Internal Medicine Coding Alert

CPT® Coding Strategies: Report Vaccine Administration Scenarios With Success

Hint: Use modifier when reporting significant and separately identifiable E/M service.

When your internist administers vaccine(s) to a patient, you'll focus on the patient's age, counseling (if performed), route of administration, and the number of vaccines/toxoids or vaccine/toxoid components provided to choose the appropriate administration code(s).

Counseling in Young Patients

When your internist administers a vaccine to a patient that is 18 years or younger and provides **counseling** about the vaccine to either the patient or to the patient's parents, you begin by reporting the administration with 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered). "Remember that 90460 and 90461 require counseling and not just the administration of the vaccine to a patient 18 years or younger," says **Alan L. Plummer, MD**, Professor of Medicine, Division of Pulmonary, Allergy, and Critical Care at Emory University School of Medicine in Atlanta. As the descriptor clearly states, the same code is used regardless of whether the vaccine was given intramuscularly, orally, or intranasally.

If more than one single-component vaccine is administered along with counseling to a patient that is 18 years or younger, each vaccine administered should be reported with 90460, according to the AMA CPT® 2012 Errata (http://www.ama-assn.org//resources/doc/cpt/cpt-changes-corrections.pdf).

In other words: "Report two units of 90460 for pneumococcal and influenza given on the same day," says **Carol Pohlig, BSN, RN, CPC, ACS,** senior coding and education specialist at the University of Pennsylvania, Department of Medicine in Philadelphia..

However, if your physician is administering one combination vaccine that covers more than one condition, you should count the individual components of the vaccine to accurately report it. For example, if the vaccine administered is providing coverage for four conditions, such as Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), you would report one unit of 90460 and three units of +90461 (...each additional vaccine or toxoid component administered [List separately in addition to code for primary procedure]) even though your clinician only administered one vaccine but counseled for all four components of the vaccine.

Four Codes For Older Patients

When a vaccine is administered to a patient older than 18 years and no counseling is provided, you report the administration using these four codes, depending on the route of administration and the number of vaccines (not components) involved:

- 90471 (Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; 1 vaccine [single or combination vaccine/toxoid])
- +90472 (...each additional vaccine [single or combination vaccine/toxoid] [List separately in addition to code for

primary procedure])
- 90473 (Immunization administration by intranasal or oral route; 1 vaccine [single or combination vaccine/toxoid])
- +90474 (...each additional vaccine [single or combination vaccine/toxoid] [List separately in addition to code for primary procedure])

So, if your clinician administers two vaccines intramuscularly, you report the first vaccine administration with 90471 and the second with +90472. If the two vaccines were administered orally or through the nose, you report the first vaccine with 90473 and the second with +90474.

Caveat: "Different from 90460-90461, 90471 and 90473 have reporting limitations," reminds Pohlig. "90471 and 90473 are initial administration codes and cannot be billed together on the same date of service" says **Mary Falbo, MBA, CPC**, President of Millennium Healthcare Consulting, Inc. in Lansdale, Penn. 90473 is bundled into 90471 as per Correct Coding Initiative (CCI) edits with the modifier indicator '0,' which means that these two codes cannot be reported together under any circumstances.

"When billing for multiple vaccine administrations, you can either report administration add-on codes per line or report as multiple units on one line" says Falbo. So, if your clinician is providing one vaccine intramuscularly and the other through the nose as a spray, you'll have to report the injected vaccine with 90471 and the intranasally administered vaccine with the add-on code +90474. "To report an intramuscular and an intranasal vaccine on the same day, one needs a base code and an add-on code to report the administrations," reminds Plummer. "Payment would be the same for each code pair."

Example: Your physician administers pneumovax-23 and trivalent Flulaval to a 50-year-old male patient. Since your physician administered two vaccines intramuscularly, you report the administration of the first vaccine with 90471 and the second one with +90472. Don't forget to report the supply of the vaccines with 90732 (Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use) for the pneumovax and 90658 (Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use) for the Flulaval.

Suppose, instead of Flulaval, that your clinician administered FluMist spray. In that case, you report the intramuscular injection of the pneumovax with 90471 and the administration of the FluMist with +90474. Alternatively, you can report 90473 for the FluMist administration and report the pneumovax administration with the add-on code +90472. Don't forget to report 90672 (Influenza virus vaccine, quadrivalent, live, for intranasal use) for the supply of the FluMist.

Use Alternate G Codes for Administration to Medicare Patients

When your internal medicine physician administers vaccines to Medicare patients, you may have to use other codes than 90471-90474 to report the administration. The administration of vaccines covered under Part B to Medicare patients is reported specifically depending on the vaccine that is administered.

So, depending on the vaccine administered, you'll have to report the following G codes when a Medicare patient receives the vaccine:

- G0008 (Administration of influenza virus vaccine)
- G0009 (Administration of pneumococcal vaccine)
- G0010 (Administration of hepatitis B vaccine)

Example: As in the example described earlier, if your internist was administering Flulaval and pneumovax 23 to a Medicare patient, you'll report G0008 for administration of Flulaval and report G0009 for the pneumovax administration. You may also have to report other codes for the supply of the influenza vaccine. You'll have to report Q2036 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use [Flulaval]) for

the supply of the Flulaval.

For other vaccines (e.g. those covered under Part D) administered to Medicare patients, you may still use codes 90471-90474 for the administration.

Know When to Report Separate E/M Code with Vaccine Administration Codes

When your internist administers a vaccine to a patient, certain things may be assumed to be included in the administration. These include a brief history, checking the patient's vital signs, and ruling out any contraindications to the administration of the vaccine. If your internist and his or her staff are only doing the things typically associated with vaccine administration, you should only report the vaccine administration codes and not report any evaluation and management (E/M) codes for the visit.

Per the Correct Coding Initiative (CCI) edits, any E/M office or inpatient codes are bundled into the vaccine administration codes 90460, 90471, and 90473 with the modifier indicator '1,' which means you can unbundle the codes if an appropriate modifier (such as 25) is appended to the E/M code, . The one exception is code 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services). The modifier indicator for CCI edits involving 99211 and the vaccine administration codes is '0,' which means you cannot override the edit with any modifiers.

So, you can report an E/M service with a vaccine administration code if and only if the E/M service was significant and separately identifiable from the vaccine administration. If a significant and separately identifiable E/M service was performed, you report the appropriate E/M code with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) appended to it to show that the E/M service was distinct from the vaccine administration performed.

Example: An asthmatic patient who is under the care of your physician reports for his influenza vaccination. During the visit, the patient complains that his wheezing symptoms have increased and the occurrence of symptoms at night has increased the incidence of his awakening in the night.

Your physician reviews the patient's history, checks his medication history, performs an expanded problem focused examination of the patient, and makes adjustments to the use of the metered dose inhaler the patient is using.

The patient also receives his flu vaccine as scheduled. So, in this case scenario, since your internist also reviewed and managed the patient's asthmatic condition, you can report an E/M service, such as 99213, with the modifier 25 along with the flu vaccine administration code, 90471, and the appropriate code for the type of influenza vaccine administered.