Capital BLUE

**PROFESSIONAL NETWORK REIMBURSEMENT POLICY**

| POLICY TITLE | Immunization Administration |
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| POLICY NUMBER | NR-09.003 |

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DESCRIPTION/BACKGROUND | DEFINITIONS | POLICY
EXCLUSIONS | VARIATIONS - Yes | REFERENCES


## I. DESCRIPTION/BACKGROUND

TOP

This policy addresses the reimbursement methodology for the administration of immunizations.

## II. DEFINITIONS

TOP

American Medical Association (AMA) – An organization whose missions is to promote the science and are of medicine and the betterment of public health. The AMA speaks out on issues important to patient and the nation's health and exercises a strong advocacy agenda on behalf of patients and provider. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (for example, medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Immunization – The protection of individuals or groups from specific diseases by vaccination or the injection of immune globulins.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payors with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the American Medical Association; Level II (HCPCS) modifiers are developed by the Centers for Medicare and Medicaid Services; Level III modifiers are unique to each Medicare Part B carrier and begin with an alpha prefix of S, W, X, Y or Z.

Toxoid – A toxin that has been chemically modified to retain its antigenicity but is no longer poisonous.

Vaccine – Any suspension containing antigenic molecules derived from a microorganism, given to stimulate an immune response to an infectious disease.

## III. POLICY

TOP

Capital BlueCross is modifying this policy to include new Immunization Administration codes for SARS-CoV-2 [COVID-19] vaccine.

When a provider sees a member for the **sole purpose** of administering the SARS-CoV-2 {COVID-19] vaccine **AND** no additional physician fee schedule service is provided, the provider should report the procedure code specific to the administration of the immunization (0001A, 0002A, 0011A or 0012A).

0001A, Immunization administration by intramuscular injection of severe respiratory syndrome coronavirus 2 (SARS-CoV-2) Coronavirus disease [COVID-19] vaccine, Mrna-LNP, spike protein, preservation free, **30 mcg/0.3Ml** dosage, diluent reconstituted; first dose

- 0002A, second dose

- 0011A, Immunization administration by intramuscular injection of severe respiratory syndrome coronavirus 2 (SARS-CoV-2) Coronavirus disease [COVID-19] vaccine, Mrna-LNP, spike protein, preservation free**, 100 mcg/0.5Ml** dosage
- 0012A, second dose

| Vaccine Codes | Vaccine Administration Codes | Vaccine Name and Manufacturer |
| --- | --- | --- |
| • 91300, Severe respiratory syndrome coronavirus 2 (SARS-CoV-2) Coronavirus disease [COVID-19] vaccine, Mrna-LNP, spike protein, preservation free,**30 mcg/0.3Ml** dosage, diluent reconstituted; first dose | 0001A,1st dose<br><br>0002A, 2nd dose | **Pfizer-BioNTech COVID-19 Vaccine** |
| • 91301, Severe respiratory syndrome coronavirus 2 (SARS-CoV-2) Coronavirus disease [COVID-19] vaccine, Mrna-LNP, spike protein, preservation free**, 100 mcg/0.5Ml** dosage | 0011A, 1st dose<br><br>0012A, 2nd dose | **Moderna COVID-19 Vaccine** |

When a provider sees a member for the **sole purpose** of administering the influenza virus vaccine, the pneumococcal vaccine or the hepatitis B vaccine, **AND** no additional physician fee schedule service is provided, the provider should report the procedure code specific to the administration of the immunization (G0008-G0010), in addition to the appropriate procedure code for the vaccine/toxoid administered.

- G0008 – Administration of influenza virus vaccine *when no professional fee schedule service on the same day*

- G0009 – Administration of pneumococcal vaccine when no professional fee schedule service on the same day
- G0010 – Administration of hepatitis B vaccine *when no professional fee schedule service on the same day.*

When a provider sees a member for the **sole purpose of administering any immunization**, separate reimbursement will not be made for an evaluation and management service.

When the provider sees the member to administer influenza, pneumococcal or hepatitis B immunization **and *at least* one other immunization**, the provider should not report G0008, G0009 or G0010. Instead, the provider should report the most appropriate administration procedure codes, as well as the appropriate vaccine/toxoid codes for all immunizations. In this example, procedure codes G0008, G0009, and G0010 will not be eligible for separate reimbursement consideration because an additional professional fee schedule service has been performed on the same day.

When the provider sees the member **to administer an immunization other than or in addition to** the influenza, pneumococcal, or hepatitis B vaccine, the provider should report the most appropriate code to describe the service rendered. Examples include:

- 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
- 90461 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)
- 90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
- 90472 – Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid); Add-on code (List separately in addition to code for primary procedure).
- 90473 – Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).

- 90474 – Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid); Add-on code (list separately in addition to code for primary procedure).

While not the norm, in certain circumstances, it may be appropriate and necessary for a provider to administer multiple immunizations via different routes (e.g. intranasal, subcutaneous, intramuscular, and oral) during a single patient encounter on the same date of service. When more than one immunization is administered during the same patient encounter providers may need to report a combination of codes from the age specific pediatric counseling administration codes (90460-90461) and administration codes that do not include physician counseling (90471-90474) for reimbursement consideration. Only one "first administration" code (90460, 90461, and 90471) will be eligible for reimbursement consideration per date of service regardless of the patient's age and/or whether physician counseling was provided. Any additional administrations should be reported using the appropriate add-on code based on the route of administration and patient's age, regardless of whether or not counseling was provided.

**When a member receives an immunization(s) and a separately identifiable evaluation and management service is documented in the patient's medical record, the provider may submit a claim for the evaluation and management procedure code appended with Modifier –25, the immunization(s) (vaccine/toxoid when applicable), and the administration of the immunization(s).**

Please refer to the following Professional Network Reimbursement Policies for additional information:

NR-10.001 *Add-On Procedure Codes*
NR-30.019 *Correct Coding and Reimbursement Methodology*

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

## IV. EXCLUSIONS TOP

N/A

## V. VARIATIONS TOP

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

HMO[1] BlueJourney HMO[1]

[1]Generally, the administration of vaccines is a capitated service and is not eligible for separate reimbursement consideration; however, the vaccine/toxoid may be eligible for separate reimbursement.

## VI. REFERENCES

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*CPT 2020 Professional Edition*
*American Medical Association*

*EncoderPro for Payers*
*Optum™ 2020*

*HCPCS Level II Expert*
*Optum™ 2020*

*Taber's Cyclopedic Medical Dictionary, 21st Edition*