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_forms/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

Please note: This section is new from previous version

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

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

CDC Guidelines

Please note: This section is new from previous version

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).

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