



ADHD Coding Fact Sheet for Primary Care Pediatricians

Current Procedural Terminology(CPT®) Codes

Initial assessment usually involves substantial time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor or a consultation code for the initial assessment:

Physician Evaluation & Management Services

- ★ 99201 Office or other outpatient visit, new patient; self limited or minor problem, 10 min.
- ★ 99202 low to moderate severity problem, 20 min.
- ★ 99203 moderate severity problem, 30 min.
- ★ 99204 moderate to high severity problem, 45 min.
- ★ 99205 high severity problem, 60 min.

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

- ★ 99211 Office or other outpatient visit, established patient; minimal problem, 5 min.
- ★ 99212 self limited or minor problem, 10 min.
- ★ 99213 low to moderate severity problem, 15 min.
- ★ 99214 moderate severity problem, 25 min.
- ★ 99215 moderate to high severity problem, 40 min.
- ★ 99241 Office or other outpatient consultation, new or established patient; self-limited or minor problem, 15 min.
- ★ 99242 low severity problem, 30 min.
- ★ 99243 moderate severity problem, 45 min.
- ★ 99244 moderate to high severity problem, 60 min.
- ★ 99245 moderate to high severity problem, 80 min.

NOTE: Use of these codes (99241-99245) requires the following:

- a) Written or verbal request for consultation is documented in the patient chart;
- b) Consultant's opinion as well as any services ordered or performed are documented in the patient chart; and
- c) Consultant's opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source (*Note:* Patients/Parents may not initiate a consultation)
- d) For more information on consultation code changes for 2010 see AAP Position Paper at http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/AAP_Position_Medicare_Consultation_Policy.pdf

Reporting E/M services using "Time"

- When counseling or coordination of care dominates (more than 50%) the physician/patient or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time shall** be considered the key or controlling factor to qualify for a particular level of E/M services.

+ Codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided

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- This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.
- For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.
- When codes are ranked in sequential typical times (such as for the office-based E/M services or consultation codes) and the actual time is between 2 typical times, the code with the typical time closest to the actual time is used.
- Prolonged services can only be added to codes with listed typical times such as the ones listed above. In order to report prolonged services the reporting provider must spend a minimum of 30 minutes beyond the typical time listed in the code level being reported. When reporting outpatient prolonged services only count face-to-face time with the reporting provider. When reporting inpatient or observation prolonged services you can count face-to-face time, as well as unit/floor time spent on the patient's care. However, if the reporting provider is reporting their service based on time (ie, counseling/coordinating care dominate) and not key components, then prolonged services cannot be reported unless the provider reaches 30 minutes beyond the listed typical time in the highest code in the set (eg, 99205, 99226, 99223). It is important that time is clearly noted in the patient's chart. Refer to CPT for codes to define prolonged clinical staff time.
- **Example:** A physician sees an established patient in the office to discuss the current ADHD medication the patient was placed on. The total face-to-face time was 22 minutes, of which 15 minutes was spent in counseling the mom and patient. Because more than 50% of the total time was spent in counseling, the physician would report the E/M service based on time. The physician would report a 99214 instead of a 99213 because the total face-to-face time was closer to a 99214 (25 minutes) than a 99213 (15 minutes).

ADHD Follow-up During a Routine Preventive Medicine Service

- A good time to follow-up with a patient regarding their ADHD could be during a preventive medicine service.
 - If the follow-up does not require a lot of additional work on behalf of the physician, then it should be reported under the preventive medicine service and not separate.
 - If the follow-up work requires an additional evaluation and management service in addition to the preventive medicine service, it should be reported as a separate service.
 - Chronic conditions should not be listed in the ICD-10-CM codes if not separately addressed
 - When reporting a preventive medicine service in addition to an office-based E/M service that are significant and separately identifiable, modifier 25 will be required on the office-based E/M service
 - **Example:** A 12-year-old established patient presents for his routine preventive medicine service and while they are there mom asks about changing her son's ADHD medication due to some side effects the child is experiencing. The physician completes the routine preventive medicine check and then addresses the mom's concerns in a separate service. The additional E/M service takes 15 minutes, of which the physician spends about 10 minutes in counseling/coordinating care, therefore the E/M service is reported based on time.
 - Code 99394 and 99213 25 (append modifier 25) to account for both E/M services and link each to the appropriate ICD-10-CM code
- ★+99354 Prolonged services in office or other outpatient setting, with direct patient contact; first hour (*use in conjunction with time-based codes 99201-99215, 99241-99245, 99324-99337, 99341-99350, 90837*)
- ★+99355 each additional 30 min. (*use in conjunction with 99354*)

- Used when a physician or other qualified health care professional provides prolonged services beyond the usual service (ie, beyond the typical time).

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- Time spent does not have to be continuous.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
- If reporting your E/M service based on time and not key factors (hx, exam, medical decision making), the physician must reach the typical time in the highest code in the code set being reported (eg, 99205, 99215, 99245) before face-to-face prolonged services can be reported.

Physician Non-Face-to-Face Services

*For more information on reporting these and other non-face-to-face services see the [Care Management](#) fact sheet.

Chronic Care Management

Codes are selected based on the amount of time spent by the physician or qualified health care professional providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.

(For time spent by the physician directing clinical staff, refer to codes **99490**, **99487**, **99489** below)

Online Digital Evaluation and Management Service

These are patient-initiated services with physicians or other qualified health care professionals (QHPs) who are allowed to report E/M services. Online digital E/M services require physician or other QHP's evaluation, assessment, and management of the patient and are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. These are more appropriate when dealing with a more minor issue or during a month when you are not coding or providing more robust care thus this time would be reported under another service like care management.

- Patient must be established (problem can be new)
- Services must be initiated through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms
- Reported once for the physician's or other QHP's (including all in the same group practice) cumulative time during a seven-day period
- The seven-day period begins with the physician's or other QHP's initial, personal review of the patient-generated inquiry.
- Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.
- Do not report these codes separately if the patient is seen within 7 days of the service for an issue related to the encounter.

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- Your *date of service* will be the date the initiation of the e-visit began or the range of dates it took place because this service is cumulative time over 7 days.

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

Care Plan Oversight

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

99340 30 minutes or more

Prolonged Services

99358 Prolonged services before or after direct patient contact; first hour **Note:** This code is now published on the Medicare physician fee schedule as a payable service. Many private payers and state Medicaid will follow suit. Report when performed.

+**99359** each additional 30 min. (*Use in conjunction with 99358*)

Medical Team Conference

99367 Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more

Telephone Care Services

99441 Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

Physician-Directed Non-Face-to-Face Services

Behavioral health integration care management, chronic care management, psychiatric collaborative care management services and transition care management are reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional. See each code set for details.

Behavioral Health Integration Care Management

99484 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- behavioral health care planning in relation to behavioral/psychiatric health problems, including

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- revision for patients who are not progressing or whose status changes;
- facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- continuity of care with a designated member of the care team.

Tips:

- Reported by the supervising physician or other qualified health care professional.
- The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490).
 - May be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.
 - Behavioral integration care management (99484) and chronic care management services may be reported by the same professional in the same month, as long as distinct care management services are performed.

Psychiatric Collaborative Care Management Services

99492 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- review by the psychiatric consultant with modifications of the plan if recommended;
- entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

99493 Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- tracking patient follow-up and progress using the registry, with appropriate documentation;
- participation in weekly caseload consultation with the psychiatric consultant;
- ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- monitoring of patient outcomes using validated rating scales; and
- relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

+ 99494 Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

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Care Management Services:

Codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

Do not report **99490** for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

99487 Complex chronic care management services;

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Do not report **99487** for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

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

Complex chronic care management is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)
2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
3. commonly require the coordination of a number of specialties and services.

Psychiatric Diagnostic or Evaluative Interview Procedures

- ★ 90791 Psychiatric diagnostic interview examination evaluation
- ★ 90792 Psychiatric diagnostic evaluation with medical services

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Psychiatry

+90785 Interactive complexity (Use in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350], and group psychotherapy [90853])

Other Psychiatric Services/Procedures

90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (Use in conjunction with 90832, 90834, 90837)

- For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report E/M codes, use the appropriate E/M codes 99201-99255, 99281-99285, 99304-99337, 99341-99350 and the appropriate psychotherapy with E/M service 90833, 90836, 90838).

90885 Psychiatric evaluation of hospital records, other psychiatric reports, and psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

90887 Interpretation or explanation of results of psychiatric, other medical exams, or other accumulated data to family or other responsible persons, or advising them how to assist patient

90889 Preparation of reports on patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers

Assessment and Testing

Psychological Testing

96130 Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+ **96131** each additional hour (List separately in addition to code **96130**)

96136 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes

+ **96137** each additional 30 minutes (List separately in addition to **96136**)

96146 Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

Assessment of Aphasia

96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

Emotional/Behavioral Assessment

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Developmental Screening/Testing

96110 Developmental screening, with scoring and documentation per standardized instrument (Do not report for

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ADHD scales)

96112 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

+ **96113** each additional 30 minutes (List separately in addition to code **96112**)

Neurobehavioral Status Exam

★ **96116** Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

Other Qualified Nonphysician Healthcare Professional Services

CPT defines a *qualified nonphysician health care professional* is a professional who may independently report services but may not report the physician or other qualified health care professional E/M services. These include but not limited to speech-language pathologists, physical therapists, occupational therapists, social workers, or dietitians.

Medical Team Conference

99366 Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, participation by a nonphysician qualified healthcare professional

99368 Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, participation by a nonphysician qualified healthcare professional

Telephone Assessment: Nonphysician Healthcare Professional

98966 Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 11-20 minutes of medical discussion

98968 21-30 minutes of medical discussion

Online Digital Evaluation and Management Service

Refer to codes **99421-99423** for more details.

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

98970 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

98971 11-20 minutes

98972 21 or more minutes

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Health Behavior Assessment and Intervention

- 96156** Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
- 96158** Health behavior intervention (HBI), individual, face-to-face; initial 30 minutes
- 96159** each additional 15 minutes (Report with 96158)
- 96164** HBI, group (2 or more patients), face-to-face; initial 30 minutes
- 96165** each additional 15 minutes (Report with 96164)
- 96167** HBI, family (with the patient present), face-to-face; initial 30 minutes
- 96168** each additional 15 minutes (Report with 96167)
- 96170** HBI, family (without the patient present), face-to-face; initial 30 minutes
- 96171** each additional 15 minutes (Report with 96170)

*Report the family HBI codes only when the intervention is centered around the family. Do not report if the parent is present because of the age of the patient, but they not involved in the intervention. Refer to the individual or group codes instead.

Care Management Services

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2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

- 99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
 - chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
 - comprehensive care plan established, implemented, revised, or monitored.

Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. If 20 minutes are not met within a calendar month, you do not report chronic care management. Refer to *CPT* for more information.

Miscellaneous Services

- 99071** Educational supplies, such as books, tapes or pamphlets, provided by the physician for the patient's education at cost to the physician

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International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Codes

- Use as many diagnosis codes that apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental.

Behavioral/Emotional Disorders

- F90.0** Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.8 Attention-deficit hyperactivity disorder, other type
F90.9 Attention-deficit hyperactivity disorder, unspecified type
F91.1 Conduct disorder, childhood-onset type
F91.2 Conduct disorder, adolescent-onset type
F91.3 Oppositional defiant disorder
F91.9 Conduct disorder, unspecified
F93.0 Separation anxiety disorder
F93.8 Other childhood emotional disorders (relationship problems)
F93.9 Childhood emotional disorder, unspecified
F94.9 Childhood disorder of social functioning, unspecified
F95.0 Transient tic disorder
F95.1 Chronic motor or vocal tic disorder
F95.2 Tourette's disorder
F95.9 Tic disorder, unspecified
F98.8 Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (nail-biting, nose-picking, thumb-sucking)

Depressive Disorders

- F34.1** Dysthymic disorder (depressive personality disorder, dysthymia neurotic depression)
F39 Mood (affective) disorder, unspecified
F30.8 Other manic episode

Anxiety Disorders

- F06.4** Anxiety disorder due to known physiological conditions
F40.10 Social phobia, unspecified
F40.11 Social phobia, generalized
F40.8 Phobic anxiety disorders, other (phobic anxiety disorder of childhood)
F40.9 Phobic anxiety disorder, unspecified
F41.1 Generalized anxiety disorder
F41.9 Anxiety disorder, unspecified

Feeding and Eating Disorders/Elimination Disorders

- F50.89** Eating disorders, other
F50.9 Eating disorder, unspecified
F98.0 Enuresis not due to a substance or known physiological condition
F98.1 Encopresis not due to a substance or known physiological condition
F98.3 Pica (infancy or childhood)

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Impulse Disorders

F63.9 Impulse disorder, unspecified

Trauma- and Stressor-Related Disorders

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 and depressed mood

F43.24 Adjustment disorder with disturbance of conduct

Neurodevelopmental/Other Developmental Disorders

F70 Mild intellectual disabilities

F71 Moderate intellectual disabilities

F72 Severe intellectual disabilities

F73 Profound intellectual disabilities

F79 Unspecified intellectual disabilities

F80.0 Phonological (speech) disorder (speech-sound disorder)

F80.1 Expressive language disorder

F80.2 Mixed receptive-expressive language disorder

F80.4 Speech and language developmental delay due to hearing loss (code also hearing loss)

F80.81 Stuttering

F80.82 Social pragmatic communication disorder

F80.89 Other developmental disorders of speech and language

F80.9 Developmental disorder of speech and language, unspecified

F81.0 Specific reading disorder

F81.2 Mathematics disorder

F81.89 Other developmental disorders of scholastic skills

F81.9 Developmental disorder of scholastic skills, unspecified

F82 Developmental coordination disorder

F84.0 Autistic disorder (Autism spectrum)

F88 Specified delays in development; other

F89 Unspecified delay in development

Other

F07.81 Postconcussional syndrome

F07.89 Personality and behavioral disorders due to known physiological condition, other

F07.9 Personality and behavioral disorder due to known physiological condition, unspecified

F48.8 Nonpsychotic mental disorders, other (neurasthenia)

F48.9 Nonpsychotic mental disorders, unspecified

F45.41 Pain disorder exclusively related to psychological factors

F51.01 Primary insomnia

F51.02 Adjustment insomnia

F51.03 Paradoxical insomnia

F51.04 Psychophysiologic insomnia

F51.05 Insomnia due to other mental disorder (Code also associated mental disorder)

F51.09 Insomnia, other (not due to a substance or known physiological condition)

F51.3 Sleepwalking [somnambulism]

F51.4 Sleep terrors [night terrors]

F51.8 Other sleep disorders

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- F93.8** Childhood emotional disorders, other
- R46.89** Other symptoms and signs involving appearance and behavior

Substance-Related and Addictive Disorders:

If a provider documents multiple patterns of use, only one should be reported. Use the following hierarchy: use–abuse–dependence (eg, if use and dependence are documented, only code for dependence).

When a minus symbol (-) is included in codes **F10–F17**, a last digit is required. Be sure to include the last digit from the following list:

- 0 anxiety disorder
- 2 sleep disorder
- 8 other disorder
- 9 unspecified disorder

Alcohol

- F10.10** Alcohol abuse, uncomplicated (alcohol use disorder, mild)
- F10.14** Alcohol abuse with alcohol-induced mood disorder
- F10.159** Alcohol abuse with alcohol-induced psychotic disorder, unspecified
- F10.18-** Alcohol abuse with alcohol-induced
- F10.20** Alcohol dependence, uncomplicated
- F10.21** Alcohol dependence, in remission
- F10.24** Alcohol dependence with alcohol-induced mood disorder
- F10.259** Alcohol dependence with alcohol-induced psychotic disorder, unspecified
- F10.28-** Alcohol dependence with alcohol-induced
- F10.94** Alcohol use, unspecified with alcohol-induced mood disorder
- F10.959** Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
- F10.98-** Alcohol use, unspecified with alcohol-induced

Cannabis

- F12.10** Cannabis abuse, uncomplicated (cannabis use disorder, mild)
- F12.18-** Cannabis abuse with cannabis-induced
- F12.20** Cannabis dependence, uncomplicated
- F12.21** Cannabis dependence, in remission
- F12.28-** Cannabis dependence with cannabis-induced
- F12.90** Cannabis use, unspecified, uncomplicated
- F12.98-** Cannabis use, unspecified with

Sedatives

- F13.10** Sedative, hypnotic or anxiolytic abuse, uncomplicated (use disorder, mild)
- F13.14** Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
- F13.18-** Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced
- F13.21** Sedative, hypnotic or anxiolytic dependence, in remission
- F13.90** Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
- F13.94** Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
- F13.98-** Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced

Stimulants (eg, Caffeine, Amphetamines)

- F15.10** Other stimulant (amphetamine-related disorders or caffeine) abuse, uncomplicated (use disorder, mild)

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- F15.14** Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced mood disorder
- F15.18-** Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced
- F15.20** Other stimulant (amphetamine-related disorders or caffeine) dependence, uncomplicated
- F15.21** Other stimulant (amphetamine-related disorders or caffeine) dependence, in remission
- F15.24** Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced mood disorder
- F15.28-** Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced
- F15.29** Other stimulant (amphetamine-related disorders or caffeine) dependence with unspecified stimulant-induced disorder
- F15.90** Other stimulant (amphetamine-related disorders or caffeine) use, unspecified, uncomplicated
- F15.94** Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant-induced mood disorder
- F15.98-** Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant-induced

Nicotine (eg, Cigarettes)

- F17.200** Nicotine dependence, unspecified, uncomplicated (tobacco use disorder, mild, moderate, severe)
- F17.201** Nicotine dependence, unspecified, in remission
- F17.203** Nicotine dependence unspecified, with withdrawal
- F17.20-** Nicotine dependence, unspecified, with
- F17.210** Nicotine dependence, cigarettes, uncomplicated
- F17.211** Nicotine dependence, cigarettes, in remission
- F17.213** Nicotine dependence, cigarettes, with withdrawal
- F17.218-** Nicotine dependence, cigarettes, with

Symptoms, Signs, and Ill-Defined Conditions

Use these codes in absence of a definitive mental diagnosis or when the sign or symptom is not part of the disease course or considered incidental.

- G47.9** Sleep disorder, unspecified
- H90.0** Conductive hearing loss, bilateral
- H90.11** Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
- H90.12** Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
- K11.7** Disturbance of salivary secretions
- K59.00** Constipation, unspecified
- N39.44** Nocturnal enuresis
- R10.0** Acute abdomen pain
- R11.11** Vomiting without nausea
- R11.2** Nausea with vomiting, unspecified
- R19.7** Diarrhea, unspecified
- R21** Rash, NOS
- R25.0** Abnormal head movements
- R25.1** Tremor, unspecified
- R25.3** Twitching, NOS
- R25.8** Other abnormal involuntary movements
- R25.9** Unspecified abnormal involuntary movements
- R27.8** Other lack of coordination (excludes ataxia)
- R27.9** Unspecified lack of coordination
- R41.83** Borderline intellectual functioning
- R42** Dizziness
- R48.0** Alexia/dyslexia, NOS

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R51	Headache
R62.0	Delayed milestone in childhood
R62.52	Short stature (child)
R63.3	Feeding difficulties
R63.4	Abnormal weight loss
R63.5	Abnormal weight gain
R68.2	Dry mouth, unspecified
T56.0X1A	Toxic effect of lead and its compounds, accidental (unintentional), initial encounter

Z Codes

Z codes represent reasons for encounters. Categories **Z00–Z99** are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories **A00–Y89** are recorded as 'diagnoses' or 'problems'. This can arise in 2 main ways.

- When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem is in itself not a disease or injury.
- When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.
- When a social determinant of health is identified during an encounter and it is either addressed or shown to complicate the encounter, it should be coded.

Z13.89	Encounter for screening for other disorder
Z55.0	Illiteracy and low-level literacy
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified (Z55 codes exclude those conditions reported with F80–F89)
Z62.0	Inadequate parental supervision and control
Z60.4	Social exclusion and rejection
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified
Z62.21	Foster care status (child welfare)
Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Z63.72	Alcoholism and drug addiction in family
Z63.8	Other specified problems related to primary support group
Z65.3	Problems related to legal circumstances
Z71.89	Counseling, other specified
Z71.9	Counseling, unspecified
Z72.0	Tobacco use
Z77.011	Contact with and (suspected) exposure to lead
Z79.899	Other long term (current) drug therapy
Z81.0	Family history of intellectual disabilities (conditions classifiable to F70–F79)

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Z81.8	Family history of other mental and behavioral disorders
Z83.2	Family history of diseases of the blood and blood-forming organs (anemia) (conditions classifiable to D50-D89)
Z86.2	Personal history of diseases of the blood and blood-forming organs
Z86.39	Personal history of other endocrine, nutritional and metabolic disease
Z86.59	Personal history of other mental and behavioral disorders
Z86.69	Personal history of other diseases of the nervous system and sense organs
Z87.09	Personal history of other diseases of the respiratory system
Z87.19	Personal history of other diseases of the digestive system
Z87.798	Personal history of other (corrected) congenital malformations
Z87.820	Personal history of traumatic brain injury
Z91.128	Patient's intentional underdosing of medication regimen for other reason (report drug code)
Z91.138	Patient's unintentional underdosing of medication regimen for other reason (report drug code)
Z91.14	Patient's other noncompliance with medication regimen
Z91.19	Patient's noncompliance with other medical treatment and regimen
Z91.411	Personal history of adult psychological abuse

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