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).

What Does Bright Futures Recommend?

History
- Initial/Interval[1]

Measurements
- Height and Weight[1]
- Body Mass Index (BMI)[1]
- Blood Pressure[1]

Sensory Screening
- Vision[4]
- Hearing[4]

Developmental/ Behavioral Assessment
- Developmental Surveillance[1]
- Psychosocial/Behavioral Assessment[1]

Physical Examination[1]

Procedures
- Immunizations[2]
- Hematocrit or Hemoglobin[4]
- Tuberculosis Testing[4]
- Dyslipidemia Screening[2]

Anticipatory Guidance[1]

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.

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 *CPT* codes are used to report the services provided in the 9 year visit?

Preventive Medicine Services: New Patients

CPT Code		*ICD-9-CM* Code	
99383	Late childhood (age 5 through 11 years)	**V20.2**	Routine infant or child health check (over 28 days of age)
• 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. • A *new patient* 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 CPT 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.			

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.

Preventive Medicine Services: Established Patients

CPT Code		*ICD-9-CM* Code	
99393	Late childhood (age 5 through 11 years) • 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.	**V20.2**	Routine infant or child health check (over 28 days of age)

Vision

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

CPT Code		*ICD-9-CM* Code	
99173	Screening testing of visual acuity, quantitative, bilateral	**V20.2**	Routine infant or child health check (over 28 days of age)
99174	Instrument-based ocular photoscreening with interpretation and report (eg, photoscreening, automated-refraction, automated visual evoked potential), bilateral		

Hearing

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

CPT Code		*ICD-9-CM* Code	
92551	Screening test, pure tone, air only	**V20.2**	Routine infant or child health check (over 28 days of age)
92552	Pure tone audiometry (threshold); air only		
92567	Tympanometry (impedance testing)		

Immunizations

Influenza (yearly as appropriate)

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.

Hematocrit or Hemoglobin

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

CPT Code		*ICD-9-CM* Code	
36415	Collection of venous blood by venipuncture	**V78.0**	Special screening for iron deficiency anemia
36416	Collection of capillary blood specimen	**V72.6**	Laboratory examination (NOTE: reported secondary to code[s] for screening[s])
85014	Blood count; hematocrit (only report if a lab will not be reporting)		
85018	Blood count; hemoglobin (only report if a lab will not be reporting)		

Tuberculosis Testing

These codes are used if the risk assessment is positive and 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	
Administration of purified protein derivative (PPD) test		**V74.1**	Special screening for examination of pulmonary tuberculosis
86580	Skin test; tuberculosis, intradermal (NOTE: Administration is included.)		
Reading of PPD test		**V74.1**	Special screening for examination of pulmonary tuberculosis (IF TEST IS NEGATIVE)
		or	
99211	Office or other outpatient services (nurse visit)	**795.51**	Nonspecific reaction to tuberculin skin test without active tuberculosis (IF TEST IS POSITIVE)

Dyslipidemia Screening

CPT Code		*ICD-9-CM* Code	
80061	Lipid panel (includes total cholesterol, high-density lipoprotein [HDL] cholesterol, and triglycerides)	**V77.91**	Screening for lipoid disorders
82465	Cholesterol, serum, total	**V72.6**	Laboratory examination (NOTE: reported secondary to code[s] for screening[s])
83718	Lipoprotein, direct measurement, HDL cholesterol		
84478	Triglycerides		

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.