Inattention, Impulsivity, Disruptive Behavior and Aggression Coding Fact Sheet for Primary Care Pediatricians

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

★99202  Office or other outpatient visit, new patient; straightforward medical decision making (MDM), 15-29 min.
★99203  low MDM, 30-44 min.
★99204  moderate MDM, 45-59 min.
★99205  high MDM, 60-74 min.

A new patient is one who has not received any professional services face-to-face services rendered by physicians and other qualified health care professionals (QHP) who may report evaluation and management services reported by a specific CPT code(s) from the physician/QHP or another physician/QHP 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  straightforward MDM, 10-19 min.
★99213  low MDM, 20-29 min.
★99214  moderate MDM, 30-39 min.
★99215  high MDM, 40-54 min.

★+99417  Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour (use in conjunction with codes 99205, 99215 only)
  • Used only with the highest level E/M services (99205, 99215)
  • Time spent does not have to be continuous but must occur on the same day as the face-to-face encounter
  • Prolonged service begins at 75 minutes for new patients (99205 and 99417) and 55 minutes for established patients (99215 and 99417)
  • Prolonged time can include non-direct services on the same day as the encounter

Reporting E/M services using “Time” vs MDM

• A physician will report their level of E/M service using time or MDM
• If reporting based on “time” count all time on the encounter date, including pre- and post service time spent on that patient, even if the patient is not present
• You do not have to meet “time” requirements in the code descriptor to meet a code level if billing based on MDM

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★ 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.
- 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 and parents may not initiate a consultation).

★ +99354  **Prolonged services** in office or other outpatient setting, with direct patient contact; first hour (*use in conjunction with time-based codes 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).
- 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 are not reported separately.

**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.*

**Principal Care Management**

1. A single (i) chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
2. A condition that requires development, monitoring, or revision of disease-specific care plan,
3. A condition that requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities
4. Ongoing communication and care coordination between relevant practitioners furnishing care may be reported by different physicians or QHPs in the same calendar month for the same patient
5. Documentation in the patient's medical record should reflect coordination among relevant managing clinicians
6. Principal care management services are disease-specific management services. Even if a patient may have multiple chronic conditions they may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management

99424  Principal care management services, for a single high-risk disease, with the following required elements:
- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management.
of the condition is unusually complex due to comorbidities,
• ongoing communication and care coordination between relevant practitioners furnishing care;
first 30 minutes provided personally by a physician or other QHP, per calendar month.
+ 99425 each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to 99424)

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

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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

**Psychiatric Diagnostic or Evaluative Interview Procedures**
★ 90791 Psychiatric diagnostic interview examination evaluation
★ 90792 Psychiatric diagnostic evaluation with medical services

**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 ADHD scales)

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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 (Non-Direct and Direct)**

CPT defines a qualified nonphysician health care professional as 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 (Direct Care)**

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.*

**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.

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G47.9</td>
<td>Sleep disorder, unspecified</td>
</tr>
<tr>
<td>H90.0</td>
<td>Conductive hearing loss, bilateral</td>
</tr>
<tr>
<td>H90.11</td>
<td>Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side</td>
</tr>
<tr>
<td>H90.12</td>
<td>Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side</td>
</tr>
<tr>
<td>K11.7</td>
<td>Disturbance of salivary secretions</td>
</tr>
<tr>
<td>K59.00</td>
<td>Constipation, unspecified</td>
</tr>
<tr>
<td>N39.44</td>
<td>Nocturnal enuresis</td>
</tr>
<tr>
<td>R10.0</td>
<td>Acute abdomen pain</td>
</tr>
<tr>
<td>R11.11</td>
<td>Vomiting without nausea</td>
</tr>
<tr>
<td>R11.2</td>
<td>Nausea with vomiting, unspecified</td>
</tr>
<tr>
<td>R19.7</td>
<td>Diarrhea, unspecified</td>
</tr>
<tr>
<td>R21</td>
<td>Rash, NOS</td>
</tr>
<tr>
<td>R25.0</td>
<td>Abnormal head movements</td>
</tr>
<tr>
<td>R25.1</td>
<td>Tremor, unspecified</td>
</tr>
<tr>
<td>R25.3</td>
<td>Twitching, NOS</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R25.8</td>
<td>Other abnormal involuntary movements</td>
</tr>
<tr>
<td>R25.9</td>
<td>Unspecified abnormal involuntary movements</td>
</tr>
<tr>
<td>R27.8</td>
<td>Other lack of coordination (excludes ataxia)</td>
</tr>
<tr>
<td>R27.9</td>
<td>Unspecified lack of coordination</td>
</tr>
<tr>
<td>R41.83</td>
<td>Borderline intellectual functioning</td>
</tr>
<tr>
<td>R41.840</td>
<td>Attention and concentration deficit</td>
</tr>
<tr>
<td>R41.89</td>
<td>Other symptoms and signs involving cognitive functions and awareness</td>
</tr>
<tr>
<td>R42</td>
<td>Dizziness</td>
</tr>
<tr>
<td>R45.0</td>
<td>Nervousness</td>
</tr>
<tr>
<td>R45.1</td>
<td>Restlessness and agitation</td>
</tr>
<tr>
<td>R45.4</td>
<td>Irritability and anger</td>
</tr>
<tr>
<td>R45.5</td>
<td>Hostility</td>
</tr>
<tr>
<td>R45.6</td>
<td>Violent behavior</td>
</tr>
<tr>
<td>R45.87</td>
<td>Impulsiveness</td>
</tr>
<tr>
<td>R45.89</td>
<td>Other symptoms and signs involving emotional state</td>
</tr>
<tr>
<td>R48.0</td>
<td>Alexia/dyslexia, NOS</td>
</tr>
<tr>
<td>R51</td>
<td>Headache</td>
</tr>
<tr>
<td>R62.0</td>
<td>Delayed milestone in childhood</td>
</tr>
<tr>
<td>R62.52</td>
<td>Short stature (child)</td>
</tr>
<tr>
<td>R63.3</td>
<td>Feeding difficulties</td>
</tr>
<tr>
<td>R63.4</td>
<td>Abnormal weight loss</td>
</tr>
<tr>
<td>R63.5</td>
<td>Abnormal weight gain</td>
</tr>
<tr>
<td>R68.2</td>
<td>Dry mouth, unspecified</td>
</tr>
<tr>
<td>T56.0X1-</td>
<td>Toxic effect of lead and its compounds, accidental (unintentional)</td>
</tr>
</tbody>
</table>

### Anxiety Related Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F06.4</td>
<td>Anxiety disorder due to known physiological condition</td>
</tr>
<tr>
<td>F40.00</td>
<td>Agoraphobia, unspecified</td>
</tr>
<tr>
<td>F40.01</td>
<td>Agoraphobia with panic disorder</td>
</tr>
<tr>
<td>F40.02</td>
<td>Agoraphobia without panic disorder</td>
</tr>
<tr>
<td>F40.10</td>
<td>Social phobia, unspecified</td>
</tr>
<tr>
<td>F40.11</td>
<td>Social phobia, generalized</td>
</tr>
<tr>
<td>F40.8</td>
<td>Phobic anxiety disorders, other (phobic anxiety disorder of childhood)</td>
</tr>
<tr>
<td>F40.9</td>
<td>Phobic anxiety disorder, unspecified</td>
</tr>
<tr>
<td>F41.0</td>
<td>Panic disorder [episodic paroxysmal anxiety] without agoraphobia (panic attack)</td>
</tr>
<tr>
<td>F41.1</td>
<td>Generalized anxiety disorder</td>
</tr>
<tr>
<td>F41.9</td>
<td>Anxiety disorder, unspecified</td>
</tr>
</tbody>
</table>

### Behavioral/Emotional Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F90.0</td>
<td>Attention-deficit hyperactivity disorder, predominantly inattentive type</td>
</tr>
<tr>
<td>F90.1</td>
<td>Attention-deficit hyperactivity disorder, predominantly hyperactive type</td>
</tr>
<tr>
<td>F90.8</td>
<td>Attention-deficit hyperactivity disorder, other type</td>
</tr>
<tr>
<td>F90.9</td>
<td>Attention-deficit hyperactivity disorder, unspecified type</td>
</tr>
<tr>
<td>F91.1</td>
<td>Conduct disorder, childhood-onset type</td>
</tr>
<tr>
<td>F91.2</td>
<td>Conduct disorder, adolescent-onset type</td>
</tr>
<tr>
<td>F91.3</td>
<td>Oppositional defiant disorder</td>
</tr>
<tr>
<td>F91.9</td>
<td>Conduct disorder, unspecified</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F93.0</td>
<td>Separation anxiety disorder</td>
</tr>
<tr>
<td>F93.8</td>
<td>Other childhood emotional disorders (relationship problems)</td>
</tr>
<tr>
<td>F93.9</td>
<td>Childhood emotional disorder, unspecified</td>
</tr>
<tr>
<td>F94.9</td>
<td>Childhood disorder of social functioning, unspecified</td>
</tr>
<tr>
<td>F95.0</td>
<td>Transient tic disorder</td>
</tr>
<tr>
<td>F95.1</td>
<td>Chronic motor or vocal tic disorder</td>
</tr>
<tr>
<td>F95.2</td>
<td>Tourette's disorder</td>
</tr>
<tr>
<td>F95.9</td>
<td>Tic disorder, unspecified</td>
</tr>
<tr>
<td>F98.8</td>
<td>Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (nail-biting, nose-picking, thumb-sucking)</td>
</tr>
</tbody>
</table>

**Mood [Affective] Disorders**
- F30.8 Other manic episodes
- F34.1 Dysthymic disorder
- F39 Unspecified mood [affective] disorder

**Neurodevelopmental/Other Developmental Disorders**
- F70 Mild intellectual disabilities
- 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
- F80.89 Other developmental disorders of speech and language
- F80.9 Developmental disorder of speech and language, unspecified
- F81.0 Specific reading disorder (dyslexia)
- F81.2 Mathematics disorder
- F81.81 Disorder of written expression
- F81.89 Other developmental disorders of scholastic skills
- F82 Developmental coordination disorder
- F84.0 Autistic disorder
- F88 Specified delays in development; other
- F89 Unspecified delay in development
- F81.9 Developmental disorder of scholastic skills, unspecified

**Substance Induced Anxiety Disorders**
- F10.980 Alcohol use, unspecified with alcohol-induced anxiety disorder
- F12.180 Cannabis abuse with cannabis-induced anxiety disorder
- F12.980 Cannabis use, unspecified with anxiety disorder
- F13.180 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
- F13.980 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
- F14.180 Cocaine abuse with cocaine-induced anxiety disorder
- F14.980 Cocaine use, unspecified with cocaine-induced anxiety disorder
- F15.180 Other stimulant abuse with stimulant-induced anxiety disorder
- F16.180 Hallucinogen abuse with hallucinogen-induced anxiety disorder
- F16.980 Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder

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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.

(a) 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.

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

(c) 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.

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- 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
- 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)
- Z81.8 Family history of other mental and behavioral disorders
- 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

* 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