



When is it Appropriate to Report an Evaluation & Management Service During Immunization Administration?

American Academy of Pediatrics Committee on Coding and Nomenclature

For temporary changes due to COVID-10 pandemic see page 6

When vaccines are given in the pediatric office, questions often arise concerning the reporting of evaluation and management (E/M) services performed during the same encounter where vaccines are administered. The answer always depends on whether the provider performs a *medically necessary and significant, separately identifiable E/M visit, in addition to the immunization administration*. If such a service is performed, an E/M code is reported, most likely from the 99201-99215 code family (office or other outpatient service), in addition to the appropriate code for immunization administration (90460-90461 or 90471-90474) plus the code for the vaccine product(s). In such cases, payers may require that modifier 25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) be appended to the E/M code to distinguish it from the actual administration of the vaccine.

The identification of a significant, separately identifiable service for E/M codes usually involves the performance and documentation of the “key components” (ie, history, physical examination, and medical decision making) or time spent in counseling or coordination of care.

It is important to note that the reporting of code 99211 is unique among E/M codes in having no key component requirements. The *Current Procedural Terminology (CPT®)* descriptor for code 99211 states, “Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.”

What justifies the separate reporting of an E/M code and immunization administration requires further clarification.

To address this issue, it becomes important to determine the following:

- What services are included in the immunization administration codes?
- What additional services are required to appropriately report an E/M code?
- And, since 99211 lacks the “key component” requirement, what are its documentation requirements?

What Services Are Included in the Immunization Administration Codes?

The following services are included in the immunization administration CPT codes:

- Administrative staff services, such as making the appointment, preparing the patient chart, billing for the service, and filing the chart
- Clinical staff services, such as greeting the patient, taking routine vital signs, obtaining a vaccine history on past reactions and contraindications, presenting a Vaccine Information Sheet (VIS) and answering

routine vaccine questions, preparing and administering the vaccine with chart documentation, and observing for any immediate reaction

The Centers for Medicare and Medicaid Services (CMS) views the services that are included in the immunization administration codes equivalent to the services provided in a 99211 E/M service and thus the relative value units (RVUs) for the immunization administration codes are valued similarly to the 99211 code. In addition, CMS recognizes that the immunization administration services are typically performed in conjunction with an E/M visit and the immunization administration RVUs reflect this.

The immunization administration codes are valued on the Medicare physician fee schedule (Resource-Based Relative Value Scale [RBRVS]) as follows:

CPT Code	Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Total Non-Facility RVUs	2021 Medicare Non-Facility Payment
90460†	0.17	0.34	0.01	0.52	\$16.85*
90461†	0.15	0.24	0.01	0.40	\$12.96
90471	0.17	0.34	0.01	0.53	\$16.85
90472	0.15	0.24	0.01	0.40	\$12.96
90473	0.17	0.34	0.01	0.52	\$16.85
90474	0.15	0.24	0.01	0.40	\$12.96

RVUs = Relative Value Units

†Codes 90460 and 90461 require vaccine counseling to be performed by the physician or other qualified health care professional

*Sample conversion for 90460

Medicare 2021 conversion factor = \$32.41

0.52 RVUs x \$32.41 = \$16.85

What Additional Services Are Required to Appropriately Report an E/M Code In Addition to an Immunization Administration Code?

The E/M service must exceed those services included in the immunization administration codes. In addition, there are 2 principles to keep in mind. They are as follows:

1. The service must be medically necessary.
2. The service must be separate and significant from the immunization administration.

When the provider evaluates, manages, and documents the significant and separate complaint(s) or problem(s), the additional reporting of an E/M code is justified. In such circumstances, the provider typically conducts a brief history and record review along with a physical assessment (eg, indicated vital signs and observations) and provides patient education in helping the family or patient manage the problem encountered. These activities are related to the significant, separate complaint, and unrelated to the immunization administration.

What Are the Documentation Requirements for a 99211?

All reported E/M codes must meet documentation requirements as outlined in *CPT* guidelines or in the CMS Documentation Guidelines. All office-based E/M services that physicians perform require either a defined time or documented medical decision making must be met to reach a code level.

Code 99211 is the one E/M service typically provided by clinical staff and not the physician. As such, its documentation requirements differ. There are no required key components typical of the 99211 service and no time range. The American Academy of Pediatrics encourages documenting the date of service and reason for the visit, a brief history of any significant problems evaluated or managed, any examination elements (eg, vital signs and/or general appearance), a brief assessment and/or plan along with any counseling or patient education done, and signatures of the clinical staff and supervising physician.

While not required, it may help payers to better understand the medical necessity of the 99211 service if it is linked to a different *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)** code than the one used for the vaccine given when appropriate. Further, encounter documentation for the 99211 service should be a separate entry from the charting of the vaccine itself (product, lot number, site and method, VIS date, etc, which usually are all recorded on the immunization history sheet). Each practice should consider developing protocols and progress note templates for vaccine services.

Finally, if the clinical staff provides the 99211 visit, it is reported under the physician's name/tax ID number, making it inherently an "incident to" service. In such situations, it is a service restricted to established patients and requires the supervising physician's "direct supervision," which is defined by the CMS as the physician being physically present in the office suite (not in the patient's room) and immediately available to provide assistance. Most "nurse" E/M services are carried out under a protocol of orders developed by the physician for the particular service and should be fully documented in the record.

Coding Information from *Current Procedural Terminology* and CMS

The American Medical Association provides some instruction on the correct reporting of 99211 at the time of immunization administration via *Current Procedural Terminology* guidelines. Within the Immunization Administration for Vaccines/Toxoids section of the CPT nomenclature, it states,

"If a significant separately identifiable Evaluation and Management service (eg, office of other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes."

CMS also provides direction for reporting 99211 during visits where only the clinical staff sees the patient and gives an injection. Under CMS Medicare payment policy, it is not correct to report an E/M service if the clinical staff services are only related to the injection itself. CMS already provides reimbursement for the activities of the clinical staff related to the injection via the immunization administration codes.

Coding Examples

Vignette #1

A five-year-old is brought in by the father for a catch-up measles-mumps-rubella (MMR) vaccine. The child is healthy and has already been counseled on the vaccine and has no concerns. The nurse proceeds to review the vaccine

history, presents the VIS, and receives an order for the vaccine from the physician. She then administers and documents the vaccine. In this situation, the service is only vaccine related and no significant or separate E/M service is provided. Therefore, the only services reported are the immunization administration and the vaccine product code.

This encounter will be reported as follows:

CPT

90707 (MMR vaccine)

90471 (immunization administration)

ICD-10-CM

Z23 [link to both vaccine product and administration]

Vignette #2

A 7-month-old girl visits your office to be immunized against influenza and is seen only by your nurse. The mother mentions that the child had a cough and asks the nurse for advice about the potential contraindications to receiving the influenza vaccine. The nurse takes a brief history and brief exam and determines that the child has no other concerning symptoms (ie, no fever, no change in appetite, sleep, or activity level). He takes vital signs and assesses that the infant has no contraindications to getting the vaccine, and discusses the office practice protocol for the management of the respiratory problem with the mother. Additionally, the nurse documents that the patient meets the current guidelines for vaccination and has no contraindications to the immunization per the Centers for Disease Control and Prevention (CDC) guidelines. Next, he reviews the VIS with the mother and obtains consent for the immunization. The nurse then administers the influenza vaccine.

This encounter will be reported as follows:

CPT

99211-25 (E/M service)

90657 (influenza vaccine)

90471 (immunization administration)

ICD-10-CM

R05 (cough)

Z23 (encounter for immunization) [link to both the vaccine product and administration]

Note: There is an NCCI edit on 99211 and 90471 and no modifier can override. Some payers do not follow this, and it is appropriate to report. See the [October 2021: NCCI Edit Update](#)

An example of written documentation for this 99211 encounter follows (the actual vaccine data with lot number and site/route and VIS date are recorded on a separate immunization record):

The patient is here for the influenza vaccine. Mother reports a cough for several days without any fever. She is eating well and there has been no wheezing or rapid breathing. Her temperature is 98.7°F and respiratory rate is 38/minute – she appears well. The symptomatic treatment of the cough per protocol was discussed and the mother was instructed to call or return if the problem worsened. She has no allergies to foods or history of reactions to past vaccines. The risks and potential side effects of the hepatitis B vaccine were discussed after the VIS was given, and the mother was informed of the correct dosage of an antipyretic should fever or fussiness occur afterwards. An influenza vaccine was given.

K. Brooks, LPN/R. Dunn, MD (signatures/date)

Vignette #3

A 4-month-old patient was brought in for her well child check by her father. The father asked that the vaccines be delayed until the mom could bring the child back. During the routine encounter, poor weight gain was noted and bloody stools. Labs were sent out and father advised to change to a soy-based formula. Mom returns two weeks later with the baby to evaluate weight-gain and discuss the results of the labs. The physician performs a problem focused

history, finding the symptoms from the earlier illness had resolved. Vitals show the infant has gained weight. A milk protein allergy is diagnosed. After assessing the patient, she confirms that there are no contraindications to the immunization per the CDC guidelines. The physician counsels the mom and answers her questions and then writes the order for the nurse to give the vaccines. Next, the nurse reviews the VIS with the mother and antipyretic dosage for weight. The nurse then administers the DTaP-IPV/Hib, Pneumococcal and Rotavirus.

This encounter will be reported as follows:

CPT

99213-25 (E/M service)

90698 (DTaP-IPV/Hib)

90680 (Rotavirus)

90670 (Pneumococcal)

90460 x3 (immunization administration)

90461 x 4

ICD-10-CM

R19.5 (blood in stool)

Z91.011 (allergy to milk protein)

Z23 [link to both vaccine product and administration]

NOTE: Some payers may inappropriately deny claims that link code 99211 to a “Z” ICD-10-CM code. Neither CPT nor ICD-10-CM guidelines prohibit such reporting when the ICD-10-CM code reported is the most specific one available to describe the patient encounter. Furthermore, CPT guidelines clearly outline the requirements for reporting a given level E/M code. If the key components of history, physical examination, and medical decision making or time requirements (when greater than 50% of the visit is spent counseling/coordinating care) are met for a given code, the physician is correct in the reporting of that code. *Current Procedural Terminology* guidelines do not make the reporting of a certain level E/M code contingent upon the patient exhibiting certain symptoms or falling under a particular diagnosis. *Current Procedural Terminology* guidelines correctly recognize that there can be considerable variation in the treatment of a patient with a particular diagnosis and that it is inappropriate to validate the legitimacy of a reported E/M code by the presence of a certain diagnosis(es). Claims adjudication processes that prohibit the reporting of “Z” ICD-10-CM codes with anything other than Preventive Medicine Services CPT codes are inconsistent with CPT and ICD-10-CM guidelines and are counterintuitive to the continuum of care that can be provided for a patient with a given diagnosis. Further, it should be noted that the Office or Other Outpatient Services CPT codes (**99201-99215**) are *not* limited to “sick” visits only. Therefore, it is appropriate to report “Z” codes or any other ICD-10-CM codes that most appropriately reflect the reason for the encounter with the Office or Other Outpatient Services codes.

a. Use of Z codes in any healthcare setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

b. Z Codes indicate a reason for an encounter

Z codes are diagnosis codes not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure or service performed.

c. Categories of Z Codes

2) Inoculations and vaccinations

Code Z23 is for encounters for vaccinations. It indicates that a patient is being seen to receive a vaccine. Procedure codes are required to identify the actual vaccine given through the product code. Code Z23 is used as a secondary code if the vaccine is given as a routine part of preventive health care, such as a well-baby visit. Report the appropriate Z00.12- code as primary followed by the Z23.

October 2021: NCCI Edit Update

Through AAP advocacy, the Centers for Medicare and Medicaid Services (CMS) has removed the existing NCCI edit on CPT codes 99211 and immunization administration codes 90460, 90461, 90471-90474. While we believe this to be temporary, this is in response to CMS' guidance on coding for COVID-19 testing in the office-setting.

Per CMS:

Q14: If a physician/non-physician practitioner (NPP) reports CPT code 99211 "Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician," for assessment and collection of COVID-19 diagnostic laboratory test specimen for a new patient as permitted under Medicare during the COVID-19 PHE, and the physician/Non-physician practitioner (NPP) subsequently, on a different day, furnishes an Evaluation and Management (E/M) visit to the patient for other reasons, can he/she report a new patient E/M visit code for the subsequent visit?

Answer: Yes, in this situation, under the unique circumstances of the PHE, the patient is not considered an established patient merely due to the reporting of CPT code 99211 for assessment and collection of COVID-19 specimen for a new patient. We note that if a higher level E/M visit is furnished to a new patient at the time of COVID-19 specimen collection, the encounter should be reported using the higher level new patient visit code rather than CPT code 99211, and in this case the patient would be considered an established patient for the subsequent visit and a new patient E/M visit code should not be reported until 3 years have passed, as specified under the usual billing rules.

Source: <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

Vignette #4

A 7-month-old presents to the office to be immunized against influenza and is seen only by the nurse. The caregiver mentions that the child has a very slight cough and asks the nurse for advice about the potential contraindications to receiving the influenza vaccine and concerns over COVID-19. The nurse takes a brief history and brief exam and determines that the child has no other concerning symptoms, but given the current rates of COVID-19 positivity in the county, a COVID-19 test is ordered. Vital signs are taken and the baby is briefly assessed by the nurse. The COVID test is completed in the office and the result is negative. The nurse then discusses the office's protocol for the management of the mild respiratory problem. Additionally, the nurse documents that the patient meets the current guidelines for vaccination and has no contraindications to the immunization per the CDC guidelines. The VIS is reviewed with the mother and obtains consent for the immunization. The nurse then administers the influenza vaccine.

This encounter will be reported as follows:

CPT

99211-25 (E/M service)

90657 (influenza vaccine)

90471 (immunization administration)

Appropriate CPT code for the COVID-19 test

ICD-10-CM

R05 (*cough*)

Z20.822 Contact with and (suspected) exposure to COVID-19

Z23 (encounter for immunization) [link to both the vaccine product and administration]

For questions, please contact the [AAP Coding Hotline](#)