



**Manual:** Reimbursement Policy

**Policy Title:** **Modifier SL - State Supplied Vaccine**

**Section:** Modifiers

**Subsection:** None

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### Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### Reimbursement Guidelines

#### I. **Combination Vaccines versus All Components Administered Separately**

The following guidelines apply to all lines of business, including Medicaid:

CPT codes exist to describe combination vaccines with multiple components which are commonly administered together. Use of combination vaccines enables the provider to administer multiple needed vaccines with only one needle-stick. For example, the DTaP - Hib – IPV vaccine (90698) is a five-component vaccine which enables the provider to administer Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine at the same time in a single shot. If each individual component were to be purchased and administered as a separate vaccine, five separate needle-sticks would be required.

When components of a more comprehensive code are billed in combination, automated edits identify the unbundling and combine the component codes and charges into a single line item with the available comprehensive code for claims processing to avoid overpayments due to unbundling the comprehensive service. These rebundling edits exist for all types of services (surgical, radiology, laboratory, medicine, and vaccines).

If a combination vaccine exists, but the provider has either run out of or chooses not to stock the combination vaccine and administers each component as single vaccines, the first component may be billed as usual. Modifier 59 (distinct procedural service) needs to be appended to all remaining components of the combination vaccine to signify that the available

combination vaccine was not used, but separate injections of separate vaccines were performed. If modifier 59 is not used, the rebundle edit will apply.

**Example # 1:**

Hepatitis A and hepatitis B would normally be administered as a HepA-HepB combination vaccine (90636). The provider chooses to administer two single vaccines in two separate shots, hepatitis A (90632) and hepatitis B (90746).

The billing office will need to submit the claim with a separate and distinct modifier attached to 90746 to signify that the vaccines were administered as distinct procedural services, rather than in combination.

<u>Either:</u>	<u>Or:</u>	<u>Or:</u>
90632 x 1	90632 x 1	90632 x 1
90746-XS x 1	90742-XU x 1	90746-59 x 1

Billing in this manner will allow the claim to adjudicate both components separately without rebundling the codes into the comprehensive procedure code for the combination vaccine.

**II. Billing For State-Supplied Vaccine**

**A. The following guidelines apply to all plans except Medicaid and providers in the State of Washington:**

Moda Health does not reimburse for vaccines which have been obtained at no cost to the provider from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and younger. Moda Health requires CPT codes on the claim to identify the specific vaccines administered in order to properly adjudicate claims for the administration services. Modifier SL is to be used to identify that the vaccine itself was obtained at no cost to the provider.

Report the administration of state-supplied vaccines as follows:

1. Procedure codes for both the vaccine supply and the administration must be submitted on the same claim.
2. Report the vaccine supply using the appropriate procedure code(s) with modifier SL appended and a zero dollar amount (\$0.00) for billed charges. The vaccine supply line item is for identification and reporting of the specific vaccine(s) administered.
3. Report the administration service(s) with the CPT code(s) in the range of 90460 to 90474 that accurately reflects the administration of the vaccine(s). Do not append modifier SL to the administration procedure code(s).
4. All vaccines administered on a single date of service must be reported on the same claim.

Refer to CPT book and CPT Assistant guidelines for proper selection of administration codes for single- or multiple-component vaccines.

**Example # 2:**

The following state-supplied vaccines are administered IM:

- DtaP-HepB-IPV
- Hemophilus influenza B (Hib) PRP-T conjugate
- Pneumococcal conjugate vaccine, 13 valent

Counseling was performed by the physician, nurse practitioner, or physician assistant.

The billing office should submit the claim as follows:

- 90723-SL x 1 with zero charges (vaccine supplied by state, not from provider-purchased stock)
- 90460 x 1
- 90461 x 4
- 90648-SL x 1 with zero charges (vaccine supplied by state, not from provider-purchased stock)
- 90460 x 1 (*codes continued next page*)
- 90670-SL x 1 with zero charges (vaccine supplied by state, not from provider-purchased stock)
- 90460 x 1

**Example # 3:**

The following state-supplied vaccines are administered IM:

- DtaP-HepB-IPV
- Hemophilus influenza B (Hib) PRP-T conjugate
- Pneumococcal conjugate vaccine, 13 valent

No counseling was performed by the physician, nurse practitioner, or physician assistant.

The billing office should submit the claim as follows:

- 90723-SL x 1 with zero charges (vaccine supplied by state, not from provider-purchased stock)
- 90471 x 1
- 90648-SL x 1 with zero charges (vaccine supplied by state, not from provider-purchased stock)
- 90670-SL x 1 with zero charges (vaccine supplied by state, not from provider-purchased stock)
- 90472 x 2

B. The following guidelines apply to providers in the State of Washington:

Washington Vaccine Association uses modifier -52 to bill for state supplied vaccines provided to MD's/providers at no cost. The use of modifier -52 indicates they are billing at a reduced rate. The AMA indicates in CPT Assistant, Spring 1991 that Modifier -52 should not be used to report a full service (or vaccine supply) with a reduced or discounted fee. (AMA<sup>6</sup>)

Although modifier SL is more appropriate, the practice of billing with modifier -52 is based on instructions from the State of Washington, so Moda Health will accept modifier 52 on Washington Vaccine Association claims and reimburse without further pricing reductions for modifier 52.

Due to this practice, the Washington Department of Health instructs providers to bill only for the vaccine administration. (90471-90474, 90460-90463). Moda Health will not reimburse a provider for the vaccine itself if they are using state supplied vaccines.

**Example #4:**

Washington Vaccine Association (WVA) bills:

90648-52 Haemophilus influenza type b vaccine (Hib), PRP-T conjugate, 4 dose schedule for intramuscular use at a reduced rate and is reimbursed based on allowable for the billed charge.

The provider bills:

90471 (*no counseling*) OR 90460 (*if counseled*) and notes the type of vaccine given in the comments field on the claim.

The provider is reimbursed for the administration only.

**Example #5:**

Washington Vaccine Association bills:

90723-52 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use

90648-52 Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use

90670-52 Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use

90680-52 Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use

WVA is reimbursed based on allowable for the billed charges.

Provider/MD bills:

90471, 90472 x2, and 90473 (*no counseling*) OR 90460 x 4, 90461 x 6, 90474 x 1 (*if counseled*) and notes the vaccines given in the comments field on the claim. The provider is reimbursed for Administrations only.

C. The following guidelines apply to Moda Health Medicaid claims: (Moda Health<sup>5</sup>)

- Providers should bill the specific immunization CPT code with modifier 26 or SL, which indicates administration only.
- Providers should *not* bill for the administration of these vaccines using CPT codes 90460-90474 or 99211 (immunization administration codes).

## **Background Information**

### State-supplied Vaccines

A number of vaccines are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program, the Federal Vaccines for Children program, or any other program.

The Vaccine for Children (VFC) program is a federally funded program that provides vaccines at no cost to children 18 years of age and younger, who might otherwise not be vaccinated. Participating VFC providers are not to impose charges for state supplied vaccines.

### Definition, Purpose, and Use of Billing Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

## Codes and Definitions

Modifier SL	State supplied vaccine
Modifier XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
Modifier XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
Modifier 59	<p><b>Distinct Procedural Service:</b> Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different excision, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.</p> <p><b>Note:</b> Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, see modifier 25.</p>

## Coding Guidelines

Modifier -SL is to be used with the immunization procedure codes to identify those immunization materials obtained from the Department of Health. (DOH<sup>2</sup>)

“Procedures should be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code.” (CMS <sup>1</sup>)

## Cross References

- A. “Modifier 52 – Reduced Services.” Moda Health Reimbursement Policy Manual, RPM003.
- B. “Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service.” Moda Health Reimbursement Policy Manual, RPM027.

## References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §A, "Introduction".
2. *Medicaid Provider Guide, Physician-Related Services/Healthcare Professional Services*. Washington State Healthcare Authority – Medicaid. Last Accessed April 12, 2013; [http://www-stage.medicaid.hca.wa.gov/billing/documents/physicianguides/physician-related\\_services\\_mpg.pdf](http://www-stage.medicaid.hca.wa.gov/billing/documents/physicianguides/physician-related_services_mpg.pdf)
3. "State-Supplied Vaccine Claims." *MedicAide* June 2012: pg 2. Idaho Department of Health and Welfare, Division of Medicaid.
4. "Medicaid Information Release MA06-39." Idaho Department of Health and Welfare, Division of Medicaid. November 22, 2006. April 12, 2013. <http://www.healthandwelfare.idaho.gov/Providers/MedicaidProviders/InformationReleases/tabid/264/ctl/ArticleView/mid/1944/articleId/1431/MEDICAID-INFORMATION-RELEASE-MA0639.aspx> .
5. Vaccines for Children Billing. Moda Health Companies. April 12, 2013. [https://www.odscpanies.com/medical/claims\\_ohp.shtml](https://www.odscpanies.com/medical/claims_ohp.shtml)
6. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, Spring 1991, p. 7.

## IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health

reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.