**Question:** Is it required that all LHDs bill/charge for immunization services?

**Answer: Yes,** According to Comar regulations 10.02.01.01

 .01 Purpose

It is the intent of these regulations that:

A. Charges for health services reflect the full costs of rendering those services;

B. There be a single charge for each service rendered in each unit;

C. The methods for determining full costs be uniform among all units."

The only exception is items listed on the non-chargeable list.

\*\*The regulations do not require the LHD has to bill the payer(s) \*\*

[http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.02.01.\*](http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.02.01.*)

**Question:** Are the LHDs required to bill Medicaid for immunizations given to any child who receives Medicaid?

**Answer: No**

**Vaccine For Children (VFC)**

**Question:** If I bill a VFC vaccine administration fee to Medicaid or a Medicaid MCO, do I have to charge uninsured or underinsured patients a vaccine administration fee?

**Answer: Yes,** however, if the uninsured patient does not have the ability to pay the vaccine administration fee, the vaccine must be provided and the administration fee must be waived.

**Question:** If a VFC vaccine administration fee of $23.28 per vaccine is charged to Medicaid or a Medicaid MCO, can I charge uninsured or underinsured patients who receive VFC vaccines **less than** $23.28 per vaccine?

**Answer: No**, you cannot charge a patient less than you bill Medicaid/MCO for the same service. However, if the uninsured patient does not have the ability to pay the VFC administration fee, the vaccine must be provided and the administration fee must be waived.

**Question:** If an uninsured or underinsured child receives a VFC vaccine(s), can the LHD charge the vaccine administration fee per vaccine?

**Answer: Yes.** The vaccine administration fee should be charged per vaccine, not per day.

**Question:** How do we code Medicaid or a Medicaid Managed Care Organization (MCO) for VFC vaccine administration?

**Answer:** Bill thevaccine code with a SE modifier. Do not use the vaccine administration codes.



**Question:** Why do we receive rejections from Medicaid/MCOs when we use CPT codes 90633 and 90471?

**Answer:** Medicaid does not reimburse the CPT vaccine administration codes

* + VFC vaccines must be used for pediatric Medicaid patients.
	+ VFC vaccines should always be billed with the SE modifier appended to the vaccine code.
	+ Adult vaccines are reimbursed but the vaccine administration services are not reimbursed.

The 2014 VFC Provider Agreement states the following regarding administration fees:

* I will not charge a vaccine administration fee to non-Medicaid a federal vaccine eligible child that exceeds the administration fee cap of $23.28 per vaccine dose. Non-Medicaid children include children without insurance or children who are under-insured. Per the VFC agreement, these children cannot be denied services because they can't pay the fee.
* I will not deny administration of a **publicly purchased vaccine** to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
* For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
* Since this is a HHS/CDC agreement/policy, this policy meets the requirements of the ACA.

**Question:** We are concerned about charging administration fees for 317 and VFC vaccines.  We understand that we can charge Medicaid the administration fee, but can we charge patients the administration fee if they don’t have insurance?  How does that work with the ACA guidelines that there should be no out of pocket expenses for preventive services?  Vaccines are preventive.

**Answer:** The ACA guidelines for no out-of-pocket expenses for preventative services **only applies to patients that have a qualifying health plan and receive preventative/immunization services from a participating provider.**

For additional information go to:

<http://obamacarefacts.com/benefitsofobamacare.php>

 or

<http://obamacarefacts.com/obamacare-preventive-care.php>

The new ObamaCare health care law states that health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace (also called Health Insurance Exchanges), offer essential health benefits. Please note that grandfathered plans purchased before the bill was signed into law may not be required to provide these services.

Read more information about [ObamaCare grandfathered health plans at:](file:///C%3A/Users/cperkey/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.Outlook/M6Q95M4V/ObamaCare%20grandfathered%20health%20plans%20at%20http%3A/obamacarefacts.com/grandfathered-plans.php)  <http://obamacarefacts.com/grandfathered-plans.php>

\*For additional information about ObamaCare, see the end of this document.

**Privately Purchased Vaccines**

**Question:** If the child doesn't meet the qualifications for the VFC and if the responsible party doesn't pay for these services, can the LHD forward the account to Central Collections Unit?

**Answer: Yes,** if the patient receives privately purchased vaccines. VFC vaccines can only be administered to children who qualify to receive VFC vaccines.

**Question:** Does Medicaid cover adult vaccines?

**Answer**: **Yes,** most vaccines are covered.

**Refer to the Maryland Medicaid fee schedule for a complete list:** <https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>

**Question:** Does Medicaid cover the administration of adult vaccines?

**Answer**: **No**, Medicaid does not reimburse for vaccine administration. You should bill Medicaid using the appropriate vaccine code. **Do not bill administration codes 90471-90474.**

**Medicare Immunizations**

**Question:** Does Medicare pay for immunizations?

**Answer: Medicare Part B** covers the following immunizations and their administration for qualified beneficiaries:

* **Influenza immunizations** - Medicare covers both the costs of the vaccine and its administration by recognized providers. There is no coinsurance or co-payment applied to this benefit, and a beneficiary does not have to meet his or her deductible to receive this benefit.
* **Pneumococcal vaccinations** - Medicare provides coverage for one pneumococcal vaccine for all beneficiaries. One vaccine at age 65 generally provides coverage for a lifetime, but for some high-risk persons, revaccination may be appropriate. Medicare will also cover a pneumococcal vaccine for persons at the highest risk if 5 years have passed since the last vaccination. There is no coinsurance or co-payment applied to this benefit, and a beneficiary does not have to meet his or her deductible to receive this benefit.
* **Hepatitis B vaccinations** - Persons at high or intermediate risk - such as people with renal disease, hemophilia and diabetes mellitus - are among those who are eligible to receive coverage for this immunization benefit under Medicare Part B, when administered by qualified providers. The coinsurance or co-payment applies after the yearly deductible has been met.

**October 2013 Medicare Resource**:

[**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr\_immun\_bill.pdf**](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf)

**Question:** Can I bill Medicare for the flu vaccine and administration if I do not charge any other payer or patient for the flu vaccine?

**Answer: Yes**. State and local government entities, such as public health clinics, may bill Medicare for immunizations given to beneficiaries even if they provide immunizations free to all patients, regardless of their ability to pay.

**Question:** In order to bill a secondary insurance for non-covered Medicare immunization services we must first file a claim with Medicare, obtain a denial and bill the secondary insurance. But the Medicare EOB we receive states that we must adjust off the charge and does not allow us to bill the secondary insurance or the patient. How can we obtain a denial from Medicare that allows us to bill the secondary insurance or the patient for non-covered Medicare immunization services?

**Answer:**  To receive a denial from Medicare that will allow you to bill the secondary payer or the patient use a **GY modifier** when filing the Medicare claim. The GY modifier indicates that the provided service is not a covered Medicare benefit. The service is being reported to Medicare in order to receive a denial.

**Miscellaneous Questions**

**Question:** We are receiving denials from Medicaid for immunization services.  We think it is related to the place of service code (POS) we use: 71 (LHD).  Some payers require us to use the place of service code 11 (office) to get paid.  Previously, the representative at Medicaid told us to bill 11 instead of 71 to get paid, so we did.  Is this a legitimate change?  I don't want to bill fraudulently.

* Place of Service **Code 71** is defined as **- State or Local Public Health Clinic** - A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
* Place of Service **Code 11** is defined as **- Office Location, other than** a hospital, skilled nursing facility (SNF), military treatment facility, community health center, **State or local public health clinic**, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

**Answer: Yes,** it is acceptable to use POS 11–if the LHD has been instructed to by the payer. Maryland Medicaid and several other MCOs have instructed LHDs to use POS 11 instead of 71.

* **Exception**: immunizations and services provided at a School Based Health Center’s **must always use POS 03** when billing Medicaid or an MCO for services.
* Per **COMAR** regulations, Medicaid MCOs must reimburse in-network rates for all SBHC services. This includes a reimbursement of $23.28 for each VFC vaccine provided to a Medicaid patient.

**Question:** Do you have any sample “superbills” for immunizations that can be shared?

**Answer: Yes,** an immunization specific superbill was created and is posted on the DHMH website. <http://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/immunization-for-local-health-departments.aspx>

**Question:** Where can we get a copy of the Immunization webinar’s?

**Answer:** <http://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/immunization-for-local-health-departments.aspx>

**Question:** Do R.N.s that administer vaccines need to be credentialed in CAQH?

**Answer: No,** the R.N. bills under the provider who wrote the immunization standing orders.

**Question**: Can the sliding fee schedule be applied for privately purchased vaccines?

**Answer**: **Yes**, for uninsured self-pay patients. The sliding fee schedule can be applied to both the vaccine and the administration fee. Do not apply the sliding fee scale to charges if the patient has insurance, including Medicare, Medicaid, or an MCO.

**FY15 Non-Chargeable List - Immunization Services**

|  |
| --- |
| * Immunization Record Review
 |
| * Emergency Preparedness – Screening for and administration of immunizations for traditional and other emergency responders during a local or state public health emergency event.
 |

**Question:** On the non-chargeable list, there is no mention of Rabies vaccine pre-exposure or post exposure. According to COMAR, we are required to provide anti-rabies treatment to those who are unable to pay as well as pre-exposure immunizations for employees of local health departments or individuals who provide rabies control services such as Animal Control. Please clarify.

 **Answer:** COMMUNICABLE DISEASES – RABIES COMAR 10.06.02.03 (2013)

[http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.06.02.\*](http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.06.02.*)

(1) The Department shall provide rabies vaccine free of charge and the local health officer shall provide for the administration of pre-exposure immunization against rabies for any employee of the Department, a local health department, or another individual who provides rabies control services at the request of the Department.

(2) Based on the ability-to-pay schedule developed by the Department and circulated to all local health departments, the local health officer may provide rabies pre-exposure immunization to other individuals who are determined by the Public Health Veterinarian to have a high risk of exposure to rabies infection.

\* Starting January 1st of 2014, the following **10 essential benefits** must be included under all insurance plans with no lifetime or annual dollar limits:

1. **Ambulatory patient services (Outpatient care).** Care you receive without being admitted to a hospital, such as at a doctor’s office, clinic or same-day (“outpatient”) surgery center. Also included in this category are home health services and hospice care (note: some plans may limit coverage to no more than 45 days).
2. **Emergency Services (Trips to the emergency room).** Care you receive for conditions that could lead to serious disability or death if not immediately treated, such as accidents or sudden illness. Typically, this is a trip to the emergency room, and includes transport by ambulance. You cannot be penalized for going out-of-network or for not having prior authorization.
3. **Hospitalization (Treatment in the hospital for inpatient care).** Care you receive as a hospital patient, including care from doctors, nurses and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly (note: some plans may limit skilled nursing facility coverage to no more than 45 days).
4. **Maternity and newborn care.** Care that women receive during pregnancy (prenatal care), throughout labor, delivery and post-delivery, and care for newborn babies.
5. **Mental health services and addiction treatment**. Inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. This includes behavioral health treatment, counseling, and psychotherapy. (Note: some plans may limit coverage to 20 days each year. Limits must comply with state or federal parity laws.
6. **Prescription drugs.** Medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high cholesterol. At least one prescription drug must be covered for each category and classification of federally approved drugs, however limitations do apply. Some prescription drugs can be excluded. "Over the counter" drugs are usually not covered even if a doctor writes you a prescription for them. Insurers may limit drugs they will cover, covering only generic versions of drugs where generics are available. Some medicines are excluded where a cheaper equally effective medicine is available, or the insurer may impose "Step" requirements (expensive drugs can only be prescribed if doctor has tried a cheaper alternative and found that it was not effective). Some expensive drugs will need special approval.
7. **Rehabilitative services and devices** – Rehabilitative services (help recovering skills, like speech therapy after a stroke) and habilitative services (help developing skills, like speech therapy for children) and devices to help you gain or recover mental and physical skills lost to injury, disability or a chronic condition (this also includes devices needed for "habilitative reasons"). Plans have to provide 30 visits each year for either physical or occupational therapy, or visits to the chiropractor. Plans must also cover 30 visits for speech therapy as well as 30 visits for cardiac or pulmonary rehab.
8. **Laboratory services.** Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostrate exams, are provided free of charge.
9. **Preventive services, wellness services, and chronic disease treatment.** This includes counseling, preventive care, such as physicals, immunizations and screenings, like cancer screenings, designed to prevent or detect certain medical conditions. Also, care for chronic conditions, such as asthma and diabetes. (Note: please see our full list of Preventive services for details on which services are covered.)
10. **Pediatric services.** Care provided to infants and children, including well-child visits and recommended vaccines and immunizations. Dental and vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam and corrective lenses each year.

While all qualified plans must offer the 10 essential benefits, the scope and quantity of services offered under each category can vary. Each qualified plan must offer essential health benefits which overall are equal to the scope of benefits typically covered by employers, as shown by a Department of Labor survey of employer-sponsored coverage. (Ref: [ACA, Section 1302 (b) (2) (a)](http://obamacarefacts.com/obamacarebill.pdf))

 Essential Benefits are provided with no out-of-pocket limits to the amount of care you can receive on every insurance plan sold on ObamaCare's Online Health Insurance Marketplace.

**Additional information on ObamaCare**

* <http://obamacarefacts.com/benefitsofobamacare.php>
* <http://obamacarefacts.com/obamacare-preventive-care.php>
* <http://obamacarefacts.com/grandfathered-plans.php>