

# Network OWL Booklet

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*If you have any coding questions, concerns, or are in need of assistance; please feel free to contact the Provider Services at 386.676.7100 ext. 7247 during normal business hours.*

*Thank you*



Ref #: GI-1

## Ambulatory Blood Pressure Monitoring

Medicare covers Ambulatory Blood Pressure Monitoring for patients with suspected “white coat hypertension”. The proper coding for the Ambulatory Blood Pressure Monitoring is as follows:

**CPT Code 93784** Ambulatory Blood Pressure Monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, including recording, scanning analysis, interpretation and report

**ICD-10 Code R03.0** Elevated blood pressure reading without diagnosis of hypertension



Ref #: GI-2

## Hypertension Education, Counseling, & Nutrition

In an effort to increase FHCPs members' health, avert long term illnesses associated with Hypertension, and assist in meeting one of our NCQA projects our Chief Medical Officer has requested the following action.

All members who have been diagnosed by their Physician as having Hypertension should receive Education, Counseling, and Nutritional Information as it pertains to their disease. This should ideally be given upon the first time the member has been diagnosed; however Education, Counseling, and or Nutritional Information may be given at any point within the calendar year.

This service must be done by the Physician and **clearly** documented within the note for that day's visit. Please remember that the code for Hypertension is I10. Please use the chart below for the codes to be used for Education, Counseling, and Nutrition; along with the appropriate E/M code for the member's visit.

- **Z71.3:** Dietary Counseling & Surveillance
- **Z71.89:** Other Specified Counseling

*Remember patients without a definite diagnosis of Hypertension who just have an increased Bp reading would be coded to R03.0.*



## **Impacted Cerumen Removal Via Lavage or Instrumentation**

Removal of impacted cerumen by Lavage /Irrigation is usually performed by flushing warm water into the ear canal to loosen cerumen and remove it by suction or the force of the water. This is commonly done in Nurse Clinics or in Office with Bulb or Suction canister, either perform by Nurse or at times Physician. Cerumen Softening Agents may or may not be utilized prior to or during procedure.

**Cerumen Removal by Lavage or Irrigation should be reported as follows:**

- **69209:** Removal of Impacted Cerumen using Irrigation/Lavage, Unilateral
- **H61.21:** Impacted Cerumen Right Ear
- **H61.22:** Impacted Cerumen Left Ear
- **H61.23:** Impacted Cerumen Bilateral

Removal of impacted cerumen by instrumentation is usually performed by Physician; however another Qualified Healthcare Provider may perform this “incident to”. **This method generally entails grasping the cerumen plug with curettes, hooks, or forceps, to grasp the impacted cerumen or use of a suction device.**

**Removal of Impacted of Cerumen by Instrumentation is reported as follows:**

- **69210:** Removal of Impacted Cerumen Requiring Instrumentation, Unilateral
- **H61.21:** Impacted Cerumen Right Ear
- **H61.22:** Impacted Cerumen Left Ear
- **H61.23:** Impacted Cerumen Bilateral

\* Please Note – these codes are Unilateral, therefore if they are done Bilaterally then a Modifier 50 is to be added to demonstrate it was performed on both ears. \*



Ref #: GI-4

## Preventive Services Modifier 33

With the implementation of the new Patient Protection & Affordable Care Act [PPACA] FHCP will be utilizing the new Modifier 33 to designate Preventative Services that will be “Covered in Full”.

All “Preventative” Immunizations, regardless of Plan the member is in, must have the **Modifier 33** attached to the **Administration CPT Code**, as a designation of a Preventative Service that is “Covered in Full”.

Modifier 33: **Preventative Services** – When the **primary** purpose of the service is the delivery of an *evidence* based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventative services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventative, the modifier *should not* be used.



Ref #: GI-5

## Medical Nutrition Therapy

Medical Nutrition Therapy (MNT) includes diagnostic therapy & counseling services primarily provided by a registered dietitian (RD) for managing an acute or chronic condition or disease. MNT is particularly significant for those conditions that include interdisciplinary collaboration and treatment of patients. MNT usually occurs over multiple encounters with an initial visit along with subsequent others. The following diseases are covered for MNT: Chronic Kidney Disease (CKD) Stages 3-5, Kidney Transplant Status, & Diabetes Mellitus.

### The following are the CPT Codes used for MNT:

- **97802:** MNT; Initial Assessment & Intervention, Individual, Face-To-Face with the Patient, Each 15 Minutes
- **97803:** MNT; Reassessment & Intervention, Individual, Face-To-Face with the Patient, Each 15 Minutes
- **97804:** MNT; Group (2 of More Individuals) Each 30 Minutes

**MNT can be done alongside of Diabetes Self-Management Training and will not affect the time used for that service. The maximum number of hours for the initial year is 3 hours and 2 hours the following calendar years.**

**However, if there is a reassessment & subsequent intervention following a second referral in the same calendar year for a change in diagnosis, medical condition, or treatment regimen; the following HCPCS G Codes are used.**

- **G0270:** MNT; Re-Assessment & Subsequent Intervention(s) Following Second Referral in Same Year for Change in Diagnosis, Medical Condition, or Treatment Regimen (including additional hours needed for Renal Disease), Individual, Face-To-Face with the Patient, Each 15 Minutes
- **G0271:** MNT; Re-Assessment & Subsequent Intervention(s) Following Second Referral in Same Year for Change in Diagnosis, Medical Condition, or Treatment Regimen (including additional hours needed for Renal Disease), Group (2 or More Individuals), Each 30 Minutes



## **Modifier 59 Changes**

### **Specific Modifiers for Distinct Procedural Services**

CMS has determined the use of Modifier 59 has been abused and has taken steps to ensure its use as it was intended.

Modifier 59 was intended to define a “Distinct Procedural Service”. Modifier 59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

Modifier 59 is the most widely used HCPCS modifier and can be broadly applied. Some providers incorrectly consider it to be the “Modifier to use to bypass NCCI Edits” and have used it in that manner. This has led to considerable abuse and high levels of manual audit activity.

Modifier 59 often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment; and created the following subsets of modifiers.

- XE: Separate Encounter, A Service That is Distinct Because it Occurred During A Separate Encounter
- XS: Separate Structure, A Service That is Distinct Because it Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That is Distinct Because it Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service





## New vs Established Patient

When reporting professional services using Evaluation and Management Services Codes 99201-99499 the definition of the terms New and Established found in the descriptors for these codes are as follows:

A **new** patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An **established** patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified, as it would have been by the physician who is not available.

FHCP employed physicians fall under the same federal tax ID #; therefore, those providers who fall under the same specialty would code these services as if they belonged to the same group practice.

Examples:

1. Dr. Cucchiarella treats a patient on January 25, 2002. Dr. Dayton had treated the patient on January 30, 2000. Since Dr. Cucchiarella and Dr. Dayton are both of the same specialty (Internal Medicine) and are employed by FHCP under the same Federal Tax ID# the patient would be considered an established patient to Dr. Cucchiarella in the coding arena.
2. Dr. Cucchiarella is on call for Dr. Moussly. Dr. Moussly is not an employed physician of FHCP. Dr. Cucchiarella treats a patient January 25, 2002 who had been treated by Dr. Moussly January 30, 2000. The patient is an established patient of Dr. Moussly's. Dr. Cucchiarella would report his service as an established patient because the patient is an established patient to Dr. Moussly.



## Smoking Cessation

As a preventive service to our members, FHCP covers, and encourages, our Providers to perform smoking cessation counseling during patient visits. It is very important for quality and accreditation purposes that we record when such services are rendered.

Therefore, when submitting encounters or claims where smoking cessation counseling is rendered, please report the following information:

- **99202 – 99214:** Appropriate E&M Code based on New or Established Patient and Level of Service Rendered
- **G9016:** Smoking Cessation Counseling, Individual, in the absence of or in Addition to Any Other Evaluation & Management Service, Per Session (6-10 minutes)
- **F17.200 – F17.299:** Nicotine Dependence; Cigarettes, Chewing Tobacco, Other Tobacco Products, or Unspecified; Further Defined by:
  - **Uncomplicated**
  - **In Remission**
  - **With Withdrawal**
  - **With Other Nicotine Induced Disorders/Diseases**
  - **With Unspecified Nicotine Induced Disorders/Diseases**



Ref #: GI-9

## Surgical Suture Removal

When a patient comes to a provider to have sutures removed that were put in by another provider outside of his/her office (e.g. following treatment in the emergency room), the provider should report the Evaluation and Management code that most describes that visit as per the components of the Evaluation and Management codes set forth in the CPT book. That CPT code will most likely be 99211. If the provider is removing sutures that he/she put in, the CPT code 99024, (post op care) should be reported. In both cases, the ICD-9 diagnosis code should be **Z48.02**

If a nurse is removing sutures that were put in by a provider outside of his/her office (e.g. following treatment in the emergency room), the nurse should report CPT code 99211. If the nurse is removing sutures that were put in by a provider inside his/her office, CPT code 99024 (post op care) should be reported. In both cases, the ICD-9 diagnosis code should be **Z48.02**.

Please remember this is NOT for suture removal visits related to Injuries; this diagnosis code should only be used when the patient is seen for removal of surgical sutures, i.e. operational sutures, closure of artificial openings, or skin tag removal of sutures.

*Any suture removal related to an **Injury** should not be utilizing this code, rather the same injury code with the 7<sup>th</sup> character best represented by the visit.*



## History Codes

*History codes (personal and family) are used to explain a patient's medical history. Personal history explains a patient's medical condition that *no longer exists and/or the patient is not receiving treatment but the condition can possibly reoccur* and therefore, may require continued monitoring.*

### Chicken Pox

The proper procedure of coding the personal history of chicken pox to Florida Health Care Plans is as follows:

- **Z86.19:** Personal History of Other Infectious & Parasitic Disease

### Colon Cancer

The proper procedure of coding the personal history of Colon Cancer to Florida Health Care Plans is as follows:

- **Z85.038** - Personal history of malignant neoplasm, large intestine

This code is used when a primary malignancy, in this case, Colon Cancer has been excised or eradicated from its site without any further treatment directed to that site, there is no evidence of any existing malignancy, but continued monitoring for recurrence is needed. Keep in mind, if after surgery the cancer no longer exists, but the patient is receiving treatment, the ICD-10 code for the malignant neoplasm should be reported until treatment is no longer being received.



Ref #: GI-11

## Administration of a Therapeutic /Diagnostic Injection Along with an E/M Visit

If a physician administers a therapeutic or diagnostic injection during an office visit, the administration code can be reported if the -25 modifier is added to the code for the office visit. The following is an ***example*** on how to code the visit if an injection was administered:

Dr. Smith saw Mr. Jones for his three (3) month follow-up, Mr. Jones complained about a rash on his back. Dr. Smith checked the rash and decided to give Mr. Jones 1 mg. of Decadron. This visit should be coded as:

- **99202 – 99214:** Appropriate E&M Code based on New or Established Patient and Level of Service Rendered
- **J1100:** 1 mg. of Decadron
- **96372:** Administration of Therapeutic prophylactic or diagnostic injection

*\* A nursing visit (99211) can no longer be reported with a drug administration code.*



Ref #: GI-12

## Depression and or Grief Reaction: PCP Setting

Depression is one of several mood disorders, of those linked to depression include: dysthymia, major depressive disorder, schizoaffective disorders, bipolar disorders, seasonal affective disorders and mood disorders caused by substance abuse or other medical conditions.

Since there are various types of specific depression, it should be noted that the common code used for depression: F32.9 for Major depressive disorder, single episode, unspecified. This unspecified code can be the incorrect diagnosis and lead to confusion.

Most cases that the Primary Care Physician sees that involve Depression are actually Grief Reaction, or Adjustment Reaction with Anxiety & Depression. These cases usually present when a patient has lost a family member, partner, close friend, loss of job due to cutbacks, loss of dwelling due to job loss, or any other short-term setback that affects the rational or personal drive of a patient. In the majority of these cases the patient has a short period of Depressed Mood, sometimes with Anxiety, or Grieves over the loss of a close one. Within a couple of months, those feelings go away and the patient returns to a normal state of mind. For these instances the proper coding would be the following:

- **F43.20:** Adjustment disorder, Unspecified
- **F43.21:** Adjustment disorder with Depressed Mood
- **F43.22:** Adjustment disorder with Anxiety
- **F43.23:** Adjustment disorder with Mixed Anxiety & Depressed Mood
- **F43.24:** Adjustment disorder with Disturbance of Conduct
- **F43.25:** Adjustment disorder with Mixed Disturbance of Emotions & Conduct



## Adolescent Well-Care Visits with Routine GYN & Pap Smear for Patients Under 16 Years of Age

### Routine Annual Physical With Routine GYN & Pap Smear

- **99383 or 99384:** Preventive Medicine Visit Codes – New Patient Age Specific
- **99393 or 99394:** Preventive Medicine Visit Codes – Established Patient Age Specific
- **Q0091:** Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
- **G0101:** Cervical or vaginal cancer screening; pelvis and clinical breast exam
- **Z00.121 or Z00.129:** Encounter for Routine Child Health Exam With Abnormal Findings, or Encounter for Routine Child Health Exam W/O Abnormal Findings
- **Z01.411 or Z01.419:** Encounter for Gynecological Exam With Abnormal Findings, or Encounter for Gynecological Exam W/O Abnormal Findings

### Routine GYN & Pap Smear

- **Q0091:** Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
- **G0101:** Cervical or vaginal cancer screening; pelvis and clinical breast exam
- **Z01.411 or Z01.419:** Encounter for Gynecological Exam With Abnormal Findings, or Encounter for Gynecological Exam W/O Abnormal Findings
- **Z30.09:** Encounter for Other General Counseling & Advice on Contraception

### Office Visit for GYN Problem Requiring Pap Smear

- **99202 – 99214:** Appropriate E&M Code based on New or Established Patient and Level of Service Rendered
- **Z12.4:** Encounter for screening for Malignant Neoplasm of Cervix
- **Diagnosis Code that facilitated the Repeat Pap Smear, or Signs & Symptoms of suspected Disease**

### Office Visit for GYN Problem Requiring Pelvic Exam

- **99202 – 99214:** Appropriate E&M Code based on New or Established Patient and Level of Service Rendered
- **Z01.411 or Z01.419:** Encounter for Gynecological Exam With Abnormal Findings, or Encounter for Gynecological Exam W/O Abnormal Findings
- **Diagnosis Code that facilitated the Repeat Pap Smear, or Signs & Symptoms of suspected Disease**

**\*\*HCPCS code G0101 should only be used when Cervical or vaginal cancer screening; pelvic and clinical breast examination are done. \*\***



Ref #: PC-2

## Preventative Medicine Visits

It has come to our attention that there is some confusion concerning the reporting of routine physicals (preventive medicine). To report a routine physical, please use CPT codes 99381 thru 99397.

CPT codes 99381 thru 99387 are used for a **New Patient** (patient has not received any professional services from the physician or another physician of the same specialty who is in the same FHCP facility, within the past three years) and should be coded according to the age of the patient.

CPT codes 99391 thru 99397 should be reported for an **Established** patient routine physical (patient has received professional services from the physician of the same specialty who is in the same FHCP facility, within the past three years) and should be coded according to the age of the patient.

**ICD-10 code Z00.00, or Z00.01 should be coded in conjunction with the above CPT codes when the patient is 18 years or older.**

**ICD-10 code Z00.121 or Z00.129 should be coded in conjunction with the above CPT codes when the patient is 17 years or younger.**

Other services provided during the preventive medicine visit should also be reported (e.g. Immunizations).

***An evaluation and management code (office visit code) is very rarely reported at the same time as a preventive medicine code.***





Ref #: PC-3

## **Routine Annual Children Physicals and Sports Physicals**

### **Routine Annual Physical:**

- **99381 – 99384:** Preventive Medicine Visit Codes – New Patient Age Specific
- **99391 – 99394:** Preventive Medicine Visit Codes – Established Patient Age Specific
- **Z00.121:** Encounter for Routine Child Health Exam With Abnormal Findings **or**
- **Z00.129:** Encounter for Routine Child Health Exam W/O Abnormal Findings

### **Routine Annual Physical & Sports Physical:**

- **99381 – 99384:** Preventive Medicine Visit Codes – New Patient Age Specific
- **99391 – 99394:** Preventive Medicine Visit Codes – Established Patient Age Specific
- **Z00.121:** Encounter for Routine Child Health Exam With Abnormal Findings, **or**
- **Z00.129:** Encounter for Routine Child Health Exam W/O Abnormal Findings
- **Z02.5:** Encounter for Participation in Sport

### **Sports Physical Only:**

- **99202 – 99214:** Appropriate E&M Code based on New or Established Patient and Level of Service Rendered
- **Z02.5:** Encounter for Participation in Sport



## **Routine Physicals, Well Woman Assessment or Follow-up Office Visit for GYN Problem Requiring Repeat Pap Smear**

### **Routine Annual Physical:**

- **99384 – 99387:** Preventive Medicine Visit Codes – New Patient Age Specific
- **99394 – 99397:** Preventive Medicine Visit Codes – Established Patient Age Specific
- **Z00.00 or Z00.01:** Encounter for General Adult Medical Exam W/O Abnormal Findings, **or** Encounter for General Adult Medical Exam With Abnormal Findings

### **Routine Annual Physical & Well Woman Assessment:**

- **99384 – 99387:** Preventive Medicine Visit Codes – New Patient Age Specific
- **99394 – 99397:** Preventive Medicine Visit Codes – Established Patient Age Specific
- **Q0091:** Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
- **G0101:** Cervical or vaginal cancer screening; pelvis and clinical breast exam
- **Z00.00 or Z00.01:** Encounter for General Adult Medical Exam W/O Abnormal Findings, **or** Encounter for General Adult Medical Exam With Abnormal Findings
- **Z01.411 or Z01.419:** Encounter for Gynecological Exam With Abnormal Findings, **or** Encounter for Gynecological Exam W/O Abnormal Findings

### **Well Woman Assessment Only:**

- **Q0091:** Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
- **G0101:** Cervical or vaginal cancer screening; pelvis and clinical breast exam
- **Z01.411 or Z01.419:** Encounter for Gynecological Exam With Abnormal Findings, **or** Encounter for Gynecological Exam W/O Abnormal Findings

### **F/U Office Visit for GYN Problem Requiring Repeat Pap Smear:**

- **99202 – 99214:** Appropriate E&M Code based on New or Established Patient and Level of Service Rendered
- **Z12.4:** Encounter for screening for Malignant Neoplasm of Cervix
- **Diagnosis Code that facilitated the Repeat Pap Smear, or Signs & Symptoms of suspected Disease**



## BRCA Screening, Counseling & Testing Checklist

As an added feature for our member's health, Florida Health Care Plans will now cover the following as it relates to BRCA:

- Screening for members who have a Family History that indicates possible Genetic Breast Cancer Susceptibility Genes
- Genetic BRCA Counseling for those members with Positive Screening
- BRCA Testing, if indicated after Genetic BRCA Counseling

Please follow these steps to ensure member's coverage, counseling, testing and/or post counseling are handled properly and without interruptions:

- 1) Physician performs screenings using the following BRCA Screening Questions (submit diagnosis code of Z12.39):
    - a. Does patient have a personal history of breast cancer and was diagnosed before age 50 or personal history of ovarian cancer diagnosed at any age?
    - b. Does the patient have a family history of ovarian cancer in a close female relative (regardless of age)?
    - c. Does the patient have Eastern European ancestry (Ashkenazi Jewish) heritage with a family history of breast or ovarian cancer at any age?
    - d. Are there 2 or more close relatives with breast cancer (on same side of the family) with breast cancer?
    - e. Does the patient have a family history of male breast cancer (in close male relative regardless of age)?
    - f. Please remember, in some families the presence of melanomas and/or pancreatic cancer in close relatives could be suggestive of inherited gene mutation in the family where there is also breast and/or ovarian cancer.
  - 2) After Screening using the above questions, Physician determines if patient is in need of Counseling and orders the BRCA Counseling – No Authorization is required
  - 3) Physician determines if there is a need for testing based on the patient's BRCA Screening Results and the Counseling Report generated from counselor.
  - 4) If there is a need for Testing, Physician makes an assessment and places Order for BRCA Testing which must have Prior Authorization.
  - 5) After authorization is generated complete the LabCorp Requisition selecting one of these Tests:
    - a. BRCAssure Comprehensive: BRCA ½ Analysis
    - b. BRCAssure: BRCA 1 Targeted Analysis
    - c. BRCAssure: BRCA 2 Targeted Analysis
    - d. BRCAssure: BRCA ½ Deletion/Duplication Analysis
    - e. BRCAssure: Ashkenazi Jewish Panel
  - 6) Please submit your Screening Assessment and Counseling Report along with Order to Referrals Department in Holly Hill.
  - 7) Referrals Department will contact Patient and inform them about their testing schedule and location.
  - 8) If Post Counseling after Testing is felt to be needed, there is NO authorization or referral needed.
- If you have any questions please contact Provider Services at 386.676.7100 ext. 4024.



## Continuous Glucose Monitoring (CGM)

The following CPT Codes are to be used when a member has a Continuous Glucose Monitoring device implanted subcutaneously. Please note there is a separate code for the Technical Component [Installing the Device], and a separate code for the Professional Component [Reading the Report]. This can be ordered by a FHCP Staff provider or a network provider and FHCP can implant the device and read and interpret the report. Or, FHCP could perform only the implantation, or only the interpretation of the report. Please be aware of what has been ordered and what service FHCP will be performing in order to code and bill correctly.

### Procedure Codes:

- **95250:** Ambulatory Continuous Glucose Monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of the recording. This is considered the Technical Component Code.
- **95251:** Ambulatory Continuous Glucose Monitoring of interstitial tissue fluid via subcutaneous sensor for a minimum of 72 hours; Interpretation and Report. This is considered the Professional Component Code.

### Diagnosis Codes:

- **E08.00 – E08.9:** Diabetes mellitus due to underlying condition
- **E09.00 – E09.9:** Drug or Chemical induced Diabetes mellitus
- **E10.10 – E10.9:** Type 1 Diabetes mellitus
- **E11.00 – E11.9:** Type 2 Diabetes mellitus
- **E13.00 – E13.9:** Other Specified Diabetes mellitus
- **O24.011 – O24.93:** Diabetes mellitus in Pregnancy, Childbirth & Puerperium
- **R73.01 – R73.9:** Elevated blood glucose level
- **T38.3X5A(D)(S):** Adverse effect of insulin & oral hypoglycemic drugs-antidiabetic
- **T85.614A(D)(S):** Breakdown (mechanical) of insulin pump
- **T85.624A(D)(S):** Displacement of insulin pump
- **T85.633A(D)(S):** Leakage of insulin pump
- **T85.694A(D)(S):** Other mechanical complication of insulin pump
- **Z46.81:** Encounter for fitting and adjustment of insulin pump
- **Z96.41:** Presence of insulin pump (external)(internal)

**\*\*Please Note\*\***

These codes can only be reported once per month, and there is no need for any modifiers.



Ref #: SC-3

## Quick Vue Influenza Test

When coding for a Quick Vue Influenza test you should use CPT code 87804 QW.

The diagnosis codes to use would be the signs and symptoms, i.e.: cough, respiratory congestion, etc.

Please start using these codes immediately to report this service.



## Screening Colonoscopy-Fee for Service Commercial

The codes to bill for a Screening Colonoscopy *only* for Fee for Service Commercial Insurance patients who are **NOT FHCP members** are as follows:

### Procedure Codes:

- **45378:** Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- **45379:** Colonoscopy, flexible; with removal of foreign body(s)
- **45380:** Colonoscopy, flexible; with biopsy, single or multiple
- **45381:** Colonoscopy, flexible; with directed submucosal injection(s), any substance
- **45382:** Colonoscopy, flexible; with control of bleeding, any method
- **45383:** Colonoscopy, flexible; with ablation of tumor(s), poly(s), or other lesion(s) (includes pre-and-post-dilation and guide wire passage, when performed)
- **45384:** Colonoscopy, flexible; with removal or tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
- **45385:** Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- **45386:** Colonoscopy, flexible; with transendoscopic balloon dilation

Please ensure the correct diagnosis code, that which was the reason for visit or reason for procedure to be performed, along with any other conditions that are relevant to procedure or diseases the patient may have.

### **\*\*Note\*\***

**See separate Owl (SC-5) to bill Screening Colonoscopies for all FHCP Commercial and Medicare members, and Traditional Fee for Service Medicare patients.**



## Screening Colonoscopy FHCP Members and FFS Medicare

Medicare will cover colorectal cancer screening test/procedures for the early detection of colorectal cancer. The following ICD-10 codes support medical necessity for Screening Colonoscopies for high risk beneficiaries (G0105):

### Diagnostic Codes:

- **K50.00 – K50.919:** Crohn's Disease (Regional Enteritis)
- **K51.00 – K51.919:** Ulcerative Colitis
- **K52.0 – K52.9:** Other & Unspecified Noninfectious Gastroenteritis & Colitis
- **Z85.030:** Personal History of Malignant Carcinoid Tumor of Large Intestine
- **Z85.038:** Personal History of Other Malignant Neoplasm of Large Intestine
- **Z85.040:** Personal History of Malignant Carcinoid Tumor of Rectum
- **Z85.048:** Personal History of Other Malignant Neoplasm, Rectum, Rectosigmoid Junction, and Anus
- **Z86.010:** Personal History of Colonic Polyps
- **Z80.0:** Family History of Malignant Neoplasm of Digestive Organs
- **Z83.71:** Family History of Colonic Polyps
- **Z83.79:** Family History of Other Diseases of the Digestive System

### Procedure Codes:

- **G0105:** Colorectal Cancer Screening; Colonoscopy on Individual at High Risk
- **G0121:** Colorectal Cancer Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk

Please use the above codes to report these services for **all FHCP Commercial and Medicare members and Traditional Fee For Service Medicare patients who are NOT FHCP members**

**(See separate OWL (SC-4) for FFS Commercial members).**



## Spirometry: FHCP and FFS

Now that each FHCP Primary Care Physician's office has access to a Spirometer, we need to emphasize the proper coding for Spirometry testing. According to HEDIS guidelines, all members/patients who have been diagnosed with Asthma/COPD should have a Spirometry test performed within 6 months of said Diagnosis.

The following codes will assist in the reporting of these services for FHCP members and FFS:

- **94010:** Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- **94060:** Bronchodilation responsiveness, spirometry as in 94010, pre and post-bronchodilator administration

There might be a rare occasion when the member/patient is being seen in addition to the spirometry service, in that instance the visit would be reported with the appropriate evaluation and management code (99201-99215) with the -25 modifier appended to identify it as a significant and separate identifiable service.

- **99201 – 99215 –(25):** Level of Service (E&M Code) determined by provider
- **94010:** Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- **94060:** Bronchodilation responsiveness, spirometry as in 94010, pre and post-bronchodilator administration

### **\*\*Note\*\***

Once a member/patient has been diagnosed with Asthma or COPD they must have a Spirometry test within 6 months of the date of diagnosis. Also please make sure to properly link the Procedure code to one of the Diagnosis codes [to the fullest level of specificity] listed below:

- Simple & Mucopurulent Chronic Bronchitis: J41.0, J41.1, & J41.8
- Unspecified Chronic Bronchitis: J42
- Emphysema: J43.0, J43.1, J43.2, J43.8, J43.9
- Asthma: J45.20 – J45.98
- Other Chronic Obstructive Pulmonary Disease: J44.0, J44.1, J44.9
- Personal History of Nicotine Dependence: Z87.891





Ref #: SC-7

## Rapid Strep Test

In an effort to meet our HEDIS measurement the Disease Management Committee has forwarded the following information for your practice to utilize when seeing patients, especially those between 2 – 18 years of age. It is of great importance that you do a Rapid Strep Test whenever you make a diagnosis of the following:

- Acute Pharyngitis: Diagnosis Codes J02.8 & J02.9
- Acute Tonsillitis: Diagnosis Codes J03.80, J03.81, J03.90, J03.91
- Streptococcal Pharyngitis [Streptococcal Sore Throat]: J02.9
- Streptococcal Tonsillitis: Diagnosis Codes J03.00 & J03.01

After the diagnosis has been made and the Rapid Strep Test has been performed, the discussion of antibiotics can be addressed with the patient's parents or caregiver prior to writing the standard Antibiotic prescription.

Following these steps along with *Coding the Rapid Strep Test* will ensure compliance with our HEDIS measurements' and curtailing the unnecessary use of Antibiotics.

- **87880:** Infectious agent antigen detection by Immunoassay with direct optical observation – Streptococcus Group A

Thank you for your participation in this vital program.



## Dex Meter (Glucose Monitor) Training & Distribution of New Meter

The following codes would be reported when patients are receiving glucose monitor training and Distribution of New Meter, remember there must be a diagnosis code to correlate to the training given - **Diabetes Mellitus: E10.10 – E11.9**, including other manifestation codes that are required to report, and Z71.9 for counseling.

### Procedure Codes:

- **99211:** Basic Office Visit (Nursing Visit)
- **E0607:** Home Blood Glucose Monitor (**HCPCS Code**)
- **NU Modifier:** New Equipment (**HCPCS Modifier**) **And or**
- **KS Modifier:** Glucose monitor supply for diabetic beneficiary not treated with insulin (**HCPCS Modifier**)

### Diagnostic Codes:

- **E10.10 – E11.9:** Representing Diabetes Mellitus [Type 1 or Type 2] including any other manifestation codes that are required to report
- **Z71.9:** Counseling, unspecified



## Insulin Training

The following codes would be reported when patients are receiving insulin training. Remember there must be a diagnosis code to correlate to the training given – **Diabetes Mellitus: E10.10 – E11.9**, including other manifestation codes that are required to report.

- **99211:** Basic Office Visit – utilized to adjudicate the claim
- **Diagnosis Code:** E10.10 – E11.9 Representing Diabetes Mellitus [Type 1 or Type 2] including any other manifestation codes that are required to report
- **Z79.4:** Long Term (Current) Use of insulin.

As an example: In a Nurse’s Clinic, the patient has been instructed by the Doctor to schedule a visit to the Clinic for Insulin Training; Patient arrives and completes training, this is how you would code the encounter:

99211 – For training, and the Diabetes Code that the Doctor assigned at Original Visit - **Diabetes Mellitus: E10.10 – E11.9**, including other manifestation codes that are required to report, as well as a **Z79.4:** for Long term (current) use of insulin.

However if the training is done immediately after the Doctor’s visit on the same visit, it is considered part of the office visit E/M Code.



## Nebulizer Training & Nebulizer Treatment

When coding for Nebulizer Training Only you would report code 94664.

When coding for Nebulizer Treatment Only you would report code 94640.

The following are different ways that we have identified these services can be provided.

### Patient arrives for Nebulizer Treatment Only:

- **94640:** Pressurized or Non-pressurized treatment for acute airway obstruction or for sputum induction for diagnostic purpose
- **J Code:** If the medication is NOT a sample, the appropriate HCPCS code is reported

### Patient arrives for Nebulizer Training Only:

- **94664:** Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- **J Code:** If the medication is NOT a sample, the appropriate HCPCS code is reported

### Patient arrives for Nebulizer Treatment & Training

- **94640:** Pressurized or Non-pressurized treatment for acute airway obstruction or for sputum induction for diagnostic purpose
- **94664-59:** Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device. The 59 modifier is used to separately identify the two procedures.
- **J Code:** If the medication is NOT a sample, the appropriate HCPCS code is reported

### Patient has an Office Visit & receives Nebulizer Training & Treatment

- **992\_\_-25:** Level of Service (E&M Code) determined by provider
- **94664-59:** Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device. The 59 modifier is used to separately identify the two procedures.
- **94640:** Pressurized or Non-pressurized treatment for acute airway obstruction or for sputum induction for diagnostic purpose
- **J Code:** If the medication is NOT a sample, the appropriate HCPCS code is reported

### Patient has an Office Visit and receives Nebulizer Treatment

- **992\_\_-25:** Level of Service (E&M Code) determined by provider
- **94640:** Pressurized or Non-pressurized treatment for acute airway obstruction or for sputum induction for diagnostic purpose
- **J Code:** If the medication is NOT a sample, the appropriate HCPCS code is reported

### Patient has an Office Visit and receives Nebulizer Training

- **992\_\_-25:** Level of Service (E&M Code) determined by provider
- **94664-59:** Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device. The 59 modifier is used to separately identify the two procedures.
- **J Code:** If the medication is NOT a sample, the appropriate HCPCS code is reported



## Medicare Part “D” Drugs, Preventative Medicine Vaccines, PCP Clinical Procedure

When a FHCP Medicare member presents at a PCP Clinic for a Preventative Medicine Vaccine, the service is covered under Medicare Part D. In order for FHCP to follow Medicare regulations for Medicare Part D Preventative Medicine Vaccines, the following method should be followed:

1. Physicians shall supply the member with a prescription for the vaccine;
2. Medicare member shall be directed to call the most convenient FHCP Infusion Clinic to schedule their injection. A copy of the FHCP Infusion Clinic locations should be given to the member.
3. Prior to keeping their injection appointment, the member shall take their prescription to the FHCP pharmacy.
4. The member shall pay the pharmacy for both the vaccine and its administration cost.
5. The member shall take their FHCP pharmacy *receipt*, along with the paper prescription, to their scheduled appointment at the FHCP infusion clinic to have the vaccine administered.
6. Infusion clinic staff shall administer the vaccine.

There are certain circumstances when the administration of a Vaccine is covered under Medicare Part B vaccines. For example Tetanus, ***for medical reasons other than Preventive, such as animal bite, cut, etc.*** In these cases the clinic should report these services using the correct CPT/HCPCS and ICD-10 codes including the administration CPT code.

Please refer to FHCP Policy/Procedure, MCG008 (Medical Coverage Guidelines)



## **DTaP/DT & Tdap/Td Vaccine FHCP Commercial, FFS & Medically Necessary Medicare**

The proper procedure for coding of vaccines/immunizations is to list the code for the vaccines/immunizations, the code for the administration of the medication, and the diagnosis code **Z23**. The following CPT codes are used for billing DTaP and Tdap:

**The codes below are for the vaccines only and do not include their administration.**

- **90700:** Diphtheria, Tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
- **90702:** Diphtheria, Tetanus toxoids absorbed (DT) when administered to individuals younger than 7 years, for intramuscular use
- **90714:** Tetanus and Diphtheria toxoids absorbed (TD), preservative free, when administered to individuals 7 years or older, for intramuscular use
- **90715:** Tetanus, Diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older for intramuscular use

**The codes below are used to bill for the administration of these vaccines:**

- **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* administered
- **90461:** **Each** additional vaccine or toxoid component (List separately in addition to code above for primary procedure) administered. *This includes vaccines with multiple components [combination vaccines], report for each additional component in a given vaccine*
- **90471:** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine or toxoid)
- **90472:** **Each** additional vaccine (single or combination vaccine or toxoids) (List separately in addition to above code for primary procedure)

The following diagnosis code is *used* for **ALL** Immunizations:

**Z23: Encounter for Immunization**

**\*See Ref VC-2 for Clinical Examples\***



## DTaP/DT and Tdap/Td Vaccine Coding Examples

- **Scenario #1:** A 2 year old comes in for only a DTap vaccine and the doctor answers questions the parent has about the vaccine before the vaccine is given, patient received counseling.
  - **Vaccine Code:** 90700
  - **Administration Code:** 90460, 90461, 90461 \*
  - **Diagnosis Code:** Z23
- **Scenario #2:** A 2 year old comes in and gets a DT vaccine in addition to other vaccines but the doctor doesn't answer any question the parent has about the vaccine on the day vaccines are given.
  - **Vaccine Code:** 90702
  - **Administration Code:** 90471 \*\*
  - **Diagnosis Code:** Z23
- **Scenario #3:** A 19 year old comes in to get a Tdap and another vaccine for school, the patient didn't receive any counseling nor any questions asked or answered.
  - **Vaccine Code:** 90715
  - **Administration Code:** 90471, 90472 \*\*\*
  - **Diagnosis Code:** Z23
- **Scenario #4:** A 68 year old MEDICARE patient comes in for a *Tetanus Booster shot for preventative measures* the following Procedure should be Followed.
  - **Please Refer to VC-1 for guidelines on distribution and administration of Medicare Part "D" Drugs Preventative Medicine Vaccines.**

\* If a PA, ARNP, or any other "Qualified Health Care Professional had answered the parents' questions you would use code 90460 & 90461 for multiple or combinations vaccines.

\*\* If the doctor had answered questions for the parent about the vaccine before the date of service for the vaccine it was given you would use 90471 for the first vaccine given, including multiple or combination vaccine given, and 90461 for all the other vaccines given that on that date of service.

\*\*\* 90471 is used for the first vaccine and 90472 for the Tdap.



## Hepatitis A Vaccine

The proper procedure for coding of vaccines/immunizations is to list the code for the vaccines/immunizations, the code for the administration of the medication and the diagnosis code **Z23**. The following codes are used for billing Hepatitis A Vaccine:

- **90632:** Hepatitis A vaccine, adult dosage, for intramuscular use: Ages 19 and Older
- **90633:** Hepatitis A vaccine, pediatric/adolescent dosage-2 dose, for intramuscular use: Ages 12 Months through 18 Years

The following code(s) is used to bill for administration of vaccine:

- **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 administered. ***Can only be used Once Per Day!***
- **90461:** Each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure).
- **90471:** Immunization administration ((includes percutaneous, intradermal, subcutaneous, or intramuscular injections) 1 vaccine (single or combination vaccine/toxoid).
- **90472:** Each additional injection (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).

### **Z23: Encounter for Immunization is used for ALL Immunizations**

For example, when a 30 year old patient comes in for a Hepatitis A injection, the following codes should be reported for the injection:

- **90632:** Hepatitis A vaccine, adult dosage, for intramuscular use
- **90471:** Administration of Hepatitis A vaccine
- **Z23:** Encounter for Immunization





## Hepatitis B Vaccine

The proper procedure for the coding vaccines/immunizations is to list the code for the vaccines/immunizations, the code for the administration of the medication and the diagnosis code **Z23**. The following CPT codes are used for billing Hepatitis B:

- **90744:** Hepatitis B vaccine (HepB), pediatric or pediatric/adolescent dosage (3 dose schedule), for intramuscular use.
- **90746:** Hepatitis B vaccine (HepB), adult dosage (3 dose schedule), for intramuscular use.
- **90747:** Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.
- **G0010:** Administration of Hepatitis B Vaccine

### **Z23: Encounter for Immunization is used for ALL Immunizations**

#### Examples:

When a 3-year-old patient gets a Hepatitis B vaccine, the following codes should be reported for the vaccine:

- **90744:** Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use
- **G0010:** Administration of Hepatitis B vaccine when no physician fee schedule service on the same day
- **Z23:** Encounter for Immunization

When a 68-year-old patient gets a Hepatitis B vaccine, the following codes should be reported for the vaccine:

- **90746:** Hepatitis B vaccine, adult dosage, for intramuscular use
- **G0010:** Administration of Hepatitis B vaccine when no physician fee schedule service on the same day
- **Z23:** Encounter for Immunization

When a 68-year-old patient on chemotherapy gets a Hepatitis B vaccine, the following codes should be reported for the vaccine:

- **90747:** Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use (4 dose schedule)
- **G0010:** Administration of Hepatitis B vaccine when no physician fee schedule service on the same day
- **Z23:** Encounter for Immunization



## Immunizations Needed For Patients with Hepatitis C

The following is a list of Immunizations that patients with Hepatitis C should have or received to protect their health. Please make sure all patients with Hepatitis C are current and up to date on these Immunizations.

- **Influenza:** The patient should receive one dose of the injectable influenza vaccine every year if they want to avoid getting sick with influenza or spreading it to others
- **Pneumococcal:** This vaccine is specifically recommended if the patient has liver disease. If they haven't been vaccinated, they should get one dose now. If they have already been vaccinated and were younger than age 65 when they got their shot they should get another dose now, provided at least 5 years have passed since their first dose.
- **Tetanus, diphtheria, pertussis (Td,Tdap\*):** They will need a Td booster dose every 10 years. If they are younger than 65 years, the next booster dose should also contain pertussis (whooping cough) vaccine AKA Tdap.
- **Hepatitis A (Hep A\*):** Chronic liver disease puts the patient at risk for serious complications if they get infected with the hepatitis A virus. If they have never been vaccinated against hepatitis A, they will need 2 doses of this vaccine, spaced 6-18 months apart.
- **Hepatitis B (Hep B\*):** Because of their chronic liver disease, they will need to be vaccinated. The vaccine is given as a 3-dose series. Start with dose #1 now, followed by dose #2 in 1 month, and dose #3 approximately 5 months later.
- **Measles, Mumps, Rubella (MMR\*):** If they are an adult who was born in 1957 or later, they will need at least 1 dose of MMR. Discuss the need for vaccination with the patient and provider.
- **Varicella (Chickenpox\*):** If they have never had the chickenpox disease, consult their healthcare provider to determine if vaccination is needed.
- **Zoster (Shingles\*):** If they are age 60 years or older, they should be vaccinated against Shingles.

Since the patients may be **Medicare Members Please be Aware of the Policy for Administration of These Vaccines to Medicare Members. Part D Drugs (\*) Must Follow certain Guidelines** for distribution and administration of Vaccines.

**Please refer to OWL VC-1 Medicare Part D Drugs Preventative Medicine Vaccines PCP Clinical Procedure**



## Human Papilloma Virus (HPV) Vaccine

The proper procedure for coding of vaccines/immunizations is to list the code for the vaccines/immunizations, the code for the administration of the medication and the diagnosis code of **Z23**.

### Vaccine Codes:

- **90649:** Human Papillomavirus vaccine, types 6, 11, 16, 18 Quadrivalent (4vHPV), 3 doses schedule, for intramuscular use (**Gardasil**)
- **90650:** Human Papillomavirus vaccine, types 16, 18, Bivalent, (2vHPV), 3 dose schedule, for intra muscular use (**Cervarix**)
- **90651:** Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, Nonavalent (9vHPV), 3 dose schedule for intramuscular use (**Gardasil 9**)

### Administration Procedure Codes:

- **90460:** Immunization administration **through 18 years of age** via any route of administration, with counseling by physician or other qualified healthcare professional; first or only component of each vaccine or toxoid administered ***Can only be used Once Per Day!***
- **90471:** Immunization administration ((includes percutaneous, intradermal, subcutaneous, or intramuscular injections) 1 vaccine (single or combination vaccine/toxoid).
- **90472:** Each additional injection (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).

### Z23 Encounter for Immunization is used for ALL Immunizations

**Eligible patients are:** Healthy Kids ages 11 Thru 18<sup>th</sup> Birthday & Commercial Florida Health Care Plans ages 11 up to 27<sup>th</sup> Birthday. Remember verification of eligibility, any religious exemption to immunizations, advisement of risks, & benefits, and consent, along with a written physician's order must be documented prior to submission for claim.

*Keep in mind this may be administered at the same time as other immunizations.*

**FHCP considers this a covered benefit for its members unless their status changes during the inoculation period.**

For example an 11 year old patient comes in for the 1<sup>st</sup> Human Papilloma Virus (HPV) vaccine:

- **90649:** Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (Quadrivalent), 3 doses schedule, for intramuscular use
- **90460:** Immunization administration **through 18 years of age** via any route of administration, with counseling by physician or other qualified healthcare professional; first or only component of each vaccine or toxoid administered
- **Z23:** Encounter for Immunization



## Influenza Vaccine

The following CPT/HCPCS codes are used for **Influenza Vaccines based on type of product name you are using**, the HCPCS "G" code for the administration of the medication, and Diagnosis Code.

- **90630:** Influenza virus vaccine, Quadrivalent (IIV4), split virus, preservative free, for intradermal use
- **90655:** Influenza virus vaccine, Trivalent (IIV3), split virus, preservative free, [**when administered to children 6-35 months of age**], 0.25 mL Dosage, for intramuscular use
- **90656:** Influenza virus vaccine, Trivalent (IIV3), split virus preservative free, [**when administered to individuals 3 years and older**], 0.50 mL Dosage, for intramuscular use
- **90657:** Influenza virus vaccine, Trivalent (IIV3), splint virus, [**when administered to children 6-35 months of age**], 0.25 mL Dosage, for intramuscular use
- **90658:** Influenza virus vaccine, Trivalent (IIV3), split virus, [**when administered to individuals 3 years of age and older**], 0.5 mL Dosage, for intramuscular use
- **90661:** Influenza virus vaccine (ccIIV3), derived from cell cultures, subunit, preservative & antibiotic free, 0.5 mL Dosage, for intramuscular use
- **90662:** Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- **90672:** Influenza virus vaccine, Quadrivalent, live (LAIV4), for intranasal use
- **90673:** Influenza virus vaccine, Trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative & antibiotic free, for intramuscular use
- **90674:** Influenza virus vaccine, Quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free [**when administered to individuals 4 years of age and older**], 0.5 mL Dosage, for Intramuscular use (**Flucelvax**)
- **90685:** Influenza virus vaccine, Quadrivalent (IIV4), split virus, preservative free, [**when administered to children 6-35 months of age**], 0.25 mL Dosage, for intramuscular use
- **90686:** Influenza virus vaccine, Quadrivalent (IIV4), split virus, preservative free, [**when administered to individuals 3 years and older**], 0.5 mL Dosage, for intramuscular use
- **90687:** Influenza virus vaccine, Quadrivalent, split virus, [**when administered to children 6-35 months of age**], 0.25 mL Dosage, for intramuscular use
- **90688:** Influenza virus vaccine, Quadrivalent (IIV4), split virus, [**when administered to individuals 3 years of age and older**], 0.5 mL Dosage, for intramuscular use
- **Q2034:** Influenza virus vaccine, split virus, for intramuscular use (**Agriflu**)
- **Q2035:** Influenza virus vaccine, split virus, when administered to individuals 3 years of age & older, for intramuscular use (**AFLURIA**)
- **Q2036:** Influenza virus vaccine, split virus, when administered to individuals 3 years of age & older, for intramuscular use (**FLULAVAL**)
- **Q2037:** Influenza virus vaccine, split virus, for use in individuals 3 years of age & older, for intramuscular use (**Fluvirin**)
- **Q2038:** Influenza virus vaccine, split virus, for use in individuals 3 years of age & older, for intramuscular use (**Fluzone**)
- **Q2039:** Influenza virus vaccine, split virus, when administered to individuals 3 years of age & older, for intramuscular use (**Not Otherwise Specified**)

**The HCPCS "G" code is used to bill for the administration of the influenza vaccine: G0008 – Administration of Influenza virus vaccine**

The following diagnosis code is *used* for *ALL* Immunizations: **Z23 Encounter for Immunization**



## Pneumococcal Vaccine

The proper procedure for the coding of vaccines/immunizations is to list the code for the vaccine/immunization, the code for the administration of the vaccine/immunization and the diagnosis code **Z23**.

The following CPT codes are used for billing the Pneumococcal vaccine only:

- **90670:** Pneumococcal conjugate vaccine, 13 Valent (PCV13), for intramuscular use
- **90732:** Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

This **HCPCS “G”** code is used to bill for the administration of the Pneumococcal Vaccine:

- **G0009:** Administration of Pneumococcal Vaccine
- **Z23: Encounter for Immunization is used for ALL Immunizations**

### Examples:

When any patient under 5 comes in for a pneumococcal conjugate (Pneumovax) vaccine the following codes should be reported for the vaccine:

- **90670:** Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
- **G0009:** Administration of pneumococcal vaccine
- **Z23:** Encounter for Immunization

When any patient comes in for a pneumococcal polysaccharide (Pneumovax) vaccine, the following codes should be reported for the vaccine:

- **90732:** Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), for use in individuals 2 years or older, for subcutaneous or intramuscular use
- **G0009:** Administration of pneumococcal vaccine
- **Z23:** Encounter for Immunization



## Zostavax Vaccine FHCP Commercial & FFS Only Age 60 & Over

### **\*\* Note\*\***

### **Non-Medicare Members Only**

The proper procedure for coding of vaccines/immunizations is to list the code for the vaccines/immunizations, the code for the administration of the medication and the diagnosis code **Z23**. The following CPT code is used for billing Zostavax.

- **90736 Zostavax** – Zoster (shingles) vaccine, live, for subcutaneous injection

The following administration codes are reported in conjunction with the vaccine:

- **90471 Immunization Administration** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
- **90472** Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) (**This is to only be used when there is an additional vaccine**)

### **Z23 Encounter for Immunization is used for ALL Immunizations**

For example, a 75-year-old woman comes in for the Zostavax – Zoster (shingles) vaccine, live, for subcutaneous injection:

- **90736:** Zostavax – Zoster (shingles) vaccine, live, for subcutaneous injection
- **90471** Immunization Administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
- **Z23:** Encounter for Immunization

**For Medicare Members See OWL - Medicare Part “D” Drugs (Ref VC-1)**