertion of intrauterine contraceptive device
V25.12	Encounter for removal of intrauterine contraceptive device	**Z30.432**	Encounter for removal of intrauterine contraceptive device
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device	**Z30.433**	Encounter for removal and reinsertion of intrauterine contraceptive device
V25.40	Surveillance of previously prescribed contraceptive methods; contraceptive surveillance, unspecified	**Z30.40**	Encounter for surveillance of contraceptives, unspecified
V25.41	Surveillance of previously prescribed contraceptive methods; contraceptive pill	**Z30.41**	Encounter for surveillance of contraceptive pills
V25.42	Surveillance of previously prescribed contraceptive methods; intrauterine contraceptive device	**Z30.431**	Encounter for routine checking of intrauterine contraceptive device
V25.43	Surveillance of previously prescribed contraceptive methods; implantable subdermal contraceptive	**Z30.42**	Encounter for surveillance of injectable contraceptive
V25.49	Surveillance of previously prescribed contraceptive methods; other methods	**Z30.49**	Encounter for surveillance of other contraceptives
V72.31	Routine gynecologic examination	**Z01.411** **Z01.419**	Encounter for gynecological examination with abnormal findings Encounter for gynecological examination w/o abnormal findings
V72.32	Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear	**Z12.72** **Z11.51**	Encounter for screening for malignant neoplasm of vagina Encounter for screening for human papillomavirus (HPV)

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

[B]Health Risk Assessment

[C]*CPT* Code

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

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

[C]*ICD-9-CM* Codes*

V20.32 Health supervision for newborns 8 to 28 days old
V20.2 Routine infant or child health check (eg, for postpartum depression screening)

[B]Unlisted Preventive Medicine Service

99429 Unlisted preventive medicine service

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

[A]Case Management or Care Plan Oversight Services

[B]Telephone Services

[C]*CPT* Codes

99441 Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion
99442 11 to 20 minutes of medical discussion
99443 21 to 30 minutes of medical discussion

[B]Online Medical Evaluation

[C]*CPT* Code

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

[B]Care Plan Oversight

[C]*CPT* Codes

99339 Individual physician supervision of a patient (patient not present) in home, domiciliary, or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian), or key caregiver(s) involved in patient's care; integration of new information into medical treatment plan; or adjustment of medical therapy; within a calendar month; 15 to 29 minutes
99340 30 minutes or more

- Care plan oversight (CPO) codes are *reported once per calendar month.*
- Telephone service codes are reported for *each* physician telephone call made or received from a patient or parent, excluding those that occur 7 days after or 24 hours before a face-to-face visit.

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

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

[A]Complex Chronic Care Coordination Services

99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

99488 first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

[A]Transitional Care Management Services

99495 Transitional care management services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Reporting of complex chronic care coordination and transition care management requires that a lot of criteria be met and guidelines followed. Please refer to the 2014 *CPT* manual for complete details.

[A]Screening Codes

[B]Vision Screening

CPT Codes		*ICD-9-CM* Codes*	
99173	Screening test of visual acuity quantitative, bilateral	**V20.2**	Routine infant or child health check
99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral	**V20.2**	Routine infant or child health check

ICD-9-CM code* **V72.0** (examination of eyes and vision) is reported for diagnostic vision examinations only.

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

- To report code **99173,** you must employ graduate visual acuity stimuli that allow a quantitative estimate of visual acuity (eg, Snellen chart).
- Code **99174** is reported for instrument-based ocular screening for esotropia, exotropia, anisometropia, cataracts, ptosis, hyperopia, and myopia.
- When acuity **(99173)** or instrument-based ocular screening **(99174)** is measured as part of a general ophthalmologic service or an E/M service of the eye (eg, for an eye-related problem or symptom), it is considered part of the diagnostic examination of the office or other outpatient service code **(99201–99215)** and is not reported separately.
- Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).
- Failed vision screenings will most likely result in a follow-up office visit (eg, **99212–99215)** linked to the diagnosis code for the reason for the failure (eg, **367.1** [myopia] or *ICD-10-CM* code **H52.1-** [use 5th digit to indicated eye]); when a specific code cannot be identified, report **368.8** (other specified visual disturbance or *ICD-10-CM* code **H53.8**).

[B]Hearing Screening

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

ICD-9-CM codes* **V72.11** (encounter for hearing examination following failed hearing screening) and **V72.19** (other examination of ears and hearing) are reported for diagnostic hearing examinations only.

- Requires use of calibrated electronic equipment; tests using other methods (eg, whispered voice, tuning fork) are not reported separately.
- Includes testing of both ears; append modifier **52** when a test is applied to only one ear.
- Other identifiable services unrelated to the screening test provided at the same time are reported separately (eg, preventive medicine services).
- Failed hearing screenings will most likely result in a follow-up office visit (eg, **99212–99215)** linked to the diagnosis code for the reason for the failure; when a specific code cannot be identified, report *ICD-9-CM* code **389.8** (other specified forms of hearing loss) or *ICD-10-CM* code **H91.9-** (Use 5th digit to specify ear).

[B]Developmental Screening

CPT Code		*ICD-9-CM* Code*	
96110	Developmental screening, with scoring and documentation, per standardized instrument	**V79.3**	Special screening for developmental handicaps in early childhood

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

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

- Examples of **96110** instruments include, but are not limited to
  - *Ages and Stages Questionnaire-Third Edition (ASQ)* Modified Checklist for Autism in Toddlers (M-CHAT)

[B]Emotional/Behavioral Assessment

CPT Code	*ICD-9-CM* Code*
96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	**V79.0** Special screening for depression **V79.8** Special screening for other specified mental disorders

- Used to report administration of standardized emotional and/or behavioral instruments.

- Often reported when performed in the context of preventive medicine services but may also be reported when screening is performed with other E/M services such as acute illness or follow-up office visits.

- Clinical staff (eg, registered nurse) typically administers and scores the completed instrument while the physician incorporates the interpretation component into the accompanying E/M service.
- When a limited standardized screening test is performed along with any E/M service (eg, preventive medicine service), both services should be reported and modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

- Examples of **96127** instruments include, but are not limited to
  Patient Health Questionnaire PHQ-2 or PHQ-9
  Beck Youth Inventory

[A]Immunizations

[B]Immunization Administration

[C]Pediatric Immunization Administration Codes

Report a *CPT* and an *ICD-9-CM*/*ICD-10-CM* code for *each component administered* as well as for *each vaccine product* given during a patient encounter.

90460 Immunization administration (IA) through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
+90461 each additional vaccine or toxoid component administered
Report **90461** in conjunction with **90460.**

Component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined above.

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

*Code **90460** is used to report the first or only component in a single vaccine given during an encounter. You can report more than one **90460** during a single office encounter. Code **90461** is considered an add-on*

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

*code to **90460** (hence the + symbol next to it). This means that the provider will use **90461** in addition to **90460** if more than one component is contained within a single vaccine administered. CPT* codes **90460** and **90461** are reported regardless of route of administration.

Pediatric 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 nonage-specific IA code(s) **(90471–90474)** instead.

[C]Nonage-Specific Immunization Administration Codes

Report a *CPT* and an *ICD-9-CM* code for *each vaccine administration* as well as for *each vaccine product* given 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)
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)
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 one vaccine is administered during a visit. Note that there can only be one first administration during a given visit. (See vignettes #3 and 4.)

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 their correct use (please note that these coding vignettes are for teaching purposes and do not necessarily follow every payer's reporting requirements):

[D]Vignette #1

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

How are the appropriate code(s) for this service selected?

[E]Step 1: Select appropriate E/M code.

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

[E]Step 2: Select appropriate vaccine product code(s).

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

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

90700 DTaP, for use in individuals younger than 7 years, for intramuscular use
90672 Influenza virus vaccine, quadrivalent, live, for intranasal use

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

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

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

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

90460 IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
+90461 each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure.)

[E]Step 4: Select the appropriate *ICD-9-CM** diagnosis code(s).

Diagnosis codes are used along with *CPT* codes to reflect the outcome of a visit. *CPT* codes tell a carrier what was done and *ICD-9-CM* codes tell a carrier why it was done.

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

ICD-9-CM does list specific codes to describe an encounter in which a patient does receive a certain vaccine (ie, codes **V03–V05);** however, when immunizations are administered during a routine well-child visit, *ICD-9-CM* code **V20.2** should be linked to the individual vaccine product and administration code(s). This is due to *ICD-9-CM* guidelines that allow for the linkage of age-appropriate vaccines to be reported under **V20.2** during a routine well-baby or well-child encounter. Under *ICD-10-CM*, you will report **Z23** (Encounter for vaccines) for all vaccine-related encounters.

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

CPT Codes		*ICD-9-CM* Codes*
99393	Preventive medicine service, established patient, 5–11 years	**V20.2**
90633	Hepatitis A vaccine product	**V20.2**
90460	Pediatric IA (hepatitis A vaccine), first component	**V20.2**
90700	DTaP vaccine product	**V20.2**
90460	Pediatric IA (DTaP vaccine), first component	**V20.2**
90461 (x2)	Pediatric IA (DTaP vaccine), each additional component	**V20.2**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**V20.2**
90460	Pediatric IA (influenza vaccine), first component	**V20.2**

Alternative Coding

CPT Codes		*ICD-9-CM* Codes*
90633	Hepatitis A vaccine product	**V20.2**
90700	DTaP vaccine product	**V20.2**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**V20.2**
90460 (x3)	Pediatric IA (hepatits A, DTaP, influenza vaccines), first component	**V20.2**
90461 (x2)	Pediatric IA (DTaP vaccine), second and third components	**V20.2**

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

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

Rationale

Because the patient is younger than 18 years of age and there is physician counseling, pediatric IA codes are reported **(90460, 90461).** Each vaccine administered will be reported with its own **90460** (hepatitis A, DTaP, influenza). The only vaccine with multiple components is DTaP. Because the first component (ie, diphtheria) was counted in **90460,** only the second and third components (tetanus and acellular pertussis) are reported with **90461** with 2 units. Also, even though an intranasal vaccine is administered, you still report **90460** because the code descriptor reads "any route."

[D]Vignette #2

A 2-month-old established patient presents for her checkup. The following vaccines are ordered: DTaP-*Haemophilus influenzae* type b (Hib)-inactivated poliovirus (IPV) (Pentacel), pneumococcal, and rotavirus. The physician counsels the parents on all of them and the nurse administers them all.

CPT Codes		*ICD-9-CM* Codes*
99391	Preventive medicine service, established patient, <1 year	**V20.2**
90698	DTaP-Hib-IPV (Pentacel) product	**V20.2**
90670	Pneumococcal product	**V20.2**
90680	Rotavirus vaccine	**V20.2**
90460 (x3)	Pediatric IA (Pentacel, pneumococcal, rotavirus), first component	**V20.2**
90461 (x4)	Pediatric IA (Pentacel), each additional component	**V20.2**

Rationale

Because the patient is younger than 18 years and there is physician counseling, pediatric IA codes are reported **(90460, 90461).** Clinical staff may administer the vaccine. The vaccines are administered during the patient's routine well-baby visit; therefore, code **V20.2** is the appropriate *ICD-9-CM* code for all vaccines.Also, even though an oral vaccine is administered, you still report **90460** because the code descriptor reads "any route."**[D]Vignette #3**

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

CPT Codes		*ICD-9-CM* Codes*
99395	Preventive medicine service, established patient, 18–39 years	**V70.0** and **V70.3**
90715	Tdap product	**V06.1**
90471	IA, first injection	**V06.1**
90734	Meningococcal (MCV4) product	**V03.89**
90472	IA, each additional injection	**V03.89**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**V04.81**
90474	IA, each additional oral or intranasal	**V04.81**

Rationale

The patient is older than 18 years; therefore, despite physician counseling, pediatric IA codes cannot be reported. Instead, codes **90471–90474** must be used. Because the patient received 2 injections and 1 intranasal vaccine, code **90471** is reported for the first injection, **90472** for the second injection, and **90474** for the intranasal vaccine. It is important to remember that a first injection code **(90471)** cannot be reported in addition to a first oral or intranasal code **(90473);** therefore, code **90474** must be used. The patient's age also requires the reporting of *ICD-9-CM* code **V70.0;** therefore, the vaccine product and IA codes must be linked to their appropriate *ICD-9-CM* codes (eg, **V06.1).**

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

[D]Vignette #4

A 17-year-old patient presents to the office for her annual checkup and to complete a college physical examination (in college the patient will be living in a dorm). The patient is due for a Tdap booster, meningococcal vaccine, and intranasal influenza vaccine. The physician counsels the patient only on the meningococcal vaccine and the nurse administers each.

CPT Codes		*ICD-9-CM* Codes*
99394	Preventive medicine service, established patient, 12–17 years	**V20.2** and **V70.3**
90734	Meningococcal (MCV4) product	**V03.89**
90460	Pediatric IA (meningococcal), first component	**V03.89**
90715	Tdap product	**V06.1**
90472	IA, each additional injection (Tdap)	**V06.1**
90672	Influenza virus vaccine, quadrivalent, live, intranasal	**V04.81**
90474	IA, each additional oral or intranasal	**V04.81**

Rationale

Because the physician only documents counseling for the meningococcal vaccine, code **90460** can only be reported for that vaccine. For the Tdap and intranasal influenza vaccines, defer to non-pediatric IA codes **(90471–90474).** In this case, however, a first vaccine code is already reported with code **90460,** so the additional IA codes **(90472, 90474)** have to be reported based on route of administration. Because the encounter was also related to an examination for administrative purpose (eg, college examination), link the appropriate *ICD-9-CM* code to the vaccine product and IA codes (eg, **V04.81).**

[D]Vignette #5

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

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

First Visit:

CPT Codes	*ICD-9-CM* Codes*
99391 Preventive medicine service, established patient, <1 year (An appropriate acute sick visit (eg, **99213**) may also be reported, appended with modifier **25** and linked to an appropriate diagnostic code.)	**V20.2**

Return Visit:

CPT Codes		*ICD-9-CM* Codes
90700	DTaP product	**V06.1**
90670	Pneumococcal product	**V03.82**
90744	Hepatitis B vaccine product	**V05.3**
90471	IA (DTaP), first vaccine	**V06.1**
90472 (x2)	IA (pneumococcal, hepatitis B), each additional vaccine	**V03.82** and **V05.3**

Rationale

If counseling occurs outside of the IA service, there is no way to report it separately. Therefore, in this vignette, there is nothing separate to report during the well-child visit, and when the patient returns and sees the nurse only, pediatric IA codes cannot be reported; defer to codes **90471–90474.** During the preventive medicine service, when an acute illness is detected, a code from **99212–99215** can be reported if the service is significant and separately identifiable. Code **9921x** is reported with modifier **25.** When the patient returns for vaccines only, an E/M service is not reported because one is not completed or documented.

For more information on IA codes, see "Frequently Asked Questions for the Pediatric Immunization Administration Codes" and the Vaccine Coding Table at http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/FAQ.aspx

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

For more information on when it is appropriate to report a 99211 in addition to vaccine administration see http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Private/When-Is-It-Appropriate-to-Report-99211-During-Immunization-Administration.aspx . For a complete list of vaccines and their corresponding CPT codes, including product names, see

[B]How to Code When Immunizations Are Not Administered

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

Vaccination not carried out due to

ICD-9-CM	**Description**	*ICD-10-CM*
V64.00	Unspecified reason	**Z28.20**
V64.01	Acute illness	**Z28.01**
V64.02	Chronic illness or condition	**Z28.02**
V64.03	Immunocompromised state	**Z28.03**
V64.04	Allergy to vaccine or component	**Z28.04**
V64.05	Caregiver refusal	**Z28.82**
V64.06	Patient refusal	**Z28.21**
V64.07	Religious reasons	**Z28.1**
V64.08	Patient has disease being vaccinated against	**Z28.81**
V64.09	Other reason	**Z28.89**

[C]Vignette

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

Report the following *ICD-9-CM* codes linked to the E/M service:
V05.4 Need for prophylactic vaccination against varicella
V64.08 Vaccination not carried out due to patient had disease being vaccinated against

Vaccines for Children (VFC) Program

The rules for reporting vaccines for those patients who qualify for the VFC program will vary greatly. Some states require that the product code be submitted, while others, the IA codes. Currently the VFC program does not recognize component-based vaccine counseling, therefore you will not be paid for CPT code **90461**. The AAP is working on changing this so that pediatric providers can be properly compensated for giving multiple component vaccines.

[A]Healthcare Common Procedure Coding System Codes

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

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

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

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S0610 Annual gynecologic examination; new patient
S0612 Annual gynecologic examination; established patient
S0613 Annual gynecologic examination, clinical breast examination without pelvic examination
S0622 Routine examination for college, new or established patient (List separately in addition to appropriate E/M code.)
S9444 Parenting classes, nonphysician provider, per session
S9445 Patient education, not otherwise classified, nonphysician provider, individual, per session
S9446 Patient education, not otherwise classified, nonphysician provider, group, per session
S9447 Infant safety (including cardiopulmonary resuscitation) classes, nonphysician provider, per session
S9451 Exercise classes, nonphysician provider, per session
S9452 Nutrition classes, nonphysician provider, per session
S9454 Stress management classes, nonphysician provider, per session

[A]Laboratory Codes

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

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

In the latter situation, the practice must have the appropriate Clinical Laboratory Improvement Amendments (CLIA) license to conduct non–CLIA-waived tests. Tests granted CLIA-waived status should be reported with modifier **QW** appended. You should never report the laboratory code for a lab that your practice does not run in-house or are not financially responsible for and billed by the outside lab. In those cases, only report the blood draw and specimen handling as appropriate.

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

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

[C]Venipuncture

[D]*CPT* Codes

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

[D]*ICD-9-CM* Codes*

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

[B]Model 2: Blood is drawn and laboratory tests are performed in the physician's practice.

[C]Venipuncture

[D]*CPT* Codes

36406 Venipuncture, younger than 3 years, necessitating physician's skill, not to be used for routine venipuncture
36410 Venipuncture, 3 years or older, necessitating physician's skill, for diagnostic or therapeutic purposes (not be used for routine venipuncture)
36415 Collection of venous blood by venipuncture

*Indicates that the appropriate *ICD-10-CM* code can be found within one of the crosswalk charts throughout the resource. *ICD-10-CM* becomes effective on 10-1-15.
+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

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

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

[C]Cholesterol Screening

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

[D]*ICD-9-CM* Codes*
V77.91 Screening for lipid disorders
V72.6 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)

[C]Hematocrit/Hemoglobin

[D]*CPT* Codes
85014 Blood count; hematocrit
85018 Blood count; hemoglobin

[D]*ICD-9-CM* Codes*
V78.0 Special screening for iron deficiency anemia
V72.6 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)

[C]Lead Screening

[D]*CPT* Code
83655 Lead

[D]*ICD-9-CM* Codes*
V82.5 Special screening for chemical poisoning and other contamination
V72.6 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)

[C]Newborn Metabolic Screening

[D]HCPCS Code
(Note: See "Healthcare Common Procedure Coding System Codes" on pages 28 and 29 for explanation of HCPCS codes.)

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

[D]*ICD-9-CM* Codes*
Report the diagnosis code(s) for the state-specific newborn screening test(s) conducted. Examples include

V77.0 Special screening for thyroid disorders
V77.3 Special screening for PKU
V77.4 Special screening for galactosemia
V77.7 Special screening for other inborn errors of metabolism

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders
V78.0 Special screening for iron deficiency anemia
V78.1 Special screening for other and unspecified deficiency anemia
V78.2 Special screening for sickle cell disease or trait
V78.3 Special screening for other hemoglobinopathies
V78.8 Special screening for other disorders of blood and blood-forming organs
V72.60 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)

[C]Papanicolaou Smear

[D]HCPCS Code

(Note: See "Healthcare Common Procedure Coding System Codes" for explanation of HCPCS codes.)
Q0091 Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory

[D]*CPT* Code

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

[D]*ICD-9-CM* Codes*

V15.89 Other specified personal history presenting as hazards to health (for high-risk patients only)
V76.2 Special screening for malignant neoplasms; cervix
V76.47 Special screening, malignant neoplasms, vagina
V76.49 Special screening, malignant neoplasms, other sites (for patients without a uterus or cervix)
V72.60 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)

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

[D]Administration of PPD Test

CPT Code
86580 Skin test; tuberculosis, intradermal

ICD-9-CM Code
V74.1 Special screening examination for pulmonary Tuberculosis
ICD-10-CM Code
Z11.1 Encounter for screening for respiratory tuberculosis

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

[D]Reading of PPD Test

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

CPT Code
99211 Office or other outpatient services (nurse visit)

ICD-9-CM Code
V74.1 Special screening examination for pulmonary tuberculosis *(if test is negative)*
or
795.51 Nonspecific reaction to tuberculin skin test without active tuberculosis *(if test is positive)*
ICD-10-CM Code
Z11.1 *(if test is negative)*
Or
R76.11 Nonspecific reaction to tuberculin skin test without active tuberculosis (*if test is positive*)

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

[C]Sexually Transmitted Infection Screening

[D]*CPT* Codes

86631 Antibody; chlamydia
86632 Antibody; chlamydia, IgM
86701 Antibody; HIV-1
86703 Antibody; HIV-1 and HIV-2; single assay
87081 Culture, presumptive, pathogenic organisms, screening only
87110 Culture, chlamydia, any source
87205 Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87210 Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87270 Infectious agent antigen detection by immunofluorescent technique; *Chlamydia trachomatis*
87320 Infectious agent detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; *C trachomatis*
87490 Infectious agent detection by nucleic acid (DNA or RNA); *C trachomatis,* direct probe technique
87491 Infectious agent detection by nucleic acid (DNA or RNA); *C trachomatis,* amplified probe technique
87590 Infectious agent detection by nucleic acid (DNA or RNA); *Neisseria gonorrhoeae,* direct probe technique
87591 Infectious agent detection by nucleic acid (DNA or RNA); *N gonorrhoeae,* amplified probe technique
87800 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801 Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe technique
87810 Infectious agent detection by immunoassay with direct optical observation; *C trachomatis*
87850 Infectious agent detection by immunoassay with direct optical observation; *N gonorrhoeae*

[D]*ICD-9-CM* Codes*

V73.88 Special screening examination for other specified chlamydial diseases
V74.5 Special screening examination for bacterial and spirochetal diseases; venereal disease
V75.9 Special screening examination for unspecified infectious disease
V72.60 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)

[C]Urinalysis

For urinalysis by dipstick or table reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, or any number of these constituents, code as follows:

[D]*CPT* Codes

81000 Nonautomated, with microscopy
81001 Automated, with microscopy
81002 Nonautomated, without microscopy
81003 Automated, without microscopy

[D]*ICD-9-CM* Codes*

V77.1 Special screening for diabetes mellitus
V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders
V72.60 Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].

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[A]Crosswalk: Preventive Medicine *ICD-9-CM* Codes into *ICD-10-CM Codes*

ICD-9-CM Code	Descriptor	*ICD-10-CM* Code[a]	Descriptor
Exam/Encounter Codes			
V20.31	Newborn check under 8 days old	**Z00.110**	Newborn check under 8 days old
V20.32	Newborn check 8 to 28 days old	**Z00.111**	Newborn check 8 to 28 days old
V20.2	Routine infant or child health check	**Z00.121** **Z00.129**	Encounter for routine child health examination *with abnormal findings* Encounter for routine child health examination *without abnormal findings*
V70.0	Routine general medical examination at a health care facility	**Z00.00Z00.01**	Encounter for general adult medical examination *without abnormal findings* Encounter for general adult medical examination with abnormal findings
V70.3	Other medical examination for administrative purposes	**Z02.0** **Z02.4** **Z02.5**	Encounter for examination for admission to educational institution Encounter for examination for driving license Encounter for examination for participation in sport
V72.0	Examination of eyes and vision	**Z01.00** **Z01.01**	Encounter for examination of eyes and vision without abnormal findings Encounter for examination of eyes and vision with abnormal findings
V72.11	Encounter for hearing examination following failed hearing screen	**Z01.110**	Encounter for hearing examination following failed hearing screening
V72.19	Other examination of ears and hearing	**Z01.10** **Z01.118**	Encounter for examination of ears and hearing *without abnormal findings*Encounter for examination of ears and hearing *with other abnormal findings*
Screening Codes			
V72.60	Laboratory examination, unspecified (NOTE: Reported secondary to code[s] for screening[s].)	None	
V73.88	Special screening examination for other specified chlamydial diseases	**Z11.8**	Encounter for screening for other infectious and parasitic diseases (Encounter for screening for chlamydia)
V74.1	Special screening examination for pulmonary tuberculosis	**Z11.1**	Encounter for screening for respiratory tuberculosis
V74.5	Special screening examination for bacterial and spirochetal diseases; venereal disease	**Z11.3**	Encounter for screening for infections with a predominantly sexual mode of transmission (excludes HPV and HIV)
V75.9	Special screening examination for unspecified infectious disease	**Z11.9**	Encounter for screening for infectious and parasitic diseases, unspecified
V76.2	Special screening for malignant neoplasms; cervix	**Z12.4**	Encounter for screening for malignant neoplasm of cervix (excludes HPV)
V76.47	Special screening, malignant neoplasms, vagina	**Z12.72**	Encounter for screening for malignant neoplasm of vagina Use additional code to identify acquired absence of uterus (**Z90.71-)**
V76.49	Special screening, malignant neoplasms, other sites (for patients without a uterus or cervix)	**Z12.79** **Z12.89**	Encounter for screening for malignant neoplasm of other genitourinary organs Encounter for screening for malignant neoplasms of other sites
V77.0	Special screening for thyroid disorders	**Z13.29**	Encounter for screening for other suspected endocrine disorder
V77.1	Special screening for diabetes mellitus	**Z13.1**	Encounter for screening for diabetes mellitus
V77.3	Special screening for PKU	**Z13.228**	Encounter for screening for other metabolic disorders
V77.4	Special screening for galactosemia	**Z13.228**	
V77.7	Special screening for other inborn errors of metabolism	**Z13.228**	
V77.91	Screening for lipid disorders	**Z13.220**	Encounter for screening for lipoid disorders
V77.99	Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders	**Z13.21** **Z13.228** **Z13.29**	Encounter for screening for nutritional disorderEncounter for screening for other metabolic disorder Encounter for screening for other suspected endocrine disorder
V78.0	Special screening for iron deficiency anemia	**Z13.0**	Encounter for screening for diseases of the blood and blood-forming organs and certain disordersinvolving the immune mechanism
V78.1	Special screening for other and unspecified deficiency anemia	**Z13.0**	

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V78.2	Special screening for sickle cell disease or trait	**Z13.0**	
V78.3	Special screening for other hemoglobinopathies	**Z13.0**	
V78.8	Special screening for other disorders of blood and blood-forming organs	**Z13.0**	
V79.0	Special screening for depression	**Z13.89**	Encounter for screening for other disorders (depression)
V79.3	Special screening for developmental handicaps in early childhood	**Z13.4**	Encounter for screening for certain developmental disorders in childhood (*excludes routine screening)*
V79.8	Special screening for other specified mental disorders and developmental handicaps	**Z13.4**	Encounter for screening for certain developmental disorders in childhood *(excludes routine screening)*
V82.5	Special screening for chemical poisoning and other contamination	**Z13.88**	Encounter for screening for disorder due to exposure to contaminants
Other Codes			
V03–V06.9	Need for prophylactic vaccination and inoculation	**Z23**	Encounter for immunization
V15.83	Underimmunized status	**Z28.3**	Underimmunized status

[a]*International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* codes do not become effective until October 1, 2014. Use of these codes prior to that date will result in a carrier denial. Please do not implement these codes until they are effective.

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+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

The Business Case for **Pricing Immunization Administration**
In a Federal or State Supplied Vaccine Environment

One of the goals of the American Academy of Pediatrics (AAP), shared by the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), is to promote maximum immunization coverage for all infants, children, adolescents, and young adults. To achieve this goal, physicians must be paid a fee that includes three components: the entire costs (direct and indirect) of vaccine product-related expenses, vaccine administration expenses, and a realistic margin for overall overhead expenses.

AAP Endorsed Principles for Enhancing Access to Vaccines for Children (VFC) Immunizations

To optimize access to the VFC program, the following principles are proposed:

1. **Federal and State vaccine policies should support the VFC program and no policy should inadvertently or deliberately decrease opportunities for vaccine distribution and immunization administration**

2. **All stakeholders (vaccine manufacturers, payers, providers, local, state and federal agencies and programs) should cost share the resources to supply and store vaccines for VFC including appropriate storage units (refrigerators and freezers), temperature monitors, locks and alarms. Pediatricians should not be financially liable for storage accidents that are outside of the practice's control (i.e., power disruptions, weather calamities, acts of God, etc.) and not due to gross negligence by the practice.**

3. **State VFC programs must ensure timely and accurate verification of VFC eligibility that does not place undue administrative and financial burden to physician practices. There must be safeguards to protect and limit liability (including financial) to the physician practice from incorrect eligibility information by the family and/or VFC program.**

4. **Pediatricians should not be penalized for swapping of vaccines to correct supply issues between private purchase, VFC, CHIP, 317 funded or Medicaid vaccine supplies.**

5. **As fiduciary agents of VFC supplied vaccines, pediatricians should be accountable for reasonable tracking methodology of vaccines in their practice that does not place an undue or unnecessary administrative or financial burden to the practice.**

The pediatric practice is the backbone of the immunization delivery infrastructure. It is a business venture that must run on sound, generally accepted business principles to remain solvent and vaccine purchase, storage, maintenance, counseling, administration, and overhead expenses related to these activities are among the top expenses for the pediatric practice. Private physician practice for children, as we know it, will fail if the total cost of providing immunizations exceeds payments for that service. Therefore, payments from public and private sector payers must ensure recovery of the total direct and indirect practice expenses, including the time spent counseling families on the indications for and potential adverse effects of each vaccine product.

Federal and state provided vaccines represent benefits and challenges for vaccinating children. In the Vaccines for Children (VFC) program, a federal program administered by the states, the vaccine product is provided at no cost to physician offices to administer to children meeting eligibility criteria. Some states have created universal purchase programs, which purchase all vaccine for all children in the state and distribute it to immunization sites, including pediatric practices. The greatest benefit of the VFC and universal purchase programs is that the vaccine product is provided to practices at no upfront cost, thus relieving the provider of the financial outlay to purchase the vaccine product. However, practices incur additional overhead expenses for vaccines, including storage, maintenance, inventory, administration, and vaccine spoilage and loss. In the private sector, those expenses would be covered through the vaccine product payment. As the vaccine product payment does not exist for VFC vaccine or in a universal purchase state, all overhead costs related to the vaccine product still must be paid either through enhanced payment of the immunization administration fee, or some other arrangement by the payer. It is important for payers, particularly for public payers, to recognize and cover all costs associated with the vaccine and its administration, even if the vaccine product is provided at no cost.

<u>Immunization Administration Fees</u>

The Centers for Medicare and Medicaid Services (CMS) uses its Medicare Resource-Based Relative Value Scale (RBRVS), which assigns relative value units (RVUs) to services based on the resources utilized. The RVUs of a *Current Procedural Terminology* (CPT) code take into account the physician work, practice expenses, and professional insurance liability expenses associated with that service. For immunization administration, these components are detailed below.

1. Physician Work Component: The total value of physician work contained in the Medicare RBRVS physician fee schedule includes:

- Physician time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with the physician's concerns about the iatrogenic risk to the patient

2. Practice Expense Component: Medicare RBRVS uses both direct and indirect practice expenses to determine practice expense RVUs, including the resources used within the facility or physician's office (or patient's home) in providing the service. The practice expense component of the immunization administration fee includes: 1) clinical staff time (RN/LPN/MA blend, including time for vaccine registry input, refrigerator/freezer temperature log monitoring/documentation, and refrigerator/freezer alarm monitoring/documentation); 2) medical supplies (1 pair non-sterile gloves, 7 feet of exam table paper, 1 OSHA-compliant syringe with needle, 1 CDC information sheet, 2 alcohol swabs, 1 band-aid) and; 3) medical equipment (exam table, dedicated full size vaccine refrigerator with alarm/lock [commercial grade], and refrigerator/freezer vaccine temperature monitor/alarm and/or back-up system, and continuous logging/monitoring devises that must be regularly calibrated and certified).

3. Professional Liability Insurance Expense Component: The professional liability insurance RVUs assigned to a code are based on CMS historic malpractice claims data.

Additional Overhead Costs Related to the Vaccine Product

Maintaining a vaccine inventory incurs costs, whether the vaccine is publically or privately purchased. These vaccine related costs to the physician practice are traditionally covered by payers (i.e., patients, third party payers) as consumers of the vaccine product and immunization service. Because vaccine product is not traditionally billed in a VFC or state supplied vaccine environment, these costs must be covered with enhanced payment for immunization administration or other arrangement.

- ***Personnel costs for ordering and inventory:*** Medical office staff (clinical and administrative) time to monitor vaccine stock; place orders; prepare reports as required; review safe storage procedures are practice expenses that are not included in the practice expense component for immunization administration RVUs.
- ***Storage costs:*** Vaccines must be stored at very specific temperature ranges and, therefore, require special monitoring and storage equipment. The practice expense component of the total immunization administration code pays for part of the vaccine storage costs; however, there are certain expenses that are **not** included that must be compensated: freezer(s), freezer lock(s), freezer alarm system(s), and generators for continued electrical supply (all of which are depreciated).
- ***Insurance against loss of the vaccine:*** Professional liability malpractice insurance does not cover vaccine product, so additional insurance coverage is needed by the practice. This is especially important as states implement recovery programs if a practice can no longer use their vaccine stock due to disasters, equipment failure, etc.
- ***Recovery of costs attributable to uncontrollable circumstances*:** If practices are held accountable for lost vaccine, this could include situations of drawing up the vaccine and having the patient/family reconsider and refuse or a loss of dose that may occur in attempting to vaccinate an uncooperative/combative patient.
- ***Federal or state-specific requirements:*** In an environment where vaccine is supplied, there are frequently additional inventory and reporting requirements, which adds staff time that must be compensated appropriately.

Pediatricians must receive adequate payment to cover the total direct and indirect expenses of the vaccine product and the immunization administration service. To account for the indirect (overhead) vaccine expenses, the AAP recommends vaccine payments to be at least 125% of the vaccine cost as reported by the Centers for Centers for Disease Control (CDC) vaccine price list for the private sector.[1,2] One method to ensure payment of vaccine related expenses in a VFC or state supplied vaccine program would be to enhance payment of the Medicare Resource Based Relative Value Scale (RBRVS) physician fee schedule rate for each immunization administration code. For state supplied vaccines, the payment would cover the total relative value of the immunization administration ***plus*** the additional overhead costs of the vaccine product. At a minimum, this rate would be at least 100% of the Medicare Resource Based Relative Value Scale (RBRVS) physician fee schedule rate for each immunization administration code[3] ***plus*** an additional percentage to cover the additional overhead costs of the vaccine product An alternative to this method may be paying on the reported vaccine code a surcharge that reflects the overhead expenses of the vaccine (but not the acquisition cost since the vaccine is state supplied) with separate payment for the immunization administration.

Pediatric practices are the public health infrastructure for the nation's childhood immunization program. It is imperative there be appropriate payment for the vaccine and immunization administration for pediatricians to participate in immunization efforts. Pediatric practices will fail if immunizations are not adequately paid. Complete coverage by payers for the cost and administration of childhood immunizations with a margin for practice overhead is necessary to support immunizations.

References:

[1] American Academy of Pediatrics. Endorsed Principles on Benefit Plan Coverage and Payment, at: http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/PaymentPrinciples.pdf

[2] American Academy of Pediatrics, The Business Case for Pricing Vaccines, at: http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/BusCasePricingVacc.pdf

[3] AAP Committee on Child Health Financing. Principles of Health Care Financing, *Pediatrics* Vol. 126 No. 5 November 1, 2010 pp. 1018 -1021

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Coding and Billing Resources

Coding for Childhood Immunizations

American Academy of Pediatrics (www.aap.org)

https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Resources.aspx

https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Pediatric-Coding-Newsletter.aspx

https://coding.solutions.aap.org/coding-hotline.aspx

https://www.aappublications.org/collection/coding-corner

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Practice-Management/Pages/Practice-Management.aspx

Centers for Medicaid Services (www.cms.hhs.gov)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

Centers for Disease Control and Prevention (www.cdc.gov)

https://www.cdc.gov/vaccines/imz-managers/index.html

Bright Futures (http://brightfuturesaap.org)

https://brightfutures.aap.org/clinical-practice/Pages/Learn-About-Coding-for-Pediatric-Preventive-Care-.aspx

https://www.aap.org/en-us/Documents/coding_preventive_care.pdf

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