



Adult Current Procedural Terminology® Coding Case Scenarios

BACKGROUND

Over the past five years, in an effort to address the continuing problem of administrative burden for physicians in nearly every specialty, changes to the CPT code set have been approved for use by the American Medical Association and finalized in the Medicare Physician Fee Schedule.^{1,2} These changes consist of new stand-alone immunization counseling and improved E/M coding options. A chart of these codes is provided in Appendix 1 and 2 (page 11).

In 2026, new standalone immunization counseling codes became available. These codes can only be used by providers for non-Medicare patients to bill for standalone immunization counseling (i.e., when a provider counsels a patient for an immunization, but a vaccine is not administered).³ Because not all commercial and Medicaid plans will cover these new codes, providers should consult individual payors.

For Medicaid plans, despite being permitted to cover these codes, each plan will have a different policy since the Centers for Medicare & Medicaid Services (CMS) is maintaining existing Healthcare Common Procedure Coding System (HCPCS) codes for nearly identical services (i.e., G0310-G0315). For example, G0310 description is *Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time.* (This code is used for Medicaid billing purposes.) Medicaid plans will either cover the new CPT codes, the HCPC codes, or both code sets. While general coding convention dictates that providers should use CPT codes instead of HCPCS codes, when both are available, **the American Academy of Pediatrics (AAP) has informed providers** that *“HCPCS codes G0310-G0315, which represent standalone immunization counseling by a physician or other QHP, may be required for quality reporting purposes.”*³ As such, providers will need to follow their individual state’s billing guidance to determine the appropriate codes to include on a claim for reimbursement of standalone immunization counseling.

In addition to the immunization counseling codes, in 2021, the CPT panel made revisions relevant to documenting an immunization office visit to allow for the use of “Total Time” or the use of “Medical Decision Making”⁴ as key contributing factors, for the basis of payment for non-standalone immunization counseling and administration. Use of codes that account for total time can be used for Medicare visits to account for time spent on vaccine counseling. See Appendix 1. However, standalone vaccine counseling codes are not approved for Medicare.

Coding based on time is well suited for non-standalone immunization counseling as there is often low medical decision making involved for implementing vaccine recommendations. The definition of time, under these new revisions, is total time, not typical time, and represents total physician/qualified health profession (QHP) time on the date of service. The use of date-of-service time also allows for the billing of work involved in non-face-to-face services like care coordination and review of immunization records.

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² American Medical Association. CPT© Evaluation and Management. www.ama-assn.org/cpt-evaluation-and-management

³ American Academy of Pediatrics. www.aap.org/en/practice-management/child-health-finance-payment-strategy/payment-and-financial-resources/vaccine-financing-and-coding/standalone-immunization-counseling/

⁴ The medical decision-making components for the revised office visits can be found at www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf. The subject of this brief is about the coding relative to use of “total time.”

The code level selection process has changed in common immunization-related scenarios from previous documentation standards for history and physical. Under the 2021 guidelines:

1. Although a *medically necessary* history and exam should be performed as appropriate, only medical decision-making or time may be used to select the level of service performed.
2. The time requirements have changed in that, rather than face-to-face time with the patient, the physician's total time on the date of the encounter is summed.

The codes, which now allow for billing total time, seek to decrease administrative burden of documentation and coding while ensuring payment for E/M is resource-based. It is important to note that providers cannot bill for prolonged counseling time plus standalone immunization counseling for the same visit. Per CPT coding conventions, providers should always use the most specific CPT codes unless their payer policy states otherwise.

For a complete description of the code changes regarding billing for total time, and numerous educational modules, see the American Medical Association website (www.ama-assn.org/cpt-office-visits). Additional information from the American Academy of Pediatrics on standalone immunization counseling can be found at: www.aap.org/en/practice-management/child-health-finance-payment-strategy/payment-and-financial-resources/vaccine-financing-and-coding/standalone-immunization-counseling

The following case studies are designed to provide guidance on appropriate coding and billing for a range of immunization counseling and vaccination scenarios for providers who care for adults.

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■ CASE 1

OFFICE VISIT: Low complexity, immunization counseling with no vaccine administration

A 48-year-old patient with private insurance visits his provider for his annual comprehensive health and wellness visit, which includes a review of the patient's past medical history, an annual physical exam, and coordination of follow-up monitoring of high cholesterol and pre-diabetes. This patient is an established patient and is indicated for an influenza vaccine and a tetanus, diphtheria, pertussis (Tdap)/ tetanus and diphtheria (Td) booster vaccination.

The physician spends 5 minutes prior to the visit, on the date of encounter, reviewing the patient's history, including looking for prior immunizations for this patient in the state immunization information system (IIS). At the visit, the provider counsels the patient for 5 minutes on the Td/Tdap booster recommendation and the importance of annual influenza vaccination. The patient decides not to get either vaccine. The total time spent on the encounter lasts 40 minutes (30 minutes visit, 5 minutes of work prior to the visit, and 5 minutes of immunization counseling).

Item Coding	CPT Code	Comment
Established Patient Preventive Medicine Services Visit	99396 age 40-64	For cholesterol and pre-diabetic condition (35 min)
Immunization Counseling, 3-10 minutes	90482	Counseling (5 min)

Explanation of code selection

Under the new policy, the provider can bill separately for immunization counseling. The correct code is the standalone immunization counseling code. Since the counseling occurred for less than 10 minutes but more than 3 minutes, 90482 is the appropriate code.

The provider can also bill the preventive visit code which is linked to age [99394 (age 18-39), 99396 (age 40-64), 99397 (age 65 and older)] since the provider counseled on preventive screening and conducted an exam. No specific times are associated with these codes. Because these codes are not time based, no changes are required relative to the AMA changes.

Under the new coding rules, the non "face-to-face" time spent on the date of the encounter can be counted regardless of the fact that the total time for this patient encounter results in the same code being previously chosen.

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CASE 2

PREVENTIVE VISIT: With separately identifiable E/M performed, immunization counseling with no vaccine administration

A 30-year-old patient with private insurance makes an appointment for her annual comprehensive preventive visit and to request a hepatitis B vaccination as part of her healthcare setting employee health recommendations. This is an existing patient.

At the visit, the provider conducts a comprehensive preventive exam and counsels the patient on age-appropriate screening labs and tests that the patient should consider. The patient is also diabetic, but stable. The physician provides appropriate counseling on properly managing the patient's diabetes.

After providing counseling on hepatitis B vaccination risks and benefits, the patient changes her mind after noting on the employee health form that the hepatitis B vaccination is optional. The physician spent 15 minutes counseling the patient. As part of the visit, the patient also complains of lower abdominal pain. A medically necessary physical exam is performed, and a diagnosis is reached. The physician prescribed medication and counsels the patient on risks and benefits regarding treatment for her abdominal complaint. Following the face-to-face visit, the physician enters documentation into the electronic health record. The total time on the date of the encounter related to the **additional reason for the office visit** (abdominal pain) is 25 minutes.

Item Coding	CPT Code	Comment
Immunization Counseling, 10-15 minutes	90483	Immunization counseling (15 min)
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99213-25: 20-29 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	For complaint of lower abdominal pain, apply the E/M modifier to the office visit because of the separately identifiable E/M performed (25 min) given the primary reason for the visit was preventive.

Explanation of code selection

Because there is a separately identifiable evaluation and management service performed, the claim would include the immunization counseling CPT code (for the discussion on hepatitis B vaccination) plus a code for an office visit (for the complaint of lower abdominal pain). You would append the CPT code for the office visit (99213) with modifier 25 (Separately Identifiable E/M Service), not the immunization counseling code. The CPT code 99213 is the correct choice as the time spent on the date of the encounter falls in the range for 99213 (20-29 minutes). The 25 modifier notes that the Established Patient Preventive Services Visit represents a distinct service over and above what is included in the immunization counseling code.

The preventive counseling code (99401) was not used in this case because "immunization counseling," which has a separate and distinct CPT code, was used as this is the more specific code. Some payors will not pay for immunization counseling; practices should verify payers' policies on immunization counseling codes and use of multiple E/M codes before billing for services.

CASE 2 (continued)

If the patient *had* accepted a 3-dose series hepatitis B vaccination, then do not use the standalone immunization counseling code. Instead, the codes would be:

Item Coding	CPT Code	Comment
Established Patient Preventive Services Visit 99395 age 18-39 for an established patient (15 minutes)	99395	For 15 minutes of immunization counseling
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
Hepatitis B vaccine, adult dosage, 3 dose-schedule, for intramuscular use	90746	Product Fee
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99213-25: 20-29 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	For complaint of lower abdominal pain, apply the E/M modifier to the office visit because of the separately identifiable E/M performed (25 min) given the primary reason for the visit was vaccination.

The preventive counseling code (99401) was not used in this case because “immunization counseling,” which has a separate and distinct CPT code, was used as this is the more specific code. Some payors will not pay for immunization counseling; practices should verify payers’ policies on immunization counseling codes and use of multiple E/M codes before billing for services.

If the patient accepted a 2-dose series hepatitis B vaccine, then the codes would be:

Item Coding	CPT Code	Comment
Established Patient Preventive Services Visit 99395 age 18-39 for an established patient (15 minutes)	99395	For 15 minutes of immunization counseling
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
Hepatitis B vaccine, adult dosage, 2 dose-schedule, for intramuscular use	90746	Product Fee
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99213-25: 20-29 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	For complaint of lower abdominal pain, apply the E/M modifier to the office visit because of the separately identifiable E/M performed (25 min) given the primary reason for the visit was vaccination.

CASE 3

OFFICE VISIT: Vaccine counseling with shared clinical decision-making, vaccine administered

A 28-year-old female is at her physician's office for an asthma-related matter and to get a refill on birth control medication. She and her physician discuss the human papilloma virus (HPV) vaccine and the benefits and risk of vaccination. The patient has significant concerns about the vaccine, as she recently viewed a social media post about negative side effects. Immunization counseling consumes a large proportion of the visit. The patient receives the HPV vaccine. Her total visit time on the date of the encounter was 60 minutes.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99215-25: 40-54 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	For Asthma and birth control
Prolonged Service	99417: each 15 minutes, beyond 99215	Bill 1 unit (15 min) for vaccine counseling
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
HPV Vaccine for intramuscular use	90651	Product Fee

Explanation of code selection

The correct billing for this service would include the CPT E/M office visit code 99215, with a time range of 40-54 minutes. In addition, because the total time on the date of the encounter was 60 minutes, a prolonged services code is appropriate. One unit of 99417 (15 minutes) would be added to the base time of the 99215 code (i.e. 40 minutes). Therefore, at 60 total minutes, a prolonged services code 99417 can be reported. A separate E/M service (vaccination) was provided in this scenario in addition to the office visit for asthma, so modifier 25 would be appended to the E/M code (99215) because vaccine administration is considered a procedure. Since the vaccine was administered, the administration code (90471) and the vaccine code (90651) are billed, but the specific code for immunization counseling (90483) would not be used.

CASE 4

OFFICE VISIT: Return visit for vaccination with series, with separately identifiable E/M

The 28-year-old female from **Case 3** returns to her physician's office 2 months later for the second of her series of three HPV vaccines. During the visit, she reports dysuria. A medically appropriate history and exam are completed. The physician orders a urinalysis. The urinalysis result shows a urinary tract infection (UTI). The physician prescribes antibiotics and provides counseling regarding prevention of future UTIs. Prior to leaving, the patient also receives her HPV vaccine. The physician enters documentation of clinical information into the electronic health record, including her immunizations. The physician's total time on the date of the encounter was 30 minutes.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99214-25: 30-39 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	Payment for separately identifiable E/M
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
HPV Vaccine, 2 or 3 dose schedule, for intramuscular use	90651	Product Fee

Explanation of code selection

The correct E/M office visit is 99214, as the time on the date of the encounter falls within the appropriate time range (30-39 minutes). Since the vaccine was administered, the administration code (90471) and the vaccine code (90651) are billed. A separate E/M service was provided in this situation in addition to the procedure, so modifier 25 would be appended to the E/M code.

If the patient comes back for the 3rd HPV vaccination at the indicated time interval according to the American Academy of Family Physicians' guidelines (6 months after initial dose and 5 months after the second dose) and receives the vaccination as a nurse only visit with no counseling involved, this visit is coded as a vaccine only visit, as no E/M service is documented.

Item Coding	CPT Code	Comment
Immunization Administration for Vaccines/Toxoids	90471	Administration Fee
HPV Vaccine, 2- or 3-dose schedule, for intramuscular use	90651	Product Fee

■ CASE 5

OFFICE VISIT: Return E/M visit and extensive immunization counseling, no vaccine administration

A 53-year-old female returns to her primary care physician's office for follow-up for diabetes and HbA1C recheck, efficacy of current blood pressure control regimen (patient has primary hypertension), and lab testing to assess appropriateness of thyroid hormone replacement dosing. A medical problem-focused history and exam are completed. During the visit, the patient reported that, while receiving her annual flu shot at a pharmacy the previous month, she became aware of the potential need for revaccinations for some vaccines and new vaccines given her diagnosis of diabetes. The patient had numerous questions about what vaccines she should consider obtaining, risks and benefits of those vaccines, vaccine necessity given her specific vaccination history/timing, and whether having had certain illnesses earlier in life made a difference in the need for additional vaccinations. The physician spends significant time (40 minutes) reconstructing and reviewing the patient's vaccination history, which consisted of both electronic and non-electronic records (traveler's vaccination books, paper records from her college health clinic) as well as recollections from the patient's memory; reviewing vaccination timing (and, in some cases, the type of vaccine administered) against the known list of potential revaccinations; and recalling the incidence and specific timing of such diseases such as measles, chickenpox and shingles, and other evidence of immunity.

Following the review and consultation, the patient decides to take additional time to 'think it over'; no vaccine is administered. The physician enters clinical documentation into the electronic health record. The physician's total time on the date of the encounter was 70 minutes.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99214: 30-39 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam	Use this code for time spent on diabetes, hypertension, and thyroid issues.
Immunization counseling, 20 minutes or more	90484: Immunization counseling, 20 minutes or more	Use this code for time spent specifically on immunization counseling.

Explanation of benefits

The correct billing for this service would include the CPT E/M 99214, with a time range of 30-39 minutes. This is because the provider spent 30 minutes on medical services that were not related to immunization counseling. In addition, because the provider spent greater than 20 minutes on vaccine counseling (i.e., 40 minutes), the provider should bill separately for vaccine counseling. The vaccine counseling codes are time bound and 90484 is specific to counseling that requires more than 20 minutes. It would not be appropriate to use a prolonged service code since the CPT code set now includes specific codes for immunization counseling unless the specific payer requires use of the prolonged service code instead of vaccine counseling code (see example below).

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99215: 40-54 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	Office visit for E/M
Prolonged Services	99417 – each 15 minutes, beyond 99215	Bill 2 units for extensive counseling.

■ CASE 6

OFFICE VISIT: Return E/M visit, Medicare Beneficiary, Vaccine Administered

A 65-year-old female Medicare beneficiary returns to her primary care physician's office for follow-up for diabetes and HbA1C recheck and her recommended pneumococcal conjugate vaccine (either PCV20 or PCV21). The physician spends 25 minutes discussing her diabetes care and reviewing the patient's vaccination history.

Item Coding	CPT Code	Comment
Established Patient Office or Other Outpatient Services for the evaluation and management of an established patient	99213-25: 20-29 minutes of total time spent on the date of encounter. Requires a medically appropriate history and/or exam.	Payment for separately identifiable E/M
Medicare Vaccine Administration Code	G0009 used with Diagnosis Code Z23 (rather than equivalent CPT code 90471)	Administration Code
Pneumococcal conjugate vaccine	If PCV20 given use CPT 90677. If PCV21 given, use CPT 90684.	Specific vaccine product code

Explanation of code selection

The correct E/M office visit is 99213, as the time on the date of the encounter falls within the appropriate time range (20-29 minutes). A separate E/M service was provided in this situation in addition to the procedure (G0009), so modifier 25 would be appended to the E/M code.

Since the vaccine was administered, the administration code (G0009) and the vaccine code are billed for the Medicare beneficiary. Guidance for billing Medicare Part B can be found at www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing.

A list of specific vaccine CPT codes can be found at www2a.cdc.gov/vaccines/IIS/IISStandards/vaccines.asp?rpt=cpt.

■ VACCINATION SCENARIOS THAT FALL OUTSIDE OF OFFICE VISIT CODING

CASE A: Pregnant Patient Visit with Vaccination

A pregnant 28-year-old patient on Medicaid is indicated for both influenza and Tdap vaccination. The provider spends an extraordinary amount of time (30 minutes) with the patient on vaccine counseling. The patient ultimately decides to vaccinate. The total visit time is 45 minutes.

Except for Medicaid* as a payor, pregnancy in most cases is billed under a global fee. The global maternity fee encompasses maternity-related services performed by all providers in uncomplicated maternity cases. The global fee includes the treatment of routine gynecological conditions during scheduled prenatal visits, typically 13 routine antepartum visits, delivery, and the six-week postpartum visit and is not billed to insurance until after delivery. Any lab work, ultrasounds, and additional or unrelated visits are billed separately. More information on coding scenarios for vaccines administered during pregnancy are available from the American College of Obstetricians and Gynecologists at www.acog.org/practice-management/coding/coding-library/optimizing-reimbursement-routinely-recommended-maternal-immunizations.

Administration of the vaccine and the vaccine product, if provided, should be reported separately for both Medicaid and commercial insurers. These services are not valued into the global obstetrics package. Services such as immunization counseling may be included in the global pregnancy fee as part of the general antepartum service for a pregnant patient for a commercial insurer's patient since some commercial payers define the global differently than CPT. CPT does not include these services in their definition of the global obstetrics package.

** Medicaid programs vary greatly in their requirements for billing pregnancy services. Check with specific Medicaid carriers with instructions on how to bill for immunization services.*

Explanation of code selection

Because this is a routine antepartum visit, there is no additional coding included for the office visit, and the new coding revisions do not apply.

CPT Global Obstetric Package

CPT's global obstetric package includes all the services normally provided in uncomplicated maternity cases (antepartum care, delivery, and postpartum care). These services are considered bundled and are therefore not coded or reimbursed separately. Most private payers follow CPT's obstetric package definition, but some have developed their own rules. Physicians should check with their individual payers about how to report these services.

CASE B: Medicare Beneficiary at Annual Wellness Visit

A 72-year old Medicare beneficiary is at her annual wellness visit (AWV) and is indicated for influenza, herpes zoster, and pneumococcal vaccines. The beneficiary receives all three vaccines. Influenza and pneumococcal vaccinations are billed under Medicare Part B and herpes zoster vaccination is billed under Medicare Part D. The visit lasts 25 minutes.

Explanation of code selection

This visit the AWV is not considered an office visit, therefore new time-related coding revisions do not apply. Coding remains unchanged. Bill separately for the vaccines and vaccine administration.

APPENDIX 1: Summary of Office Visit E/M Codes

CPT Code	Code Description for NEW Patients	Medical Decision Making	Total Time (in minutes)
99202	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	Straight-forward	15-29
99203	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	Low	30-44
99204	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	Moderate	45-59
99205	Office or other outpatient visit, new, <i>which requires a medically appropriate history and/or examination</i>	High	60-74

CPT Code	Code Description for EXISTING Patients	Medical Decision Making	Total Time (in minutes)
99212	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	Straight-forward	10-19
99213	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	Low	20-29
99214	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	Moderate	30-39
99215	Office or other outpatient visit, established, <i>which requires a medically appropriate history and/or examination</i>	High	40-54

APPENDIX 2: Summary of CPT Codes for Standalone Vaccine Counseling

CPT Code	Code Description	Total Time (in minutes)
90482	Immunization counseling by physician or other qualified healthcare professional (QHP) when immunization(s) is not administered by provider on the same date of service	3-10
90483	Immunization counseling by physician or other QHP when immunization(s) is not administered by provider on the same data of service	10-20
90484	Immunization counseling by physician or other QHP when immunization(s) is not administered by provider on the same date of service.	>20

