



Bereavement Coding Fact Sheet for Primary Care Pediatricians

CPT (Procedure) Codes

Initial assessment usually involves a lot of 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 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.
- 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.

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

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- 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 or clinical staff a minimum of 45 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 or when appropriate clinical staff. 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.

- ★+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, 99301-99350, 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).
- 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.
- Refer to codes **99415-99416** for prolonged clinical staff time

Physician Non-Face-to-Face Services

Chronic Care and Complex Chronic Care Management visit that [fact sheet](#).

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.
- 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.

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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

Telephone Care Services

Telephone care must be initiated by the parent, patient or the guardian. The telephone call cannot be related to an E/M service within the previous 7 days nor can they lead to an appointment within the next 24 hours or soonest available. This is not telehealth or telemedicine. Your *date of service* will be date the phone call takes place.

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

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

Prolonged Services

99358 Prolonged services without direct patient contact; first hour

+99359 each additional 30 min. (+ designated add-on code, use in conjunction with 99358)

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

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.

For Chronic care and Complex chronic care Management and Transition Care Management (discharge services) see the [fact sheet](#).

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;

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- behavioral health care planning in relation to behavioral/psychiatric health problems, including 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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Psychotherapy

- ★**90832** Psychotherapy, 30 min with patient and/or family;
- ★**+90833** with medical evaluation and management (Use in conjunction with **99201–99255, 99304–99337, 99341–99350**)

- ★**90834** Psychotherapy, 45 min with patient and/or family;
- ★**+90836** with medical evaluation and management services (Use in conjunction with **99201–99255, 99304–99337, 99341–99350**)

- ★**90837** Psychotherapy, 60 min with patient and/or family;
- ★**+90838** with medical evaluation and management services (Use in conjunction with **99201–99255, 99304–99337, 99341–99350**)

- +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**])
 - Refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical encounters include
 - Patients who have other individuals legally responsible for their care
 - Patients who request others to be present or involved in their care such as translators, interpreters, or additional family members
 - Patients who require the involvement of other third parties such as child welfare agencies, schools, or probation officers

- ★**90846** Family psychotherapy (without patient present)

- ★**90847** Family psychotherapy (conjoint psychotherapy) (with patient present)

- 90849** Multiple-family group psychotherapy

- 90853** Group psychotherapy (other than of a multiple family group)
 - For interactive group psychotherapy, use code **90785** in conjunction with code **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**).
- Note that code **90862** was deleted.

- 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

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Screening & 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

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

Other Qualified Nonphysician Healthcare Professional Services

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

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)

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- 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.

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes **99415**, **99416** are used when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.

- + **99415** Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
- + **99416** each additional 30 minutes

Codes **99415-99416**

- Must always be reported in addition to an appropriate office/outpatient E/M service (ie, **99201-99215**)
- Require that the physician or qualified health care professional is present to provide direct supervision of the clinical staff.
- Are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged services, even if the time spent by the clinical staff on that date is not continuous.
- Are not reported for time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.
- Requires a minimum of 45 minutes spent beyond the typical time of the E/M service code being reported. May require that the clinical staff spend more time if the physician does not meet the time criteria of the E/M service being reported
- May not be reported in addition to **99354** or **99355**.

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

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.

Bereavement

- Z63.4** Disappearance and death of family member (*General bereavement encounter)

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Feeding and Eating Disorders/Elimination Disorders

- F50.89** Eating disorders, other (psychogenic vomiting)
- 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)

Impulse Disorders

- F63.9** Impulse disorder, unspecified

Sleep Disorders

- F51.01** Primary insomnia
- F51.02** Adjustment insomnia
- F51.03** Paradoxical insomnia
- F51.04** Psychophysiologic insomnia
- F51.3** Sleepwalking [somnambulism]
- F51.4** Sleep terrors [night terrors]
- F51.8** Other sleep disorders not due to a substance or known physiological condition
- F51.9** Sleep disorder not due to a substance or known physiological condition, 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
- F43.25** Adjustment disorder with mixed disturbance of emotions and conduct
- F43.29** Adjustment disorder with other symptoms
- F43.0** Acute stress reaction
- F43.8** Other reactions to severe stress
- F43.9** Reaction to severe stress, unspecified

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

[C]Alcohol

- F10.10** Alcohol abuse, uncomplicated
- 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
- F10.19** Alcohol abuse with unspecified alcohol-induced disorder
- F10.20** Alcohol dependence, uncomplicated

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- 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
- F10.29** Alcohol dependence with unspecified alcohol-induced disorder
- 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

[C] Opioid

- F11.10** Opioid abuse, uncomplicated (mild)
- F11.11** Opioid abuse, in remission
- F11.120** Opioid abuse with intoxication, uncomplicated
- F11.20** Opioid dependence, uncomplicated (mild)
- F11.21** Opioid dependence, in remission
- F11.220** Opioid dependence with intoxication, uncomplicated
- F11.24** Opioid dependence with opioid-induced mood disorder
- F11.90** Opioid use, unspecified, uncomplicated
- F11.94** Opioid use, unspecified with opioid-induced mood disorder

[C] Cannabis

- F12.10** Cannabis abuse, uncomplicated
- F12.180** Cannabis abuse with cannabis-induced anxiety disorder
- F12.19** Cannabis abuse with unspecified cannabis-induced disorder
- F12.20** Cannabis dependence, uncomplicated
- F12.280** Cannabis dependence with cannabis-induced anxiety disorder
- F12.29** Cannabis dependence with unspecified cannabis-induced disorder
- F12.90** Cannabis use, unspecified, uncomplicated
- F12.980** Cannabis use, unspecified with anxiety disorder

[C] Sedatives

- F13.10** Sedative, hypnotic or anxiolytic abuse, uncomplicated
- F13.129** Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
- 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

[C] Stimulants (eg, Caffeine, Amphetamines)

- F15.10** Other stimulant (amphetamine-related disorders or caffeine) abuse, uncomplicated
- 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
- F15.19** Other stimulant (amphetamine-related disorders or caffeine) abuse with unspecified stimulant-induced disorder
- F15.20** Other stimulant (amphetamine-related disorders or caffeine) dependence, uncomplicated
- F15.24** Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced mood disorder

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- 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

[C]Nicotine (eg, Cigarettes)

- F17.200** Nicotine dependence, unspecified, uncomplicated
- F17.201** Nicotine dependence, unspecified, in remission
- F17.203** Nicotine dependence unspecified, with withdrawal
- 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
- F17.290** Nicotine dependence, other tobacco products, uncomplicated (This includes Electronic nicotine delivery systems (ENDS), e-cigarettes, vaping)
- Z72.0** Tobacco use

Other

- F30.8** Other manic episodes
- F32.0** Major depressive disorder, single episode, mild
- F32.1** Major depressive disorder, single episode, moderate
- F32.4** Major depressive disorder, single episode, in partial remission
- F32.5** Major depressive disorder, single episode, in full remission
- F32.89** Other specified depressive episodes (eg, atypical depression, post-schizophrenic depression)
- F32.9** Major depressive disorder, single episode, unspecified
- F39** Mood (affective) disorder, unspecified
- F45.41** Pain disorder exclusively related to psychological factors
- F45.42** Pain disorder with related psychological factors (code also associated acute or chronic pain (G89.-))
- F48.9** Nonpsychotic mental disorder, unspecified
- F93.8** Childhood emotional disorders, other

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.

- G44.201** Tension-type headache, unspecified, intractable
- G47.9** Sleep disorder, unspecified
- N39.44** Nocturnal enuresis
- R06.02** Shortness of breath
- R06.4** Hyperventilation
- R07.9** Chest pain, unspecified
- R10.0** Acute abdomen pain
- R10.84** Generalized abdominal pain
- R11.0** Nausea
- R11.11** Vomiting without nausea
- R11.2** Nausea with vomiting, unspecified
- R19.8** Other specified symptoms and signs involving the digestive system and abdomen

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R42	Dizziness
R45.0	Nervousness
R45.83	Excessive crying of child, adolescent or adult
R45.89	Other symptoms and signs involving emotional state
R47.89	Other speech disturbances
R47.9	Unspecified speech disturbances
R51	Headache
R53.81	Other malaise
R53.82	Chronic fatigue, unspecified
R53.83	Other fatigue
R63.3	Feeding difficulties
R63.4	Abnormal weight loss
R63.5	Abnormal weight gain
R68.89	Other general symptoms and signs

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.

Z13.31	Encounter for screening for depression
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
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
Z62.812	Personal history of neglect in childhood
Z62.819	Personal history of unspecified 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 other legal circumstances
Z71.89	Counseling, other specified
Z71.9	Counseling, unspecified
Z72.0	Tobacco use
Z86.59	Personal history of other mental and behavioral disorders

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

★ Indicates CPT/CMS allows as a telemedicine service

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