New Requirements for Submission of Claims for Vaccine Administration
Frequently Asked Questions

Revision Date: 3/29/2013—This FAQ supersedes all previous FAQs and vaccine memos. It provides clarification to Q & A #12 and additional FAQs are appended.

Q1	**When does the provider need to start billing using the new methodology?**
A1	Per the federal requirements, the provider is required to use the new billing methodology for dates of service on or after January 1, 2013.
Q2	**Do all providers need to use the new claims billing method?**
A2	Yes, all providers need to use the new claims billing method.
Q3	**When will eligible providers see an increase from the current VFC and non-VFC administration rate?**
A3	Enhanced payments for qualifying claims with dates of service on or after January 1, 2013 will not begin January 1 but will be made retroactively once CMS approval of the required Arizona state plan amendment and methodology is received. Providers must meet the requirements as noted in the 12/11/12 memo http://www.azahcccs.gov/commercial/downloads/rates/PCPInfoMemo.pdf to be eligible for the enhanced payment. CMS approval may be delayed as late as July 1, 2013.
Q4	**Is the SL modifier used for both the vaccine and the vaccine administration codes?**
A4	Yes, the SL modifier is used for both the vaccine and the vaccine administration codes under VFC only. Vaccines for adults or non-VFC vaccines for children do not have the SL modifier added.
Q5	**Will providers only receive payment for one administration code regardless of how many vaccines were administered?**
A5	No, if the provider individually administers more than one vaccine, the provider can bill for the administration of each vaccine, provided the additional vaccines are administered through a separate injection. The provider will not be paid for additional toxoids in the same syringe. This mirrors the current payment policy. Providers cannot divide vaccines commonly administered in a single injection in order to report multiple administrations. When medically necessary and appropriate to administer a second injection, a second administration fee may be paid.
Q6	**Is 90461 an open code?**
A6	AHCCCS has opened this code as of January 1, 2013. However, under VFC no additional payment is made for additional toxoids in the same syringe.
Q7	**Can AHCCCS provide examples of code use?**
A7	The following examples illustrate several vaccine coding situations and are **not** meant to be all inclusive. These examples do **not** reflect required NDC reporting. Refer to question **#8** for more information regarding the required NDC reporting. **NOTE: These examples illustrate reporting instructions under FFS claims billing. Contractors may require different reporting methods due to varying claims system requirements. Please consult the individual Contractor for reporting instructions.** With the changes under the ACA, both the specific vaccine code and the vaccine administration code

must be reported by all providers reporting vaccine administration services.

- If the vaccine is provided through the VFC program, the SL modifier **must be added to both the vaccine code and the vaccine administration code.** Do not add the SL modifier to vaccine and administration codes used to report services provided to members who are 19 years of age or older or for vaccines **not** covered under the VFC program administered to children.
- CPT codes identifying the vaccine or toxoid given under the VFC program should be identified with the appropriate CPT code to identify the vaccine, the SL modifier, and the charge listed as $0.00.
- Vaccines should be identified with the appropriate CPT code and the charge for that vaccine for members 19 years of age or older or for vaccines **not** covered under the VFC program administered to children.

Codes: 90460 & 90461

As noted in **Q5,** more than one vaccine administration payment can be made if multiple injections are given to the member. Reporting multiple injections depends on which vaccine administration codes are used to report the services. When more than one vaccine is administered with counseling to a member 18 years of age or younger, each single injection is reported with CPT administration code 90460 (first or only component of each vaccine or toxoid administered) and if covered under VFC, add the SL modifier.

Providers will be paid a separate administration fee for each separate injection. If more than one vaccine/toxoid is included in a single injection, the additional toxoids should be identified with the appropriate CPT code and if covered under VFC, add the SL modifier. Administration of those other components/toxoids may be identified with CPT code 90461 and if covered under VFC, add the SL modifier.

AHCCCS will not make additional payment for administration of other additional toxoids included in the injection identified with CPT code 90460. Providers are not compelled to report 90461 for the administration of those additional toxoids.

Codes: 90471, 90472, 90473, 90474

When more than one injection is given to a member who is 19 years of age or older or to a child without counseling, the administration of the first injection is identified with CPT code 90471 and additional injections are identified with CPT code 90472. Each vaccine or toxoid component should be identified with the appropriate CPT code on the claim form along with the charge for that toxoid. Intranasal or oral administration should likewise be coded with CPT code 90473 and additional administrations are identified with CPT code 90474.

Example 1: Child 18 years of age or under receiving one VFC injection

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90460 SL	1	$xx.xx	1
1/1/13-1/1/13	11		90700 SL	1	0.00	1

Example 2: Child 18 years of age or under receiving three separate VFC injections

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90460 SL	1	$xx.xx	3
1/1/13-1/1/13	11		90700 SL	1	0.00	1
1/1/13-1/1/13	11		90655 SL	1	0.00	1
1/1/13-1/1/13	11		90707 SL	1	0.00	1

Note: Examples 3 and 4 would also apply to non-VFC injections for children.

Example 3: Member 19 years of age or older receiving one injection

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90471	1	$xx.xx	1
1/1/13-1/1/13	11		90656	1	$xx.xx	1

Example 4: Member 19 years of age or older receiving three injections

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90471	1	$xx.xx	1
1/1/13-1/1/13	11		90472	1	$xx.xx	2
1/1/13-1/1/13	11		90656	1	$xx.xx	1
1/1/13-1/1/13	11		90670	1	$xx.xx	1
1/1/13-1/1/13	11		90703	1	$xx.xx	1

Q8 **Is the NDC required when billing VFC and non-VFC vaccine services?**

A8 **Yes** the NDC is required. The current billing standards for reporting NDC information on the Professional claim form for AHCCCS are consistent with the instructions and standards for the CMS1500 form as published by NUCC. To the extent an NDC is appropriate to report, the other related data elements are also required by the form and the policy we have adopted.
Refer to the pharmacy web page at:
http://www.azahcccs.gov/commercial/Downloads/PharmacyUpdates/NDCBillingRequirementsFAQs_

	Additional.pdf for additional information specific to NDC usage.
Q9	**Are G0008, G0009 and G0010 administration codes eligible for the enhanced rate?**
A9	**No** they are not. Under 42 CFR 447.400, only CPT codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successor codes are eligible for the enhanced rate. Note that these codes are eligible for the enhanced rate only if they are open codes within the State Medicaid program.
Q10	**Recently several specialty societies issued guidance directing providers reporting vaccine and vaccine administration services on the same date of service as an Evaluation and Management (E&M) service, including Preventive Medicine exams, to add Modifier 25 to the E&M code. Do these instructions apply to claims submitted to AHCCCS?**
A10	CMS has added numerous code pairs to the Correct Coding Initiative (CCI) list of codes Procedure to Procedure code edits. These new edits, effective 1/1/13, pair the vaccine administration codes (90460, 90461, and 90471-90474) with the E&M codes. These CCI edits do not allow both the vaccine administration service and the E&M service to be paid for the same date of service unless the E&M service is identified with modifier 25. AHCCCS must adopt these CCI edits. Providers administering vaccines and performing an E&M service on the same date of service must add modifier 25 to the E&M code. Modifier 25 is not added to the vaccine administration codes.
Q11	**Will the AHCCCS VFC administration rate increase to the new regional maximum for all providers?**
A11	No. AHCCCS has elected not to adopt the new regional maximum VFC rate. Providers who are eligible for enhanced payment rates will receive the enhanced rate of $21.33 for vaccine administration **under VFC**. For all other vaccine administrations under VFC, the AHCCCS rate of $15.43 remains unchanged.
Q12	**What are the potential AHCCCS vaccine VFC and non-VFC administration rates for eligible and non-eligible physicians for CY 2013 and 2014 once AHCCCS gains approval for their State Plan Amendment and methodology?** **Note: This simple chart is intended only to illustrate the reimbursement difference between ACA-eligible and non-eligible providers, as well as between VFC and non-VFC administration and does not provide for all contingencies.**
A12	

Example	Physician eligible for enhanced fees	Physician not eligible for enhanced fees
Vaccine provided through VFC	$21.33 / each separate injection	$15.43 / each separate injection
Vaccine not provided through VFC	$26.81 / each separate injection plus fee for vaccine/toxoid	$20.64 / each separate injection plus fee for vaccine/toxoid

Q13	**Can 90460 be used if the RN is giving the injection to a child?**
A13	As long as the physician has counseled the member, **90460** may be used when the nurse has given the injection.

Q14	**For an adult, when there is a series of three immunizations, the doctor consults at the point of the first immunization. When the member comes back for the 2nd and 3rd injection and the RN gives the injection does the nurse use 90471?**
A14	The use of the code is dependent on whether or not the physician has done follow up counseling to the member.
Q15	**If the physician administers multiple vaccine injections on the same day, will s/he be paid the same administration rate for each injection?**
A15	Yes the reimbursement rate will be the same for each administration of the injection.