

Implementation of the ACA Pediatric Preventive Services Provision

To ensure that all services children need are provided, it is critical that insurers pay for each separately reported service at a level that reflects the total relative value units (RVUs) of all separately reported services at each visit. For information on how to use this document, visit Achieving Bright Futures overview (http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/AchievingBF_Overview.pdf).

The *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* nomenclature includes codes used for identifying patient diagnoses. While every patient encounter includes at least one *ICD-9-CM* code, a single *CPT* code may be linked to several *ICD-9-CM* codes, depending on the diagnosis(es) involved.

What Does Bright Futures Recommend?

History

- Initial/Interval¹

Measurements

- Length and Weight¹
- Head Circumference¹
- Weight for Length¹
- Blood Pressure³

Sensory Screening

- Vision³
- Hearing³

Developmental/ Behavioral Assessment

- Developmental Surveillance¹
- Psychosocial/Behavioral Assessment¹

Physical Examination¹

Procedures

- Newborn Blood Screening²
- Immunization²
- Tuberculosis Testing⁴

Anticipatory Guidance¹

How are these services reported and paid?

Current Procedural Terminology (CPT®) codes are a set of descriptions and guidelines intended to describe procedures and services performed by physicians and other health care professionals. All services with specific *CPT* codes should be reported separately. Payment should, at a minimum, reflect the total RVUs outlined for the current year under the Medicare Resource-Based Relative Value Scale physician fee schedule, inclusive of all separately reported *CPT* and Healthcare Common Procedure Coding System (HCPCS) Level II codes. The relative values assigned to these codes recognize the significant clinical practice expense, physician work, and professional liability insurance expense involved in providing these services. HCPCS Level II codes are procedure codes used to report services and supplies not included in the *CPT* nomenclature.

What CPT codes are used to report the services provided in the “by 1 month” visit?

Preventive Medicine Services: New Patients

CPT Code	ICD-9-CM Code
99381 Infant (younger than 1 year) <ul style="list-style-type: none"> • Initial comprehensive preventive medicine evaluation and management of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures. • Only report a “new” patient if the newborn was never seen in the hospital by a physician from your group practice and of the same specialty. • A <i>new patient</i> is defined as one who has not received any professional services (face-to-face services rendered by a physician/other qualified health care professional who may report evaluation and management services reported by a specific <i>CPT</i> code[s]) from a physician/other qualified health care professional or another physician/other qualified health care professional of the exact same specialty who belongs to the same group practice, within the past 3 years. 	V20.32 Newborn check 8 to 28 days of age V20.2 Routine infant or child health check (over 28 days of age)

1. Service is recommended and its reporting is subsumed by preventive medicine services code.
 2. Service is recommended and is reported separately with its own code.
 3. Risk assessment is recommended and its reporting is subsumed by preventive medicine services code.
 4. Risk assessment is recommended and its reporting is subsumed by preventive medicine services code. If risk assessment is positive, a screening test is conducted and is reported separately with its own code.
CPT is a registered trademark of the American Medical Association.



Preventive Medicine Services: Established Patients

CPT Code	ICD-9-CM Code
99391 Infant (younger than 1 year) <ul style="list-style-type: none"> Periodic comprehensive preventive medicine reevaluation and management of an individual includes an age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures 	V20.32 Newborn check 8 to 28 days of age

Vision

If the risk assessment is positive, referral to an ophthalmologist is recommended.

Hearing

If the risk assessment is positive, referral to an audiologist is recommended.

Newborn Blood Screening

(recommended if not done previously)

The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>) establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

NOTE: HCPCS Codes

- HCPCS Level II codes are procedure codes used to report services and supplies not included in the CPT nomenclature.
- Like CPT codes, HCPCS Level II codes are part of the standard procedure code set under the Health Insurance Portability and Accountability Act of 1996.

HCPCS Code	ICD-9-CM Code
S3620 Newborn metabolic screening panel, includes test kit, postage, and the laboratory tests specified by the state for inclusion in this panel (eg, galactose; hemoglobin; electrophoresis; hydroxyprogesterone, 17-d; phenylalanine; and thyroxine, total)	V77.0 Special screening for thyroid disorders V77.3 Special screening for phenylketonuria V77.4 Special screening for galactosemia V77.7 Special screening for other inborn errors of metabolism V77.99 Special screening for other and unspecified endocrine, nutritional, metabolic, and immunity disorders V78.0 Special screening for iron deficiency anemia V78.1 Special screening for other and unspecified deficiency anemia V78.2 Special screening for sickle cell disease or trait V78.3 Special screening for other hemoglobinopathies V78.8 Special screening for other disorders of blood and blood-forming organs V72.6 Laboratory examination (NOTE: reported secondary to code[s] for screening[s])

Immunizations

Hepatitis B #1 (if not given previously)

Consult the AAP Web site (<http://aapredbook.aappublications.org/site/resources/izschedules.xhtml>) for the current immunization schedule (Recommended Immunization Schedule, 0–18 years).

Refer to the AAP Vaccine Coding Table (http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Commonly_Administered_Pediatric_Vaccines_Coding_Table.pdf) for vaccine product and immunization administration codes.

Tuberculosis Testing

These codes are used if the risk assessment is positive and a test is administered. Otherwise, the risk assessment is subsumed by the preventive medicine services code and not separately reported.

CPT Code	ICD-9-CM Code
<p>Administration of purified protein derivative (PPD) test</p> <p>86580 Skin test; tuberculosis, intradermal (NOTE: Administration is included.)</p>	<p>V74.1 Special screening for examination of pulmonary tuberculosis</p>
<p>Reading of PPD test</p> <p>99211 Office or other outpatient services (nurse visit)</p>	<p>V74.1 Special screening for examination of pulmonary tuberculosis (IF TEST IS NEGATIVE) or</p> <p>795.51 Nonspecific reaction to tuberculin skin test without active tuberculosis (IF TEST IS POSITIVE)</p>

For questions on state implementation of/state decisions on insurance plan benefit packages or working with state AAP chapters, contact stgov@aap.org. For questions about coding and payment, contact aapcodinghotline@aap.org. For general questions about Bright Futures, contact BrightFutures@aap.org.



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