



Network Notification

Date: May 13, 2011

Number: OH-P-2011-26

To: Ohio Providers

From: CareSource

Subject: Revised Immunization and Administration Billing Policy

Effective Date: May 16, 2011

CPT Codes Involved: 90460-90461, 90471-90474, 90476-90479

The following outlines CareSource's new billing and reimbursement guideline associated with immunizations/vaccinations and the corresponding administration codes.

Please note:
This section
is new from
previous
version

Effective May 16, 2011

CareSource will follow the recommendations made by the CDC regarding the two new administration codes (90460 and 90461). CareSource will continue to pay the code 90460. CareSource will no longer pay the code 90461 per the CDC recommendations.

How to Bill Correctly for Payment

1) Vaccines for Children Program (0-18 Years Old)

Please use the following administration codes when billing for vaccinations:

- 90460 - \$10/vaccine given
- 90461 - \$0 (*will no longer be reimbursed per CDC guidelines*)
- 90471 - \$10, first vaccine given
- 90472 - \$10, each additional vaccine given
- 90473 - \$10, first oral admin given
- 90474 - \$10, each additional vaccine given

Bill the following administration codes above AND the vaccination code. To obtain the correct vaccination code (as these may change), please use the ODJFS list of VFC vaccinations:

http://emanuals.odjfs.state.oh.us/emanuals/DataImages.srv/emanuals/pdf/pdf_for_ms/3412APXA.PDF

Reasons for Denials

Providers must bill with the vaccination code (e.g. 90707) AND the appropriate administration code (see the list above) for correct payment. Otherwise, you will see the following denial on remittance:

Paper Denials

- **Paper Remittance** – t22: Add-on procedure code has been submitted without appropriate primary procedure
- **Paper EOP** – X21: Age 0-18 Code Not Reimbursable – VFC Supplied Vaccine

Electronic Denials:

- **EFT Remittance** – Health care Claim Adjustment Reason Code: B15
Remittance Remark Code: N122
- **EFT Transaction** – Health care Claim Adjustment Reason Code: 9
Remittance Remark Code: N431

2) Adult (Non-VFC) Vaccines for 19+ Years Old

Providers must bill the following administration codes above AND the vaccination code. To obtain the correct vaccination code (as these may change), please use the CDC list of vaccinations:

<http://www.cdc.gov/vaccines/recs/schedules/default.htm>

Reasons for Denials

Providers must bill with the vaccination code (e.g. 90707) AND the appropriate administration code (see the list below) in order for correct payment. Otherwise, you will see the following denial on remittance:

Paper Denials

- **Paper Remittance** – t22: Add-on procedure code has been submitted without appropriate primary procedure

Electronic denials:

- **EFT Remittance** – Healthcare Claim Adjustment Reason Code: B15
Remittance Remark Code: N122

Please use the following administration codes when billing for vaccinations:

- 90471 - \$10, first vaccine given
- 90472 - \$7, each additional vaccine given
- 90473 - \$10, first oral admin given
- 90474 - \$7, each additional vaccine given

Reimbursement for the all vaccinations for non VFC will follow the State supplied fee schedule.

Definition of new Codes

The two new CPT codes are:

- 1) 90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
- 2) 90461 – Each additional vaccine/toxoid component

Please note:
This section is new from previous version

NOTE: These codes replace 90465, 90466, 90467 and 90468

CDC Guidelines

Every vaccine administered has exactly one first component. Many vaccines have second and subsequent components (e.g., MMR, DTaP, and DTaP/IPV).

In the VFC program, the regional vaccine administration fee cap rates were established on a per-vaccine basis, not a per-antigen or per-component basis.

Under the CMS policy, the administration fee for the VFC program will continue to be based on a per-vaccine basis and not on a per-antigen or per-component basis.

CMS is looking closely at the VFC administration fee cap to ensure that it keeps up-to-date with changes in underlying costs of providing vaccines and with medical practice. CMS anticipates updating the fee cap in the near future and is also examining the larger reimbursement structure of the VFC program.

In the meantime, State Medicaid agencies can increase the amount they pay providers up to their regional cap by submitting a State Plan Amendment, as most States are currently paying providers rates that are below their State caps. In addition, States can choose to establish different rates, up to their regional caps, for vaccines with multiple antigens and for those that have only a single component.

VFC enrolled providers may not charge a vaccine administration fee to VFC entitled children that exceed the regional administration fee cap per dose of vaccine.

Providers are encouraged to use the new code 90460 for the administration of a vaccine under the VFC program. If code 90461 is used for a vaccine with multiple antigens or components, it should be given a \$0 value for a child covered under the VFC program. This applies to both Medicaid-enrolled VFC-entitled children as well as non-Medicaid enrolled VFC entitled children (e.g., uninsured, underinsured, and American Indian or Alaska Native children not enrolled in Medicaid).

Please note:
This section is new from previous version

For more information on the new CDC guidelines on the new administration codes, visit the CDC website at <http://www.cdc.gov/vaccines/>.

Previous Versions of this Network Notification are below:

- [February 23, 2011](#)
- [February 4, 2011](#)
- [January 10, 2011](#)
- [December 7, 2010](#)