Immunization Coding for Obstetrician–Gynecologists

2016
Contents

Introduction  1

Reimbursement for Vaccinations  2

Coding for Vaccinations  6

Coding Examples  15

Coding Resources  21
Introduction

Immunizations are recommended as part of comprehensive care for women. Under the Affordable Care Act, vaccines recommended by the Advisory Committee on Immunization Practices are required to be provided with no cost sharing (ie, no co-pay) for children, adolescents, and adults. Check the list of vaccines covered (www.hhs.gov/healthcare/facts/factsheets/2010/09/The-Affordable-Care-Act-and-Immunization.html) for more information about the Affordable Care Act. The American College of Obstetricians and Gynecologists (the College) and its Immunization Expert Work Group recognized a need for a coding guide solely focused on immunization. Correct coding helps ensure that a practice receives payment for the vaccines given to patients. Proper coding means being sure that the code selected is appropriate as follows:

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

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

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

Medicare

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

1. Influenza (once per influenza season). Use CPT codes 90630, 90654, 90656, 90658, 90660, or 90662 or Q codes Q2034, Q2035, Q2036, Q2037, Q2038, or Q2039. They may be linked to ICD-10 diagnosis code Z23 (Encounter for immunization). Payment is 100% of the Medicare allowable reimbursement.

Influenza Vaccine Product

CPT codes:

- 90653 Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
- 90672 Influenza virus vaccine, quadrivalent, live, for intranasal use
- 90673 Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
- 90686 Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
- 90688 Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years and older, for intramuscular use

2. Pneumococcal polysaccharide (once per lifetime). Use CPT codes 90669 or 90732 linked to diagnosis code Z23. Payment is 100% of the Medicare allowable reimbursement.


Note: Although ICD-9-CM contained distinct codes for the various immunizations performed, ICD-10-CM contains a single code for immunizations (Z23 - Encounter for immunization). The CPT or Healthcare Common Procedure Coding System (HCPCS) codes linked to diagnosis code Z23 will identify the specific immunizations administered.
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 a patient receives the influenza vaccine and a pneumococcal pneumonia virus vaccine during the same visit, use diagnosis code Z23.

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

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

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

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

**Medicaid**

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

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

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

**Vaccines for Children Program**

When the Centers for Disease Control and Prevention (CDC) investigated the U.S. measles epidemic of 1989–1991, it found that more than one half of the children who had measles had not been immunized, even though many had seen a health care provider. In response, Congress created the VFC program in 1993.
The VFC program provides free vaccines to doctors who serve eligible children. It is administered at the national level by the CDC through the National Immunization Program. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Eligible children are those who meet the following criteria:

- Are eligible for Medicaid
- Are 18 years or younger
- Have no health insurance
- Are Native American or Alaska Native
- Have health insurance but no immunization coverage. In these cases, these children must go to a federally qualified health center or rural health clinic to receive their immunizations.

Vaccinations are provided for the following diseases:

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

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

Commercial Plans

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

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

The Initial Reproductive Health Visit

The College 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 ongoing immunization status as well as the new recommendations for the human papillomavirus vaccine; tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine; and meningococcal vaccine. The CPT code 99384 (Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent [age 12–17 years]) is used for a preventive visit for a new patient aged 12–17 years. The CPT code 99394 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent [age 12–17 years]) is used for a preventive visit for an established patient in the same age range.

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

ICD-10-CM Diagnosis Codes for Vaccination Services

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

Diagnosis codes used for vaccinations are categorized as follows:

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

The diagnosis codes most likely to be reported when vaccinations are administered to individuals with potential health hazards related to communicable diseases are listed as follows:

Excludes: carrier of infectious disease (Z22.-)
diagnosed current infectious or parasitic disease (Z22)
personal history of infectious and parasitic diseases (Z86.1-)

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

*Note that a dash (-) indicates that an additional character is required to complete this code.
- Z20.811 Meningococcus
- Z20.9 Unspecified communicable diseases
- Z23 Encounter for immunization
- Z51.89 Encounter for other specified aftercare (Includes: isolation)
- Z41.8 Encounter for other procedures for purposes other than remedying health state (Includes administration of Immune sera [gamma globulin] RhoGAM, antivenin, and tetanus antitoxin)

Immunization not carried out and underimmunization status:

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

Vaccination Procedures

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

Codes for Administration of the Vaccine

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Vaccine</th>
<th>Specific Method</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0008</td>
<td>Influenza</td>
<td>Injection</td>
<td>Primary</td>
</tr>
<tr>
<td>G0009</td>
<td>Pneumococcal</td>
<td>Injection</td>
<td>Primary</td>
</tr>
<tr>
<td>G0010</td>
<td>Hepatitis B</td>
<td>Injection</td>
<td>Primary</td>
</tr>
</tbody>
</table>

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

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

Codes for the Vaccine Drug Product

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

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

The following are administration codes:

- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
- +90472 Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
- +90474 Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)
**Table 3. Vaccines Commonly Administered to Adolescents and Adults (Report an Administration Code and a Vaccine Code)**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Code for Vaccine Product</th>
<th>Administration Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CPT</td>
</tr>
<tr>
<td><strong>Hepatitis A, adult, IM</strong></td>
<td>90632</td>
<td>90471–90472</td>
</tr>
<tr>
<td><strong>Hepatitis A, adolescent, 2-dose schedule, IM</strong></td>
<td>90633</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>Hepatitis A, pediatric/adolescent dosage, 3-dose schedule, IM</strong></td>
<td>90634</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>Hepatitis B, adolescent, 2-dose schedule, IM</strong></td>
<td>90743</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>Hepatitis B, pediatric/adolescent, 3-dose schedule, IM</strong></td>
<td>90744</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>Hepatitis B, adult, 3-dose schedule, IM</strong></td>
<td>90746</td>
<td>90471–90472</td>
</tr>
<tr>
<td><strong>Hepatitis B, adult, 2-dose schedule, IM</strong></td>
<td>90739</td>
<td>90471–90472</td>
</tr>
<tr>
<td><strong>Hepatitis B, dialysis or immunosuppressed patient, 3-dose schedule, IM</strong></td>
<td>90740</td>
<td>90471–90472</td>
</tr>
<tr>
<td><strong>Hepatitis B, dialysis or immunosuppressed patient, 4-dose schedule, IM</strong></td>
<td>90747</td>
<td>90471–90472</td>
</tr>
<tr>
<td><strong>HepA–HepB, adult, IM</strong></td>
<td>90636</td>
<td>90471–90472</td>
</tr>
<tr>
<td><strong>HPV virus types 6, 11, 16, 18 (quadrivalent); 3-dose schedule; IM</strong></td>
<td>90649</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>HPV virus types 16, 18 (bivalent); 3-dose schedule; IM</strong></td>
<td>90650</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>HPV types 6, 11, 16, 31, 33, 45, 52, 58 (nonavalent); 3-dose schedule; IM</strong></td>
<td>90651</td>
<td>90460–90472</td>
</tr>
<tr>
<td><strong>Influenza virus, quadrivalent (IIV4), split virus, preservative free, for intradermal use</strong></td>
<td>90630</td>
<td>90460–90472</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Code for Vaccine Product</th>
<th>Administration Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza virus, trivalent, split virus, preservative free, patient 3 years or older, IM</td>
<td>90656</td>
<td>90460–90472 G0008</td>
</tr>
<tr>
<td>Influenza virus, trivalent, split virus, patient 3 years or older, IM</td>
<td>90658</td>
<td>90460–90472 G0008</td>
</tr>
<tr>
<td>Influenza virus, trivalent, live, intranasal</td>
<td>90660</td>
<td>90473–90474 G0008</td>
</tr>
<tr>
<td>Influenza virus, quadrivalent, live, intranasal</td>
<td>90672</td>
<td>90473–90474 G0008</td>
</tr>
<tr>
<td>Influenza virus, quadrivalent, split virus, preservative free, IM</td>
<td>90686</td>
<td>90473–90474 G0008</td>
</tr>
<tr>
<td>Meningococcal polysaccharide, sub</td>
<td>90733</td>
<td>90473–90474 90471–90472</td>
</tr>
<tr>
<td>Meningococcal conjugate; serogroups A, C, Y and W-135 (tetravalent); IM</td>
<td>90734</td>
<td>90460–90472 90471–90472</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide, 23-valent, patient 2 years or older, subcutaneous or IM</td>
<td>90732</td>
<td>90460–90472 90471–90472</td>
</tr>
<tr>
<td>Tetanus toxoid adsorbed, IM</td>
<td>90703</td>
<td>90460–90472 90471–90472</td>
</tr>
<tr>
<td>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, patient 7 years or older, IM</td>
<td>90714</td>
<td>90460–90472 90471–90472</td>
</tr>
<tr>
<td>Tetanus and diphtheria toxoids and acellular pertussis (Tdap), patient 7 years or older, IM</td>
<td>90715</td>
<td>90460–90472 90471–90472</td>
</tr>
<tr>
<td>Zoster (shingles), live, subcutaneous</td>
<td>90736</td>
<td>90471–90472 90471–90472</td>
</tr>
</tbody>
</table>

### Table 4. Medicare Coding for Influenza

<table>
<thead>
<tr>
<th>Vaccine (Description)</th>
<th>Code for Vaccine Product</th>
<th>Administration Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza virus vaccine, split virus, for intramuscular use (Agriflu)</td>
<td>Q2034</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, split virus, when administered to individuals 3 years or older, for intramuscular use (Afluria)</td>
<td>Q2035</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, split virus, when administered to individuals 3 years or older, for intramuscular use (Flulaval)</td>
<td>Q2036</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, split virus, when administered to individuals 3 years or older, for intramuscular use (Fluvirin)</td>
<td>Q2037</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, split virus, when administered to individuals 3 years or older, for intramuscular use (Not otherwise specified)</td>
<td>Q2039</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, trivalent, split virus, preservative free, for intradermal use</td>
<td>90654</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years or older, for intramuscular use</td>
<td>90656</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, trivalent, live, for intranasal use</td>
<td>90660</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use</td>
<td>90662</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use</td>
<td>90653</td>
<td>G0008</td>
</tr>
<tr>
<td>Influenza virus, quadrivalent, split virus, preservative free, for intramuscular use</td>
<td>90686</td>
<td>G0008</td>
</tr>
</tbody>
</table>
### Table 5. Vaccines Commonly Administered to Children
(Report an Administration Code and a Vaccine Code)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Code for Vaccine Product</th>
<th>Administration Code (CPT and Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria and tetanus toxoids and acellular pertussis, and hemophilus influenza B (DtaP-Hib), IM</td>
<td>90721</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Diphtheria and tetanus toxoids and acellular pertussis, hemophilus influenza B and poliovirus, inactivated (DTaP-Hib-IPV), IM</td>
<td>90698</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Diphtheria and tetanus toxoids and acellular pertussis, hepatitis B, and poliovirus, inactivated (DtaP-HepB-IPV), IM</td>
<td>90723</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Diphtheria, tetanus toxoids, acellular pertussis (DTaP), patient younger than 7 years, IM</td>
<td>90700</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Diphtheria and tetanus toxoids (DT), patient younger than 7 years, IM</td>
<td>90702</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Hepatitis B and hemophilus influenza B (HepB-Hib), IM</td>
<td>90748</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Hemophilus influenza B (Hib), PRP-OMP conjugate, 3-dose schedule, IM</td>
<td>90647</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Hemophilus influenza B (Hib), PRP-T conjugate, 4-dose schedule, IM</td>
<td>90648</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Influenza virus, split, preservative free, patient 6–35 months of age, IM</td>
<td>90655</td>
<td>90460–90461</td>
</tr>
<tr>
<td>Influenza virus, split, patient 6–35 months of age, IM</td>
<td>90657</td>
<td>90460–90461</td>
</tr>
<tr>
<td>Measles–mumps–rubella virus (MMR), live, subcutaneous</td>
<td>90707</td>
<td>90471–90472</td>
</tr>
<tr>
<td>Measles–mumps–rubella and varicella (MMRV), live, subcutaneous</td>
<td>90710</td>
<td>90460–90472</td>
</tr>
</tbody>
</table>

(continued)
### Table 5. Vaccines Commonly Administered to Children
(Report an Administration Code and a Vaccine Code)  
(continued)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Code for Vaccine Product</th>
<th>Administration Code (CPT and Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcal conjugate vaccine, 7-valent, IM specification</td>
<td>90669</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Poliovirus, inactivate (IPV), subcutaneous or IM</td>
<td>90713</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Rotavirus, pentavalent, live, 3-dose schedule, oral</td>
<td>90680</td>
<td>90460–90461, 90473–90474</td>
</tr>
<tr>
<td>Varicella virus, live, subcutaneous</td>
<td>90716</td>
<td>90460–90472</td>
</tr>
</tbody>
</table>


### Table 6. Vaccines Commonly Administered for Travel
(Report an Administration Code and a Vaccine Code)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Code for Vaccine Product</th>
<th>Administration Code (CPT and Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japanese encephalitis, subcutaneous</td>
<td>90735</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Rabies, IM</td>
<td>90675</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Typhoid vaccine, live, oral</td>
<td>90690</td>
<td>90460–90461, 90473–90474</td>
</tr>
<tr>
<td>Typhoid, Vi capsular polysaccharide, IM</td>
<td>90691</td>
<td>90460–90472</td>
</tr>
<tr>
<td>Yellow fever, live, subcutaneous</td>
<td>90717</td>
<td>90460–90472</td>
</tr>
</tbody>
</table>

Coding Examples

**Case 1**
A 65-year-old woman comes in for her annual check-up. She also requests a flu vaccine. The patient has Medicare. The appropriate physical examination is performed and a Pap test specimen is collected because of her risk factors.

*Comment:* Medicare allows coverage for a pelvic examination every 2 years; 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 (e.g., vaccines) also may be performed during these encounters and should be coded and billed separately. Medicare requires specific HCPCS codes for these services. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

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

**Case 2**
A 13-year-old new patient is brought to the office by her mother. The patient and her mother want to talk about a variety of topics, including reproductive health, birth control options, and vaccinations.

The appropriate history is obtained. A physical examination limited to the head, chest, abdomen, and extremities is performed. Questions are answered and the appropriate counseling is given. The physician then administers an influenza vaccine, a Tdap vaccine, and the first of the series of three HPV vaccines.

*Comment:* This 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, examination, or both, and is not synonymous with the comprehensive examination required in other E/M codes. There are no CPT guidelines stating what
is included in a preventive visit; it will vary with the needs of each patient. In this case, a pelvic examination and breast examination were not necessary. Nevertheless, this encounter is reported as a preventive visit. Other services may be provided at the time of these encounters and should be coded and billed separately. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 99384  Initial comprehensive preventive medicine adolescent (12–17 years)
- Z01.419  Encounter for gynecologic examination (general) (routine) without abnormal findings
- 90649  HPV vaccine (quadrivalent) (drug), IM

Or

- 90650  HPV virus (bivalent) (drug), IM

Or

- 90651  HPV types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent, 3-dose schedule, IM
- Z23  Encounter for immunization
- 90460  Vaccine administration
- Z23  Encounter for immunization
- 90658  Influenza virus vaccine (trivalent split virus) (drug), IM
- Z23  Encounter for immunization
- 90460  Vaccine administration
- Z23  Encounter for immunization
- 9071  Tdap vaccine (drug), IM
- Z23  Encounter for immunization
- 90460  Vaccine administration
- +90461  Additional vaccine component
- +90461  Additional vaccine component

**Case 3**

A 34-year-old established patient requests assistance in obtaining a hepatitis B vaccine. Her insurance plan requires her to obtain the vaccine product from her local pharmacy. She brings the appropriately stored vaccine to the office. The office nurse sees the patient, checks her blood pressure, obtains appropriate informed consent documents, and administers the hepatitis B vaccine.
Comment:
This example describes a situation in which the only service provided in the office is the vaccine administration. The services provided by the nurse are integral to the vaccine administration code. A separate E/M service was not provided in this situation. Because the patient brought the vaccine product with her, it is not appropriate to bill for the vaccine product. The appropriate procedure code and ICD-10-CM linkage are listed as follows:

- Z23 Encounter for immunization
- 90471 Vaccine administration

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

CASE 4
A 21-year-old established patient comes in for her wellness examination. She has questions about the HPV vaccine. In addition to the usual age-appropriate history, counseling, comprehensive physical examination, and Pap test, the patient is given information regarding the requested vaccine. Her questions are answered and she requests that the first of the series of three vaccinations be given.

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

- 99395 Periodic comprehensive preventive medicine 18–39 years
- Z01.419 Encounter for gynecologic examination (general) (routine) without abnormal findings
- 90649 HPV vaccine (quadrivalent) (drug), IM
  Or
- 90650 HPV virus (bivalent) (drug), IM
  Or
- 90651 HPV virus (nonavalent) (drug), IM
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization
**Case 5**

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

**Comment:**

This example illustrates an encounter 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. Modifier 25 is appended to the E/M encounter to signify the distinct and separate service. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 99211–25  Office outpatient visit (nursing encounter)
- R30.0  Dysuria
  Or
- R30.9  Painful micturition, unspecified
- 81000  Urinalysis
- R30.0  Dysuria
  Or
- R30.9  Painful micturition, unspecified
- 90649  HPV vaccine (quadrivalent) (drug), IM
  Or
- 90650  HPV virus (bivalent) (drug), IM
  Or
- 90651  HPV virus (nonavalent) (drug), IM
- Z23  Encounter for immunization
- 90471  Vaccine administration
- Z23  Encounter for immunization

**Case 6**

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

**Comment:**

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

- 99203–25 Office outpatient visit new patient
- N94.4 Primary dysmenorrhea
- 90658 Influenza vaccine (trivalent) (drug), IM
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization

**Case 7**

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

**Comment:**

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

- 90656 Preservative-free influenza vaccine (trivalent) (drug), IM
  Or
- 90686 Influenza vaccine (quadrivalent), IM
  Or
- 90658 Influenza virus (trivalent), patient 3 years of age and older, IM
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z3A.12 12 weeks of gestation (optional)
■ **Case 8**

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

*Comment:*

It is appropriate to code and bill for the Rh immune globulin administration outside of 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 globulin are different than those used for administration of vaccines. The appropriate procedure codes and ICD-10-CM linkages are listed as follows:

- 90384 Rho(D) immune globulin (RhIg), full dose (drug), IM
  - Or
  - J2790 Injection, Rho D immune globulin, human, full dose, 300 micrograms (1,500 international units)
- 96372 Injection (therapeutic, prophylactic, or diagnostic), subcutaneous or IM
- 90715 Tdap vaccine (drug), IM
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z23 Encounter for immunization
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester
- Z3A.28 28 weeks of gestation (optional)

■ **Case 9**

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

*Comment:*

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

- 90707 MMR vaccine, live (drug), subcutaneous
- Z23 Encounter for immunization
- 90471 Vaccine administration
- Z39.2 Encounter for routine postpartum follow-up
Coding Resources

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

*Ob/Gyn Coding Manual: Components of Correct Procedural Coding* with thumb drive (http://sales.acog.org)—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 cosurgeons for the procedure, and other coding hints. In addition, it contains information about the included and excluded services according to Medicare’s Correct Coding Initiative and the American College of Obstetricians and Gynecologists’ Committee on Health Economics and Coding to note when these opinions differ. This information may be useful in preparing appeals to third-party payers, and it is made simpler with the included thumb-drive. Also included are sections on reproductive medicine, modifiers, relative value units, and bundling issues. This book and thumb drive are revised annually.

Other coding resources include the following:

- **Healthcare Common Procedure Coding System** (HCPCS)—A coding system established in 1978 as a way to standardize identification of medical services, supplies, and equipment. There are two sets of codes. The first level, or Level I, of the HCPCS comprises CPT, a numeric coding system maintained by the American Medical Association. The second level, or Level II, is a code set for medical services not included in Level I, such as durable medical equipment, prosthetics, orthotics, and supplies.

- **American Medical Association’s Current Procedural Terminology** (CPT)—The most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. It was developed by the American Medical Association in 1966. Each year, an annual publication is prepared that makes changes corresponding with significant updates in medical technology and practice.

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

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