

Immunization Coding

for Obstetrician–Gynecologists 2011



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
Women's Health Care Physicians

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Suggestions and comments are welcome. Address your comments to the following:

Division of Women's Health Issues
409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920
Telephone: (202) 863-2498
Fax: (202) 484-7480

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CONTENTS

Introduction **2**

Reimbursement for Vaccinations **3**

Coding for Vaccinations **5**

Coding Examples **10**

Coding Resources **13**

INTRODUCTION

Immunization is coming to the forefront for obstetric–gynecologic practices. Therefore, the American College of Obstetricians and Gynecologists (the College) and its Working Group on Immunization recognized a need for a coding guide solely focused on immunization. Correct coding enables a physician’s office immunization program to be profitable and to satisfy payer scrutiny. Codes condense a large amount of information into a short code description. Proper coding means being sure that the code selected is appropriate as follows:

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

The *Current Procedural Terminology* (CPT) coding guidelines state that the code selected must be the most accurate description of the service provided and be consistent with coding conventions and guidelines. Individuals responsible for coding should carefully review their coding books, including any coding guidelines, notes, instructions, or other explanatory statements. These may be printed under subsections, headings, subheadings, or before and after codes. The physician also should know the bundling and unbundling rules used by CPT, commercial payers, and Centers for Medicare & Medicaid Services.

REIMBURSEMENT FOR VACCINATIONS

Physicians should strive to make their vaccination services at least marginally profitable. In order to accomplish this, a clinical practice must investigate whether their third-party payers cover these services, and if so, whether the payment is allowed for vaccine drugs and administration. The practice then can determine if the services are profitable.

Medicare

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

1. Influenza (once per influenza season). Use CPT codes 90656, 90658, or 90660. They may be linked to diagnosis code V04.81. Payment is 100% of the Medicare allowable reimbursement.
2. Pneumococcal polysaccharide (once per lifetime). Use CPT codes 90669 or 90732 linked to diagnosis code V03.82. Payment is 100% of the Medicare allowable reimbursement.
3. Hepatitis B (for those in medium-risk to high-risk categories). Use CPT codes 90740–90747 linked to diagnosis code V05.3. The Part B deductible and 80% coinsurance apply.

Medicare typically pays for only one flu vaccination per year. If more than one vaccination is medically necessary (eg, multiple doses are required), then Medicare will pay for those additional vaccinations. If Medicare beneficiaries need to receive both a seasonal flu and an H1N1 vaccination, then Medicare will pay for both. If the vaccine is provided free to the health care provider, Medicare will reimburse only for the administration costs. If a patient receives both the influenza shot and a pneumococcal pneumonia virus vaccine during the same visit, use diagnosis code V06.6.

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

Hepatitis B vaccinations are reimbursed only for Medicare beneficiaries considered to be at highest risk and those most likely to have rapid decreases in

antibody levels. Medicare defines highest risk as patients with functional or anatomic asplenia, human immunodeficiency virus (HIV) infection, leukemia, lymphoma, Hodgkin disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression.

Medicare Part B does not cover other immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition (eg, tetanus or exposure to rabies). *The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnosis code attached to the vaccine must define the disease or condition.

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

Medicaid

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

Patients 19–20 years old receive routine immunizations as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Physicians can bill Medicaid for the vaccines and the administration as a fee-for-service. This public program for low-income and medically indigent individuals is administered on a state-by-state basis. Thus, the extent of immunization coverage for adults varies state by state.

Patients 18 years or younger receive vaccinations through the state's Vaccines for Children (VFC) Program. This program is described in the next section.

Vaccines for Children Program

When the Centers for Disease Control and Prevention (CDC) investigated the U.S. measles

epidemic of 1989–1991, it found that more than one half of the children who had measles had not been immunized, even though many had seen a health care provider. In response, Congress created the VFC Program in 1993.

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

- Are eligible for Medicaid
- Are 18 years or younger
- Have no health insurance
- Are Native American or Alaskan Native
- Have health insurance but no immunization coverage. In these cases, these children must go to a Federally Qualified Health Center or Rural Health Clinic to receive their immunizations.

Vaccinations are provided for these diseases:

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

Any physician or physician practice can become a VFC provider. First, contact your State and/or Territory VFC Program Coordinator. A Provider Enrollment Package will be mailed to you. After

submission of this packet, your office will have a site visit. During this visit, a representative from the program will review the administrative requirements of the program and the proper storage and handling of vaccines with physicians and staff.

Because VFC vaccines are provided free of charge to the practice, your office cannot charge the patient for the vaccine product. However, you may charge an administrative fee to offset your costs of doing business. Each state sets a maximum fee that physicians can charge for administering a VFC vaccine. If the patient has no health insurance, a VFC provider cannot refuse to administer a recommended vaccine because a patient is unable to pay the administration fee. However, the health care provider can accept whatever the patient can afford to pay. The administration fee for Medicaid patients is billed to the Medicaid plan. For more information on the VFC program, visit the CDC web site: <http://www.cdc.gov/vaccines/programs/vfc/default.htm>.

Commercial Plans

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

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

The Initial Reproductive Health Visit

The American College of Obstetricians and Gynecologists recommends that a girl’s first visit to the obstetrician–gynecologist take place between the

ages of 13 years and 15 years. This visit is designed to provide health guidance, appropriate screening, and preventive health services. It is an excellent opportunity to discuss on-going immunization status as well as the new recommendations for the human papillomavirus vaccine, tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap), and meningococcal vaccine. The CPT code 99384 is used for a preventive visit for a new patient, aged 12–17 years. The CPT code 99394 is used for a preventive visit for an established patient in the same age range.

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

CODING FOR VACCINATIONS*

ICD-9-CM Diagnosis Codes for Vaccination Services

Diagnosis codes for vaccinations usually are from the V code category (Supplementary Classification of Factors Influencing Health Status and Contact with Health Services) of ICD-9-CM. If a patient is being seen for a specific disease or symptom, report both the code for the disease or symptom and a code for the vaccination.

Diagnosis codes used for vaccinations are categorized as follows:

- Persons with potential health hazards related to communicable diseases, including patients who have been exposed to or had contact with someone with a communicable disease
- Persons with need for isolation, other potential health hazards and prophylactic measures, including prophylactic administration of vaccines

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

- Persons encountering health services in other circumstances, including encounters during which a planned vaccination was not carried out

The diagnosis codes most likely to be reported when vaccinations are administered are listed as follows.

Persons with Potential Health Hazards Related to Communicable Diseases

- Excludes: family history of infectious and parasitic diseases (V18.8)
personal history of infectious and parasitic diseases (V12.0)

- V01 Contact with or exposure to communicable diseases
 - V01.1 Tuberculosis
Conditions classifiable to 010–018
 - V01.4 Rubella
Conditions classifiable to 056
 - V01.5 Rabies
Conditions classifiable to 071
 - V01.7 Other viral diseases
Conditions classifiable to 042–078, and V08, except as above
 - V01.71 Varicella
 - V01.79 Other viral diseases
 - V01.8 Other communicable diseases
Conditions classifiable to 001–136, except as above
 - V01.84 Meningococcus
 - V01.9 Unspecified communicable diseases
- V03 Need for prophylactic vaccination and inoculation against bacterial diseases

Excludes: vaccination not carried out (V64.00–V64.09)
vaccines against combinations of diseases (V06.0–V06.9)

 - V03.2 Tuberculosis [BCG]
 - V03.7 Tetanus toxoid alone
 - V03.8 Other specified vaccinations against single bacterial diseases
 - V03.81 Hemophilus influenza, type B [Hib]
 - V03.82 Streptococcus pneumoniae [pneumococcus]
 - V03.89 Other specified vaccination
 - V03.9 Unspecified single bacterial disease

- V04 Need for prophylactic vaccination and inoculation against certain viral diseases
Excludes: vaccines against combinations of diseases (V06.0–V06.9)
- V04.0 Poliomyelitis
 - V04.2 Measles alone
 - V04.3 Rubella alone
 - V04.5 Rabies
 - V04.6 Mumps alone
 - V04.7 Common cold
 - V04.8 Other viral diseases
 - V04.81 Influenza (includes H1N1)
 - V04.82 Respiratory syncytial virus (RSV)
 - V04.89 Other viral diseases
- V05 Need for other prophylactic vaccination and inoculation against single diseases
Excludes: vaccines against combinations of diseases (V06.0–V06.9)
- V05.3 Viral hepatitis
 - V05.4 Varicella
Chicken pox
 - V05.8 Other specified disease
 - V05.9 Unspecified single disease
- V06 Need for prophylactic vaccination and inoculation against combinations of diseases
Note: Use additional single vaccination codes from categories V03–V05 to identify any vaccinations not included in a combination code.
- V06.1 Diphtheria-tetanus-pertussis, combined [DTP] [DTaP]
 - V06.3 Diphtheria-tetanus-pertussis with poliomyelitis [DTP + polio]
 - V06.4 Measles-mumps-rubella [MMR]
 - V06.5 Tetanus-diphtheria [Td] [DT]
 - V06.6 Streptococcus pneumoniae [pneumococcus] and influenza
 - V06.8 Other combinations
Excludes: multiple single vaccination codes (V03.0–V05.9)

Persons with Need for Isolation, Other Potential Health Hazards and Prophylactic Measures

- V07 Need for isolation and other prophylactic measures
Excludes: prophylactic organ removal (V50.41–V50.49)

- V07.2 Prophylactic immunotherapy
Administration of:
immune sera [gamma globulin]
RhoGAM

Persons Encountering Health Services in Other Circumstances

V64 Persons encountering health services for specific procedures, not carried out

- V64.0 Vaccination not carried out
 - V64.00 Vaccination not carried out, unspecified reason
 - V64.01 Vaccination not carried out because of acute illness
 - V64.02 Vaccination not carried out because of chronic illness or condition
 - V64.03 Vaccination not carried out because of immune compromised state
 - V64.04 Vaccination not carried out because of allergy to vaccine or component
 - V64.05 Vaccination not carried out because of caregiver refusal
Guardian refusal
Parent refusal
 - V64.06 Vaccination not carried out because of patient refusal
 - V64.07 Vaccination not carried out for religious reasons
 - V64.08 Vaccination not carried out because patient had disease being vaccinated against
 - V64.09 Vaccination not carried out for other reason

CPT and Medicare Coding for Vaccinations

Vaccination Procedures

A vaccination procedure has two components: 1) the administration of the vaccine and 2) the vaccine (drug) itself. The administration may be performed by either the physician or qualified nonphysician provider. When both the vaccine drug and the administration are provided by the physician office, report a code for the vaccine and a code for administration of the vaccine.

Table 1. CPT Codes for Vaccine Administration (Single or Combination Vaccine/Toxoid)

Code	Method	Route of Administration	Type of Service	Reporting Rules
90465	Injection	Percutaneous, intradermal, subcutaneous, or intramuscular	Primary	Report only one primary vaccine administration per day. Report for administration of first vaccine if more than one was provided. Physician also provides counseling. Patient is younger than 8 years.
+90466	Injection	Percutaneous, intradermal, subcutaneous, or intramuscular	Additional	Report for secondary or subsequent vaccine administration per day. Physician also provides counseling. Patient is younger than 8 years. Report only with code 90465 or code 90467.
90467	Intranasal or oral	Intranasal or oral	Primary	Report only one primary vaccine administration per day. Report for administration of first vaccine if more than one was provided. Physician also provides counseling. Patient is younger than 8 years.
+90468	Intranasal or oral	Intranasal or oral	Additional	Report for secondary or subsequent vaccine administration. Physician also provides counseling. Patient is younger than 8 years. Report only with code 90465 or code 90467.
90471	Injection	Percutaneous, intradermal, subcutaneous, or intramuscular	Primary	Report only one primary vaccine administration per encounter. Physician also provides counseling.
+90472	Injection	Percutaneous, intradermal, subcutaneous, or intramuscular	Additional	Report for secondary or subsequent vaccine administration. Physician also provides counseling. Report only with code 90471 or code 90473.
90473	Intranasal	Intranasal or oral	Primary or oral	Report only one primary vaccine administration per encounter. Physician also provides counseling.
+90474	Intranasal or oral	Intranasal or oral	Additional	Report for secondary or subsequent vaccine administration. Physician also provides counseling. Report only with code 90471 or code 90473.

Codes for Administration of the Vaccine

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

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

G codes are temporary codes used to identify professional health care services that would be reported using a CPT code if one existed or to

provide more information. Report the G code for administration and the applicable CPT code for the vaccine.

Table 2. Medicare’s HCPCS Codes for Vaccine Administration

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

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

Codes for the Vaccine Drug Product
Both CPT and Medicare use CPT codes 90476–90749 to report the vaccine drugs (see Table 3, Table 4, and Table 5). Beginning in 2006, CPT has included symbol *✓* in front of a code number to indicate

Table 3. Vaccines Commonly Administered to Adolescents and Adults

(Report Both an Administration Code and a Vaccine Code)

Vaccine	Code for Vaccine Product	Administration Codes	
		CPT	Medicare
Hepatitis A, adult, IM	90632	90471–90472	90471–90472
Hepatitis A, adolescent, 2-dose schedule, IM	90633	90471–90472	90471–90472
Hepatitis B, adolescent, 2-dose schedule, IM	90743	90471–90472	G0010
Hepatitis B, pediatric/adolescent, 3-dose schedule, IM	90744	90471–90472	G0010
Hepatitis B, adult, IM	90746	90471–90472	G0010
Hepatitis B, dialysis or immunosuppressed patient, 3-dose schedule, IM	90740	90471–90472	G0010
Hepatitis B, dialysis or immunosuppressed patient, 4-dose schedule, IM	90747	90471–90472	G0010
HepA-HepB, adult, IM	90636	90471–90472	90471–90472
HPV virus, types 6, 11, 16, 18 (quadrivalent), 3-dose schedule, IM	90649	90471–90472	90471–90472
HPV virus types 16, 18 (bivalent), 3-dose schedule, IM	90650	90471–90472	90471–90472
Influenza virus, split, preservative free, patient 3 years of age and older, IM	90656	90471–90472	G0008
Influenza virus, split, patient 3 years of age and older, IM	90658	90471–90472	G0008
Influenza virus, live, intranasal	90660	90473–90474	G0008
Meningococcal polysaccharide, sub	90733	90471–90472	90471–90472
Meningococcal conjugate, serogroups A,C,Y and W-135 (tetraivalent), IM	90734	90471–90472	90471–90472
Pneumococcal polysaccharide, 23-valent, patient 2 years of age or older, sub or IM	90732	90471–90472	G0009
Tetanus toxoid adsorbed, IM	90703	90471–90472	90471–90472
Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, patient 7 years of age or older, IM	90714	90471–90472	90471–90472
Tetanus and diphtheria toxoids (Td) adsorbed, patient 7 years of age or older, IM	90718	90471–90472	90471–90472
Tetanus, diphtheria toxoids and acellular pertussis (Tdap), patient 7 years of age or older, IM	90715	90471–90472	90471–90472
Zoster (shingles), live, sub injection	90736	90471–90472	90471–90472

Abbreviation: HPV, human papillomavirus; IM, intramuscular; sub, subcutaneous.

*Medicare code for vaccine product: G9142

that this vaccine was not approved by the U.S. Food and Drug Administration (FDA) at the time the CPT book was published. Once the vaccine has FDA approval, the code is considered active. The changes in vaccine status are posted at www.ama-assn.org/ama/pub/category/10902.html.

Table 3, Table 4, and Table 5 summarize coding for vaccines and their administration under both CPT and Medicare rules, assuming that you are not immunizing patients who are younger than 8 years. If you are immunizing patients younger than 8 years and providing physician counseling, then you

Table 4. Vaccines Commonly Administered to Children

(Report Both an Administration Code and a Vaccine Code)

Vaccine	Code for Vaccine Product	Administration Codes (CPT and Medicare)
Diphtheria, tetanus toxoids, acellular pertussis, and haemophilus influenza B (DtaP-Hib), IM	90721	90471–90472
Diphtheria, tetanus toxoids, acellular pertussis, haemophilus influenza Type B and poliovirus, inactivated (DTaP-Hib-IPV), IM	90698	90471–90472
Diphtheria, tetanus toxoids, acellular pertussis, hepatitis B, and poliovirus, inactivated (DtaP-HepB-IPV), IM	90723	90471–90472
Diphtheria, tetanus toxoids, and acellular pertussis (DTaP), patient younger than 7 years, IM	90700	90471–90472
Diphtheria and tetanus toxoids (DT), patient younger than 7 years, IM	90702	90471–90472
Hepatitis B and haemophilus influenza B, (HepB-Hib), IM	90748	90471–90472
Haemophilus influenza B, PRP-OMP conjugate, (Hib), 3-dose schedule, IM	90647	90471–90472
Haemophilus influenza B, PRP-T conjugate, (Hib), 4-dose schedule, IM	90648	90471–90472
Influenza virus, split, preservative free, patient 6–35 months of age, IM	90655	90471–90472
Influenza virus, split, patient 6–35 months of age, IM	90657	90471–90472
Measles, mumps and rubella virus (MMR), live, sub	90707	90471–90472
Measles, mumps, rubella and varicella (MMRV), live, sub	90710	90471–90472
Pneumococcal conjugate, polyvalent, patient younger than 5 years, IM	90669	90471–90472
Poliovirus, inactivate (IPV), sub or IM	90713	90471–90472
Rotavirus, pentavalent, live, 3-dose schedule, oral	90680	90473–90474
Varicella virus, live, sub	90716	90471–90472

Abbreviation: IM, intramuscular; sub, subcutaneous.

Table 5. Vaccines Commonly Administered for Travel

(Report Both An Administration Code and a Vaccine Code)

Vaccine	Code for Vaccine Product	Administration Codes (CPT and Medicare)
Japanese encephalitis, sub	90735	90471–90472
Rabies, IM	90675	90471–90472
Typhoid, live, oral	90690	N/A
Typhoid, Vi capsular polysaccharide, IM	90691	90471–90472
Yellow fever, sub	90717	90471–90472

Abbreviation: IM, intramuscular; sub, subcutaneous.

would use codes 90465 and 90466 instead of codes 90471 and 90472 for injectable vaccines and codes 90467 and 90468 instead of codes 90473 and 90474 for intranasal or oral vaccines.

Administration codes:

- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
- +90472 Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
- +90474 Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

CODING EXAMPLES

■ CASE 1

A 72-year-old woman comes in for her annual check-up. She also requests a flu vaccine. The patient has Medicare. The appropriate physical examination is performed and a Pap smear specimen is collected.

Comment:

Medicare allows coverage for a pelvic examination every 2 years; for certain high-risk patients, it is covered annually. Collection of a Pap specimen is also a reimbursable service at the time of these encounters. Other services (eg, vaccines) also may be performed during these encounters and should be coded and billed separately. Medicare requires specific HCPCS codes for these services. The appropriate procedure codes and ICD-9-CM linkages are listed as follows.

- G0101 Medicare pelvic exam
- V72.31 Routine gyn exam
- Q0091 Collection of Pap smear
- V72.31 Routine gyn exam
- 90658 Influenza vaccine (product), IM use
- V04.81 Need for prophylactic vaccination—influenza
- G0008 Influenza vaccine administration
- V04.81 Need for prophylactic vaccination—influenza

■ CASE 2

A 12-year-old new patient is brought to your office by her mother. The patient and her mother want to talk about a variety of topics, including reproductive health, birth control options, and vaccinations. The patient is not sexually active and declines a pelvic examination and collection of a Pap smear specimen. The appropriate history is obtained. A physical examination limited to the head, chest, abdomen, and extremities is performed. Questions are answered and the appropriate counseling is given. The physician then administers an influenza vaccine, a Tdap vaccine, and the first of the series of three HPV vaccines.

Comment:

This is an example of the initial reproductive health visit recommended by the College. This encounter should be coded using the preventive medicine codes. The comprehensive nature of preventive medicine codes reflects an age and gender appropriate history and/or examination and is not synonymous with the comprehensive examination required in other E/M codes. There are no CPT guidelines stating what is included in a preventive visit; it will vary with the needs of each patient. In

this case, a pelvic and breast examination were not necessary. Nevertheless, this encounter is reported as a preventive visit. Other services may be provided at the time of these encounters and should be coded and billed separately. The appropriate procedure codes and ICD-9-CM linkages are listed as follows.

- 99384 Initial comprehensive preventive medicine adolescent (12–17 years)
- V70.0 Routine general medical examination
- 90649 HPV vaccine (quadrivalent) (drug), IM
or
- 90650 HPV virus (bivalent) (drug) IM
- V04.89 Need for prophylactic vaccination—
other viral illnesses
- 90471 Vaccine administration
- V04.89 Need for prophylactic vaccination—
other viral illnesses
- 90658 Influenza vaccine (drug), IM
- V04.81 Need for prophylactic vaccination—
influenza
- +90472 Vaccine administration—additional
vaccine
- V04.81 Need for prophylactic vaccination—
influenza
- 90715 Tdap vaccine (drug), IM
- V06.1 Need for prophylactic vaccination—
Tdap
- +90472 Vaccine administration—additional
vaccine
- V06.1 Need for prophylactic vaccination—
Tdap

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

■ CASE 3

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

Comment:

This example describes a situation where the only service provided in the office is the vaccine administration. The services provided by the nurse are integral to the vaccine administration code. A separate E/M service was not provided in this situation. Because the patient brought the vaccine product with her, it is not appropriate to bill for the vaccine product. The appropriate procedure code and ICD-9-CM linkage is listed as follows.

- 90471 Vaccine administration
- V05.3 Need for prophylactic vaccination—
viral hepatitis

■ CASE 4

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

Comment:

This example illustrates the additional counseling that will be necessary as new vaccinations become available. The additional work involved with this counseling is integral to the preventive medicine visit and not reported separately. The appropriate procedure codes and ICD-9-CM linkages are listed as follows.

- 99395 Periodic comprehensive preventive
medicine 18–39 years
- V72.31 Gyn exam with Pap
- 90649 HPV vaccine (quadrivalent) (drug)
or
- 90650 HPV virus (bivalent) (drug), IM
- V04.89 Need for prophylactic vaccination—
viral disease
- 90471 Vaccine administration
- V04.89 Need for prophylactic vaccination—
viral disease

■ CASE 5

The 21-year-old established patient mentioned in Case 4 returns to the clinic in 1 month for the second of her series of three HPV vaccines. She also

reports dysuria. The office nurse checks her blood pressure, completes the appropriate vaccine informed consent documents, and orders a urinalysis. The urinalysis result is normal. The nurse administers the HPV vaccine, documents the encounter in the medical record, and asks the patient to make a follow-up appointment with her physician to further assess her report of dysuria.

Comment:

This example illustrates an encounter where the nurse provides a separate E/M service distinct from the vaccine administration service. Some vaccines require a multidose regimen. It is appropriate to use the same vaccine product code for each of the three injections. The appropriate procedure codes and ICD-9-CM linkages are listed as follows. Modifier 25 is appended to the E/M encounter to signify the distinct and separate service.

- 99211–25 Office outpatient visit (nursing encounter)
- 788.1 Dysuria
- 81000 Urinalysis
- 788.1 Dysuria
- 90649 HPV vaccine (quadrivalent) (drug)
- or
- 90650 HPV virus (bivalent) (drug), IM
- V04.89 Need for prophylactic vaccination—other viral illnesses
- 90471 Vaccine administration
- V04.89 Need for prophylactic vaccination—other viral illnesses

■ **CASE 6**

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

Comment:

Many times patients will request vaccine services at the time of a problem-oriented visit. It is appropriate to code and bill for the vaccine administration and vaccine product as well as a code for the E/M service. If counseling is extensive and accounts for more than 50% of the total time spent with the

patient, it may be appropriate to code based on time rather than the usual key components of history, physical examination, and medical decision making.

- 99203–25 Office outpatient visit-new patient
- 625.3 Dysmenorrhea
- 90658 Influenza vaccine (drug), IM
- V04.81 Need for prophylactic vaccination—
influenza
- 90471 Vaccine administration
- V04.81 Need for prophylactic vaccination—
influenza

■ **CASE 7**

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

Comment:

Pregnant patients will request, and in some instances require, vaccinations during their pregnancies. Vaccination services performed during pregnancy should be billed separately at the time of the service. You might also add a secondary ICD-9-CM code to indicate any condition that makes the patient high risk for influenza. This will facilitate payment from plans that only cover vaccinations for patients identified as “high-risk patients.” A separate E/M service should not be reported because the office visit is part of the global obstetric package.

- 90656 Preservative-free influenza vaccine (drug), IM
- V04.81 Need for prophylactic vaccination—
influenza
- V22.2 Pregnancy (single) (uterine) (without
sickness)
- 90471 Vaccine administration
- V04.81 Need for prophylactic vaccination—
influenza
- V22.2 Pregnancy (single) (uterine) (without
sickness)

■ **CASE 8**

The patient referenced in Case 7 is now at 28 weeks of gestation. She is Rh negative and is administered antenatal Rh immune globulin.

Comment:

It is appropriate to code and bill for the Rh immune globulin administration outside the global obstetric

package. Some payers may require the use of special HCPCS codes (“J” codes) to identify the Rh immune globulin product. Also, note that the CPT codes for administration of immune globulins are different than those used for administration of vaccines.

- 90384 Rho(D) immune globulin (RhIg),
or full dose (drug), IM
J2790
- V07.2 Prophylactic administration of RhoGAM
- 96372 Immune globulin administration,
subcutaneous or IM
- V07.2 Prophylactic administration of
RhoGAM

■ CASE 9

The patient referenced in Case 7 and Case 8 is now 6 weeks postpartum. On her antenatal screening, her Rubella titer was negative. She is given a measles, mumps, and rubella vaccination. It also is noted that the patient has not received a pertussis immunization. The Advisory Committee on Immunization Practices recommends that individuals in close contact with infants should receive a pertussis immunization to prevent the spread of pertussis to the infant. The patient is given a Tdap vaccine.

Comment:

The postpartum visit will, often times, require vaccination services. Again, these services should be coded and billed outside the global obstetric package. A separate E/M service should not be reported because the 6-week postpartum visit is part of the global obstetric package.

- 90707 MMR vaccine (drug), subcutaneous
- V06.4 Need for prophylactic vaccination—
MMR
- 90471 Vaccine administration
- V06.4 Need for prophylactic vaccination—
MMR
- 90715 Tdap vaccine (drug), IM
- V06.1 Need for prophylactic vaccination—
Tdap
- +90472 Vaccine administration—additional
vaccine
- V06.1 Need for prophylactic vaccination—
Tdap

CODING RESOURCES

Most ob-gyns will have the most current edition of *The Essential Guide to Coding in Obstetrics and Gynecology* in their offices. They may also be familiar with these coding tools:

- *Healthcare Common Procedure Coding System* (HCPCS)—a coding system established in 1978 as a way to standardize identification of medical services, supplies, and equipment. There are two sets of codes. The first, or Level I of the HCPCS comprises *Current Procedural Terminology* (CPT), a numeric coding system maintained by the American Medical Association (AMA). The second, or Level II, is a code set for medical services not included in Level I, such as durable medical equipment, prosthetics, orthotics, and supplies.
- American Medical Association’s *Current Procedural Terminology* (CPT)—the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. It was developed by the American Medical Association in 1966. Each year, an annual publication is prepared that makes changes corresponding with significant updates in medical technology and practice.
- *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM)—is based on the World Health Organization’s Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates.

A number of resources have been developed to assist physicians with selecting the correct codes and interacting with third-party payers. In addition to these publications, coding workshops, coding webcasts, and a web site for questions and information is provided at www.acog.org. Publications listed as follows can be ordered through the Publications and Educational Materials catalog, online at acog.org/bookstore, or from the distribution center (1-800-762-2264).

- *ICD-9-CM Abridged, Diagnostic Coding in Obstetrics and Gynecology*—this book provides all the ICD-9-CM diagnosis codes most commonly reported by obstetrician–gynecologists in the same format as the complete ICD-9-CM book. This version also includes guides to assist with diagnostic reporting of pregnancy termination, follow-up visits for Pap tests, and obstetric ultrasound examinations. This book is revised annually.
- *Ob/Gyn Coding Manual: Components of Correct Procedural Coding with CD-ROM*—this 400+ page book provides important information to assist physicians in correct coding for surgical procedures commonly performed by obstetrician–gynecologists. Each code is listed with services that are part of the procedure’s global surgical package, information about whether Medicare will reimburse for an assistant or co-surgeons for the procedure, and other coding hints. In addition, it includes information about the included and/or excluded services according to both Medicare’s Correct Coding Initiative and ACOG’s Committee on Coding to note when these opinions differ. This information may be useful in preparing appeals to third-party payers, made simpler with the included CD. Also included are sections on reproductive medicine, modifiers, relative value units, and bundling issues. This book and CD are revised annually.
- *Frequently Asked Questions in Obstetric and Gynecologic Coding*—this book includes more than 100 often asked coding questions received from ACOG Fellows throughout the past few years. ACOG’s Committee on Coding and Nomenclature developed the answers. Subjects include gynecologic surgery, emergency medicine services, laboratory services, modifiers, infertility, laparoscopy and hysteroscopy, Medicare, obstetrics, and ultrasound examinations. Revised every odd year.
- *The Essential Guide to Coding in Obstetrics and Gynecology*—this publication includes information from ACOG’s coding workshop syllabus and other ACOG coding resources not in workbook format. The book covers coding diagnoses and procedures, E/M Services, gynecologic surgery, obstetric services, ultrasound procedures, infusions, injections, immunizations, vaccinations, services to Medicare patients, and preventive care. Other chapters discuss use of modifiers and dealing with third-party payers. Revised every even year.
- *Procedural Coding in Obstetrics and Gynecology*—this booklet provides an introduction to the basics of CPT, Fourth Edition, procedure coding and to the new codes for the current year. In addition, chapters are devoted to ultrasound examinations and clarifying the sometimes confusing issue of modifiers. Revised every odd year.