

# Report

**THE EPIDEMIOLOGY OF U.S. IMMUNIZATION LAW:  
A NATIONAL STUDY FOR  
THE NATIONAL IMMUNIZATIONS PROGRAM,  
CENTERS FOR DISEASE CONTROL AND PREVENTION**

***MEDICAID COVERAGE OF IMMUNIZATIONS FOR  
NON-INSTITUTIONALIZED ADULTS***

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## EXECUTIVE SUMMARY

As a health policy matter, coverage of immunizations and their administration for all ages at levels recommended by the Advisory Committee on Immunization Practices (ACIP) has grown in importance for several reasons: 1) the growing attention to both manmade and naturally occurring public health threats; 2) recognition of the value of immunization to society; and 3) the relatively high cost of at least certain immunization services in relation to personal income. No population stands to benefit more from immunization coverage than low income persons. Studies suggest that adult immunization status is particularly low, and that financial barriers play a role, especially for low income persons.

Medicaid is the nation's single largest source of health insurance for children and adults. Eligibility for adults is linked to both membership in a recognized categorical status and low income, including individuals age 65 and over, adults (mostly women) in families with children, individuals with disabilities, pregnant women, and certain other categorical groups.

This review is the second in a series of studies which describes the different health insurance coverage options available to individuals and families in the United States for acquiring medically appropriate immunizations. This report analyses the provision of immunization services to adult beneficiaries of Medicaid. Coverage and payment information was reviewed from every state, while data from the District of Columbia was unobtainable. The findings from this study are the following:

48 state Medicaid programs furnish at least some immunization coverage and payment for adult immunizations for non-institutionalized adult beneficiaries.

Only Alaska and Louisiana specifically exclude immunization coverage for adults.

32 states offer coverage at ACIP standards.

The most commonly offered vaccines are pneumococcal (48/48) and influenza, (44/48) with the least common vaccines being Hepatitis A (38/48) and meningococcal (39/48) vaccine.

Cost sharing is virtually universal. Copayments are required in 27 states, prohibited in 1 state, and 20 states are silent.

Vaccine replacement programs are almost non-existent. Only 3 states offer full vaccine replacement.

There is great variation in the extent to which states will pay a separate administration fee. Fees are permissible in 26 states. In 15 states, the existence of a fee for administration is assumed as part of a rate setting method. 1 state prohibits any administration fee, and information was not obtained from 6 states.

All states prohibit any payment to the extent that immunizations are offered free of charge. In our discussions with state Medicaid officials, it became evident that there was relatively widespread assumption that vaccines for adults can be secured free of charge and that coverage and payment are not an issue. The two states that exclude coverage and payment, do so entirely on the basis of this assumption.

Our definition of comprehensive Medicaid immunization coverage includes coverage of all ACIP recommended vaccines, elimination of copayment requirements, a vaccine replacement policy, and payment of a separate fee. **No state** met that standard. By permitting nominal copayments meeting federal standards, 2 states, New York and California satisfy the test.

We recommend conducting a technical assistance effort aimed at expanding the regulation of Medicaid immunization coverage, including developing a state-by-state analysis, targeted efforts to improve coverage levels as well as payments for replacement and administration. Additionally, we should ensure that public health agencies understand the Medicaid billing requirements, since the revenues generated through adult vaccine billing could be considerable in those states with relatively high Medicaid eligibility levels.

## Introduction

This review is the second in a series of studies produced under a cooperative agreement funded by the National Immunizations Program (NIP), Centers for Disease Control and Prevention (CDC), which describes the different health insurance coverage options available to individuals and families in the United States for acquiring medically appropriate immunizations.<sup>1</sup> This report is a descriptive, nation-wide, point-in-time analysis detailing the provision of immunization services to adult beneficiaries of Medicaid. Children are excluded from this study because all Medicaid-enrolled children under age 21 are legally entitled to all ACIP recommended vaccines as a matter of federal law. In the case of adults however, states have broad discretion over coverage choices.

The purpose of this project is to facilitate planning for future national immunization policy by providing the NIP with up-to-date information regarding the accessibility of immunizations throughout the life span, and to identify possible gaps in coverage among the various health care delivery systems.

## Background

Medicaid is the nation's single largest source of health insurance for children and adults. Eligibility for adults is linked to both membership in a recognized categorical status and low income (either in absolute terms or relative to the cost of necessary care, as in the case of medically needy persons). In 1998, Medicaid provided health services to approximately 20 million low-income adults,<sup>2</sup> including individuals age 65 and over, adults (mostly women) in families with children, individuals with disabilities, pregnant women, and certain other categorical groups.

Medicaid is a federal grant in aid program administered by states and funded jointly by the federal and state governments. Persons who meet program eligibility standards are legally entitled to federally required coverage, and states are legally entitled to federal contributions in accordance with a statutory formula toward the cost of necessary medical care.

Participating states with approved plans must cover certain services for enrolled adults and children. The pediatric benefit is very broad<sup>3</sup> and includes all ACIP recommended vaccines. In the case of adults, states have broad discretion where preventive services coverage and payment are concerned. Coverage can be provided for all ACIP-approved vaccines as a discrete preventive service. In addition, even where there is no coverage as part of an approved state plan, vaccines can be *effectively* covered if a state will pay for the vaccine and its administration as an incidental procedure in certain office visits or as part of an institutional payment. Furthermore, a state can pay a discrete fee for vaccine administration or alternatively, could incorporate payment as an assumption in an overall payment for an encounter or an admission.

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<sup>1</sup> The first report in this series, *The Epidemiology of U.S. Immunization Law: Mandated Coverage of Immunizations Under State Health Insurance Laws*, Rosenbaum S., Stewart A., Cox M., Mitchell S, July 2003, is available at <http://www.gwhealthpolicy.org>.

<sup>2</sup> Schneider, A., Garfield, R., *Chapter II: Medicaid Benefits, Medicaid and the Uninsured*, p 52, The Henry J. Kaiser Family Foundation, March 2003. [www.kff.org/kcmu](http://www.kff.org/kcmu).

<sup>3</sup> See Rosenbaum, S., *Medicaid*, N Engl J Med, Vol. 346, No. 8, Feb. 21, 2002, [www.nejm.org](http://www.nejm.org).

In the case of most adult, beneficiaries, nominal copayments can be imposed.<sup>4</sup> Copayments may be as low as \$0.50 to a maximum of \$3.00, depending on how much the state pays for the service. The co-insurance payment equals five percent of the state's payment rate for the service. Despite these cost-sharing provisions, Medicaid providers are not permitted to refuse care or services to any beneficiary due to their inability to pay any portion of a cost sharing arrangement.<sup>5</sup> Additionally, Medicaid has exempted some categories of beneficiaries from copayments including: 1) pregnant women; 2) children under 18; 3) patients in a hospital, nursing facility, intermediate care facility facility/mentally retarded (ICF/MR), or other medical institution who are expected to contribute most of their income to the cost of institutional care; and 4) terminally ill persons receiving hospice care. Thus, individuals who are members of these categories may receive immunizations without incurring any out-of-pocket costs at the time of service. Studies have found that the application of any out-of-pocket requirements reduces the ability of the Medicaid-eligible population to fully utilize preventive services, in particular, immunizations.<sup>6</sup>

Immunizations are an important health service for the Medicaid population for several reasons. First, beneficiaries have greater health care needs and higher health risks than other individuals in the U.S.<sup>7</sup> Adult Medicaid beneficiaries report that they are in fair or poor health at triple the rate of any population group and tend to experience disproportionately low rates of preventive care.<sup>8</sup> Second, Medicaid beneficiaries may be more likely to live with persons who are not citizens, are at elevated risk for communicable disease, and experience reduced access to medical care. Because living arrangements alone may elevate the risk of disease for certain groups of Medicaid eligible persons, immunizations are important.

While immunizations are relatively inexpensive, this is not the case with newer vaccines. Furthermore, beneficiary income levels are so low that even copayments considered modest by middle income standards (e.g., \$10.00 for an influenza immunization) would be high as a point of service expenditure for beneficiaries. Medicaid cost sharing levels are far lower. In the absence of Medicaid coverage, low income adults would depend on public health agencies, community health centers, and other subsidized public clinics for subsidized immunization services. Funds available to public health agencies under the §317 program are quite limited in relation to the total number of institutionalized and non-institutionalized low income adults who need free vaccines.

Although Medicaid coverage and payment for vaccine can be as broad as the proper standard of care, longstanding federal Medicaid policy prohibits payment for services that are available free of charge. Where public health agencies are unable to provide adult immunization coverage or else furnish some level of coverage but bill third

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<sup>4</sup> 42 USCA § 1902(a)(14) and § 1916. Reg. §447.50

<sup>5</sup> 42 USCA § 1916 (e)

<sup>6</sup> A review of Medicaid claims from 1972-3 showed that a \$1.00 copayment per service caused Medicaid beneficiaries in California to decrease their immunizations by 45% compared to individuals not subject to the copayment. Brian E.W., Gibbens S., *California's Medi-Cal Copayment Experiment*, Medical Care, Vol.12 (12suppl): 4-56, 1974.

<sup>7</sup> See *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities*, Center for Health Care Strategies, Inc., available at <http://www.chcs.org>.

<sup>8</sup> Schneider, A., Garfield, R., *Chapter II: Medicaid Benefits, Medicaid and the Uninsured*, p 52, The Henry J. Kaiser Family Foundation, March 2003. [www.kff.org/kcmu](http://www.kff.org/kcmu).

party payers and collect fees, the Medicaid free care policy would appear to be inapplicable.

## Research Methods

Medicaid's treatment of immunization is complex because of the potential for either overt coverage through insurance design or de-facto coverage through payment methods. Thus, it is often very difficult to know what services are available to Medicaid beneficiaries. This complexity would be true for any insuring arrangement, since access to financing for any particular service can be a function of either coverage or payment principles. Studies of vaccine coverage must take both alternative approaches into account, particularly since it is highly possible that in the case of professionally administered drugs and biologicals, a state would simply fold payment for the procedure into one or more classes of office visits.

This study of access to vaccines among the non-institutionalized Medicaid adult population is an attempt to gauge the question of Medicaid vaccine financing in considerable detail. Our goal was to measure both *any coverage* as well as the *adequacy of coverage* in relation to the ACIP recommendations.

Beginning in early 2003, CHSRP researchers identified and reviewed all available material relating to coverage of and payment for adult immunizations under Medicaid. Our review included data obtained from commercially available state plan summaries,<sup>9</sup> provider manuals, billing procedures, state websites, and discussions with state Medicaid administrators regarding the provision of adult immunizations.<sup>10</sup> Relevant data was gathered from all states; however, we were unable to collect any information from the District of Columbia.

Upon review, we found the majority of materials failed to identify which specific vaccines were covered. To address this issue, we identified the Current Procedure Terminology (CPT) Code associated with the vaccines.<sup>11</sup> For each vaccine, we chose only the most general code, because some vaccines are medically appropriate in several different dosage amounts, and have been assigned several different codes.<sup>12</sup> When we were able to ascertain that a state included the general CPT code for a particular vaccine in its provider billing procedure manual, we reported that the state covered the vaccine.

In order to analyze the adequacy of Medicaid coverage, the information was compared to the immunization recommendations for adults obtained from the Advisory Committee on Immunization Practices (ACIP).<sup>13</sup> ACIP defines adults as individuals age 19

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<sup>9</sup> See Medicare Medicaid Guide, CCH, Inc., Volume 4, Chicago: Il. , Feb. 27, 2001.

<sup>10</sup> This project was approved by the George Washington University Institutional Review Board, No. U010327ER.

<sup>11</sup> The Current Procedure Terminology (CPT) codes have been developed by the American Medical Association, and function as a nationwide, uniform mechanism to report medical services and procedures. The codes are the most widely accepted reporting system, and are utilized by public and private health insurance programs for administrative management purposes such as claims processing and developing medical care review.

<sup>12</sup> The CPT codes and their associated descriptions for the vaccines used in this report, are outlined in Appendix IV of this report.

<sup>13</sup> The ACIP is a federally sponsored board that advises the CDC on immunization practices. The ACIP standards have been accepted by the American Academy of Family Physicians (AAFP), the American

and above. The recommended vaccines (with some limitations), are: 1) Hepatitis A, 2) Influenza, 3) Measles, mumps and rubella (MMR), 4) varicella, 5) tetanus and diphtheria, 6) pneumococcal, 7) meningococcal, and 8) hepatitis B.

Researchers reviewed Medicaid coverage using aspects of the typology that was developed for our previous study of state insurance mandates. The typology outlines the essential elements of comprehensive immunization coverage:

- whether the program outlines immunization coverage for adults;
- whether program administration documents detail which vaccines are covered;
- whether the program describes limitations attached to vaccine coverage;
- whether the program documents address beneficiary cost-sharing requirements; and
- whether the state addresses how providers are reimbursed for immunizations.

Once researchers scrutinized each state's coverage and payment options, states were grouped according to how their programs satisfied the following criteria:

- whether all ACIP recommended vaccines are covered;
- whether the state permits a nominal copay;
- whether the state reimburses the provider the full cost of the vaccine; and
- whether separate provider bill of the administration fee is permitted.

Our findings are presented below:

## **Findings**

### ***1. General Levels of Coverage***

Table 1 below, indicates that as of the fall 2003, out of the 50 jurisdictions surveyed, 48 programs provided *at least some degree* of immunization coverage for adults.<sup>14</sup> Two states, Alaska and Louisiana, fail to provide any immunization coverage. Researchers were unable to obtain information from the District of Columbia.

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College of Obstetricians and Gynecologist (ACOG), and the American College of Physicians—American Society of Internal Medicine (ACP-ASIM). The recommendations, updated annually, are considered the principal nationwide practice standard.

<sup>14</sup> Pertinent language is provided in Appendix I of this report.

**TABLE 1 – Medicaid Provision of ACIP-Recommended Adult Immunizations**

STATE	HEP. A 90632	FLU 90659	MMR 90707	VARICELLA 90716	T-D 90718	PNEUMOCOCCAL 90732	MENINGOCOCCAL 90733	HEP. B 90746	STATE TOTAL
Alabama		•	•	•	•	•	•	•	7
Arizona	•	•	•	•	•	•	•	•	8
Arkansas		•	•		•	•		•	5
California	•	•	•	•	•	•	•	•	8
Colorado	•	•	•	•	•	•	•	•	8
Connecticut	•	•	•	•	•	•	•	•	8
Delaware	•	•	•	•	•	•	•	•	8
Florida		•				•			2
Georgia	•	•	•	•	•	•	•	•	8
Hawaii	•	•	•	•	•	•	•	•	8
Idaho	•	•	•	•	•	•	•	•	8
Illinois	•	•	•	•	•	•	•	•	8
Indiana	•	•	•	•	•	•	•	•	8
Iowa	•	•	•	•	•	•	•	•	8
Kansas	•	•	•	•	•	•	•	•	8
Kentucky		•	•	•	•	•		•	6
Maine	•	•	•	•	•	•	•	•	8
Maryland	•	•	•	•	•	•	•	•	8
Massachusetts	•		•	•		•	•	•	6
Michigan	•	•	•	•	•	•	•	•	8
Minnesota	•	•	•	•	•	•	•	•	8
Mississippi		•				•			2
Missouri	•	•	•			•		•	5
Montana	•	•	•	•	•	•	•	•	8
Nebraska	•	•	•	•	•	•	•	•	8
Nevada	•	•	•	•	•	•	•	•	8
N. Hampshire	•	•	•	•	•	•	•	•	8
N. Jersey			•	•	•	•	•	•	6
N. Mexico	•	•	•	•	•	•	•	•	8
N. York	•	•	•	•	•	•	•	•	8
N. Carolina	•		•	•	•	•	•	•	7
N. Dakota	•	•	•	•	•	•	•	•	8
Ohio	•	•	•	•	•	•	•	•	8
Oklahoma	•	•				•			3
Oregon	•	•	•	•	•	•	•	•	8
Pennsylvania	•	•	•	•	•	•	•	•	8
Rhode Island		•				•			2
S. Carolina	•	•				•	•	•	5
S. Dakota		•	•	•	•	•	•	•	7
Tennessee			•	•	•	•	•		5
Texas	•	•	•	•	•	•	•	•	8
Utah	•	•	•	•	•	•		•	7
Vermont	•	•	•	•	•	•	•	•	8
Virginia		•				•			2
Washington	•	•	•	•	•	•	•	•	8
W. Virginia	•	•	•	•	•	•	•	•	8
Wisconsin	•	•	•	•	•	•	•	•	8
Wyoming	•	•	•	•	•	•	•	•	8
<b>Total</b>	<b>48</b>	<b>38/48</b>	<b>44/48</b>	<b>42/48</b>	<b>40/48</b>	<b>40/48</b>	<b>48/48</b>	<b>39/48</b>	<b>42/48</b>
<b>Gray Box = No coverage offered</b>									
<b>Medicaid programs in Alaska and Louisiana do not provide any immunization coverage for adults.</b>									
<b>Researchers were unable to obtain information from the District of Columbia.</b>									
<b>SOURCE: GWU/SPHHS/CHSRP Analysis of Medicaid Adult Immunization Coverage, 2003</b>									

**Coverage according to ACIP recommendations:** Thirty-two states reported *full coverage* for adult immunizations according to the ACIP standard. Of these 32 states, only Michigan and Ohio specifically articulate that ACIP recommendations must be followed, as the language below illustrates:

**Michigan**

Immunizations . . .

Vaccines and toxoids (immunizations) are covered when given according to ACIP (Advisory Committee on Immunization Practices) recommendations ... In addition, Michigan offers a similar program for Medicaid adults 19 years old and older called the MI-CRP (Michigan Replacement Program). **p 30 effective 10/1/03**

**Ohio**

Active Immunizations

(A) The active immunizations specified in proceeding paragraphs are covered by the department when administered in accordance with the “Advisory Committee on Immunization Practices” (ACIP) . . . or the “Centers for Disease Control” (CDC) recommendations.

**Failure to cover all immunizations according to ACIP standards:** Sixteen of 48 states reporting any coverage reported less than full coverage. State coverage levels fluctuate from two classes of vaccine (FL, MS, RI, and VA) to 7 (AL, NC, SD, and UT). The states that cover two vaccines follow the same pattern – covering only the influenza and pneumococcal vaccines. This coverage tracks the coverage provided by the Medicare program. An example from Florida is provided below:

**Florida**

Coverage and Limitations for Institutionalized Recipients . . .

. . . Medicaid reimburses for influenza and pneumococcus vaccines for institutionalized recipients who do not have Medicare benefits. Influenza vaccine is limited to one per year per recipient. Pneumococcus vaccine is limited to one per lifetime per recipient.

**Prescribed Drug Coverage, Limitations and Reimbursement Handbook, p 9-11**

Summary of Services . . . Prescribed Drug Services . . .

Medicaid does not reimburse pharmacies for the following products: . . . Immunizations for non-Child Health Check-Up 221 recipients 21 years of age and older, except for influenza and pneumococcal vaccines for institutionalized recipients. **p 71, 72.**

**Pneumococcal Immunization:** All of the 48 states included in this study list pneumococcal as a covered vaccine, making it the most widely covered vaccine.

**Hepatitis A:** Thirty-eight states cover Hepatitis A, making this vaccine the least common form of coverage. Information from states that do not cover this vaccine does not indicate the basis for the exclusion; the vaccine simply is not listed in Fee Schedules or Physician Manuals as the following illustrates:

**Kentucky**

2003 Physicians, Resource Based Relative Value Scale . . .

90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90746. **p 225.**

**South Dakota**

67:16:02:04. Physicians’ services covered. Physician’s services covered are limited to the following professional services, which must be medically necessary and provided by a physician to a recipient: . . . (4) Drugs and biologicals administered in a physician’s office which cannot be self-administered. 67:16:02:03 List of Physician Non-laboratory



Procedures, Appendix A . . . 90659 . . . 90707 . . . 90716; 90718 . . . 90732; 90733 . . .  
90746.

## ***2. Limitations placed on coverage of specific vaccines***

Table 2 shows that out of 48 states that offer any immunization coverage, none appears to limit vaccine use below ACIP standards. In other words, if coverage is furnished, it is furnished to ACIP standards.<sup>15</sup>

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<sup>15</sup> The ACIP limitations are provided in Appendix V of this report.

**TABLE 2 – Medicaid Limitations to ACIP Recommended Adult Immunization Coverage**

STATE	HEP. A 90632	FLU 90659	MMR 90707	PNEUMOCOCCAL 90732	MENINGOCOCCAL 90733	HEP. B 90746	GENERAL LIMITATIONS	NO LIMITATIONS	
Alabama								•	
Arizona								•	
Arkansas			• <sup>d</sup>	• <sup>a</sup>					
California	• <sup>a</sup>		• <sup>c</sup>						
Colorado		• <sup>a</sup>					• <sup>g</sup>		
Connecticut								•	
Delaware								•	
Florida		• <sup>a</sup>		• <sup>a,i</sup>					
Georgia							• <sup>g,i</sup>		
Hawaii		• <sup>a</sup>		• <sup>a</sup>		• <sup>a</sup>			
Idaho								•	
Illinois								•	
Indiana								•	
Iowa								•	
Kansas		• <sup>b</sup>							
Kentucky								•	
Maine								•	
Maryland							• <sup>g</sup>		
Massachusetts							• <sup>i</sup>		
Michigan								•	
Minnesota								•	
Mississippi							• <sup>h</sup>		
Missouri							• <sup>i</sup>		
Montana								•	
Nebraska							• <sup>g,h</sup>		
Nevada								•	
N. Hampshire								•	
N. Jersey						• <sup>a</sup>			
N. Mexico								•	
N. York								•	
N. Carolina								•	
N. Dakota	• <sup>a</sup>					• <sup>g</sup>			
Ohio					• <sup>g</sup>				
Oklahoma	• <sup>a</sup>								
Oregon								•	
Pennsylvania								•	
Rhode Island								•	
S. Carolina		• <sup>c</sup>							
S. Dakota							• <sup>g,i</sup>		
Tennessee								•	
Texas		• <sup>a,b</sup>		• <sup>a,f</sup>		• <sup>a</sup>			
Utah								•	
Vermont								•	
Virginia		• <sup>g</sup>		• <sup>g</sup>			• <sup>h</sup>		
Washington								•	
W. Virginia							• <sup>g</sup>		
Wisconsin								•	
Wyoming		• <sup>a</sup>		• <sup>a</sup>					
<b>Total</b>	<b>48</b>	<b>3</b>	<b>8</b>	<b>2</b>	<b>6</b>	<b>1</b>	<b>4</b>	<b>10</b>	<b>26</b>

**Notes:** (a) Individual must be at high risk in order to receive immunization (high risk is defined differently by state); (b) Given only once per flu season; (c) Individual must be in long-term care facility without Medicaid coverage; (d) Given only to women of child-bearing age who are at risk; (e) Medically justifiable only for adults who are known to be immune to the other two diseases protected by the MMR vaccine; (f) Given only once per lifetime; (g) Immunization must be medically necessary which is variously defined; (h) Immunization must be related to the treatment of disease or direct exposure; (i) Immunization must satisfy the standard of care as defined by state

**Gray Box = No limitation**

**NOTE: Numbers will not add up to 48 due to restrictions in multiple categories.**

**No state has placed restrictions on access to Tetanus-Diphtheria or Varicella, thus they are omitted from this Table.**

**SOURCE: GWU/SPHHS/CHSRP Analysis of Medicaid Adult Immunization Coverage, 2003**

Certain states add their own language clarifying risk factors that trigger an immunization entitlement.

**Hepatitis A:** Three states, California, North Dakota, and Oklahoma expressly limit their Medicaid coverage of Hep. A immunizations by requiring the beneficiary to be at high risk or require the treatment to be medically necessary as the following language demonstrates:

**California**

Medical Necessity. When billing . . . providers must document medical necessity in the Remarks area/Reserved For Local Use field . . . of the claim, or as an attachment, as defined by any of the following conditions. If the recipient:

. . . Resides in a high-rate hepatitis A community (epidemic occurs every 5-10 years, the epidemic lasts for several years, and rates of disease exceeds 700 cases a year per 100,000 population during the outbreaks, and a few cases occur among persons over 15 years of age).

. . . Resides in an intermediate rate hepatitis A community (epidemics often occur at regular intervals and persist for several years with rates in excess of 50 cases a year per 100,000 population) . . . **p inject 11**

**Oklahoma**

(2) Immunizations for adults. Coverage for adults is limited to: (A) influenza immunizations, (B) Pneumococcal immunizations, and (C) Gamma Globulin and Hepatitis A Vaccine when documentation shows the individual has been exposed to Hepatitis. **Title 317. Oklahoma Health Care Authority, Chapter 30. Medical Providers-Fee For Service**

**Influenza:** Eight states (CO, FL, HI, KS, SC, TX, VA, and WY) place limitations on the provision of influenza immunizations. In both Texas and Kansas, the flu vaccine may be given only once during flu season. Colorado, Florida, Hawaii, Texas, and Wyoming require that the vaccination be given only to individuals who are at high risk for influenza-related complications. South Carolina only covers those who are in long-term care and without Medicare coverage. For example, South Carolina's and Texas' restrictions are defined as shown below:

**South Carolina**

Medicaid will not directly reimburse pharmacy providers for influenza virus vaccine where the patient is dually eligible for both Medicare and Medicaid coverage. However, for those long term care patients having only Medicaid coverage, Pharmacy services reimburses for the influenza vaccine. **Medicaid Pharmacy Services Provider Manual p 200-23**

**Texas**

Influenza Vaccine. For individuals not covered by THSteps or the TVFC Program, the Texas Medicaid Program will cover the influenza vaccine . . . for patients who are at high risk for influenza-related complications when medically necessary . . . For all others, the vaccine may be administered one time per influenza season. Influenza vaccine. . . should be administered to patients at high risk for influenza October through mid-November. Influenza activity peaks between late December and early March . . . The following clients are at high risk for complications of the disease:

Clients age 65 and older

Residents of nursing facilities and other chronic-care facilities that house people of any age who have chronic medical conditions

Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma

Adults and children who have required regular medical follow-up or hospitalizations during the preceding year because of chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppressant (including immunosuppressant caused by medication) . . .  
Women who are in the second or third trimester of pregnancy during flu season . . .  
. p. 34-88 - 34-89

***Measles Mumps and Rubella:*** Two states, Arkansas and California, place restrictions on the use of the MMR vaccine (for very different reasons) as demonstrated by the following excerpts:

***Arkansas***

17. Maternal measles/mumps/rubella (MMR) when provided to women of childbearing age (ages 21 through 44) who may be at risk of exposure to these illnesses

***California***

MMR Vaccinations

The use of MMR . . . is medically justifiable only for . . . an adult who is known to be immune to the other two diseases. P inject 25

***Pneumococcal:*** Access to the Pneumococcal vaccine is limited by nine of the 48 states surveyed: Arkansas, Florida, Hawaii, Texas, and Wyoming. Four of these states limit its distribution to those who are at high risk or institutionalized (AR, HI, TX, WY) while two states (FL and TX) reimburse for one dose of the vaccine per lifetime per recipient except for specific identified reasons. Virginia covers Pneumococcal vaccination that is reasonable and necessary for the prevention of illness. Examples are provided below:

***Arkansas***

19. Pneumococcal polysaccharide vaccine 23-valent, adult dosage, is payable for eligible recipients age 12 and over. Recipients who are age 21 and older and receive this injection should be considered by the provider as high risk. All recipients over age 65 may be considered high risk.

***Wyoming***

Equality Care covers influenza vaccine and Pneumococcal vaccine for patients considered at risk.

***Texas***

Pneumococcal Polysaccharide Vaccine. For individuals not covered by the THSteps or the TVFC Program, the Texas Medicaid Program covers 1-90732, Pneumococcal polysaccharide vaccine, 23-valent, adults or immunosuppressed patient dosage for use in individuals age 2 and older . . . Pneumococcal polysaccharide vaccinations are limited to one per client per lifetime unless specific criteria for revaccination are met.

Revaccination is recommended for high-risk individuals . . . Those older than age 10 may receive it 5 years after the first dose. Revaccination is recommended for clients who are at high risk for Pneumococcal disease or complications of the disease including:

Clients age 65 and older who received their first dose before turning 65, if 5 or more years have passed since the first dose was given

Clients age 65 and older who received a 14-valent vaccine

People with the following conditions

- o Damaged spleen or no spleen (asplenic)
- o Sickle-cell disease
- o HIV infection or AIDS
- o Cancer, leukemia, lymphoma, multiple myeloma
- o Kidney failure
- o Nephrotic syndrome

- o Organ or bone marrow transplant recipients  
Immunosuppressant therapy (chemotherapy or long-term steroids) . . . p 34-98

**Virginia**

Vaccines. . . or the immunization is a pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness. . . p 82, 83

**Meningococcal:** Ohio is the only state that explicitly limits the administration of the Meningococcal immunization as their Medicaid Physician Manual language shows. However, the limitation language is vague and unspecific. Further it appears as though the state reserves the right to determine medical necessity:

**Ohio**

(D) Active immunizations identified with a (\*\*) [Meningococcal] are covered on a case-by-case basis and only if determined by ODJFS as medically necessary

**Hepatitis B.:** Four states, Hawaii, New Jersey, North Dakota, and Texas restrict access to immunization against contracting Hepatitis B. North Dakota requires the administration to be medically necessary while Hawaii, New Jersey and Texas limit the vaccine to those beneficiaries who are at high risk or have been exposed to the illness. For example:

**New Jersey**

Physicians Services Manual . . . (i) Hepatitis B Vaccine: Coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with the criteria defined by the CDC. In all such cases, the need for this vaccination must be fully documented in the recipient's medical record. In order to facilitate reimbursement for Hepatitis B immunoprophylaxis for high risk individuals, manufacturer, age, and dose specific procedure codes have been developed for use by physicians and independent clinics providing this service. . . . W9099 – Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age. \$63.57. . . . W9335 – Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age. \$62.09. p 469.

**Medicaid limitations on adult immunizations that are not illness-specific:**

Ten states include general medical necessity language in their description of coverage but would appear to adhere to ACIP standards to determine medical necessity. The following language illustrates this point:

**Mississippi**

34.05 Mississippi Division of Medicaid (DOM) covers immunizations for adults that are related to the treatment of injury or direct exposure to a disease such as rabies or tetanus . . . p 1.

**Missouri**

13.24.B Injections and Immunizations

Injections are covered only if administered by a physician, advanced practice nurse or by a nurse under the physician's supervision. Injections that are not considered by accepted standards of medical practice to be a specific or effective treatment for the particular diagnosis for which they are given are not covered.

Injections that exceed the frequency or duration indicated by accepted standards of medical practice and are not justified by extenuating circumstances are not covered.

***South Dakota***

South Dakota Administrative Rules . . . . 67:16:01:06:02. Covered services must be medically necessary. Services covered under this article must be medically necessary. To be medically necessary, the covered service must meet the following conditions: . . . (2) It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group.

**3. Medicaid Cost sharing Requirements for Adult Immunizations**

The copayment requirements for states that provide adult immunizations are outlined in a state's Medicaid plan and are summarized in Table 3 below.<sup>16</sup> Twenty-seven states require their programs to levy some degree of cost sharing for adult immunizations. One state prohibits any such charges, while twenty states do not address copayments.

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<sup>16</sup> Pertinent language, excised from state Medicaid plans is provided in Appendix II of this report.

**TABLE 3: Medicaid Copayment Requirements for Adult Immunizations**

STATE	COPAYMENT		
	<i>Required</i>	<i>Prohibited</i>	<i>Silent</i>
Alabama	•		
Arizona	•		
Arkansas			•
California	•		
Colorado	•		
Connecticut	•		
Delaware			•
Florida		•	
Georgia	•		
Hawaii			•
Idaho			•
Illinois	•		
Indiana	•		
Iowa	•		
Kansas	•		
Kentucky			•
Maine	•		
Maryland			•
Massachusetts	•		
Michigan	•		
Minnesota			•
Mississippi	•		
Missouri	•		
Montana	•		
Nebraska	•		
Nevada			•
New Hampshire			•
New Jersey			•
New Mexico			•
New York			•
North Carolina	•		
North Dakota	•		
Ohio			•
Oklahoma	•		
Oregon	•		
Pennsylvania	•		
Rhode Island			•
South Carolina			•
South Dakota	•		
Tennessee			•
Texas			•
Utah			•
Vermont	•		
Virginia	•		
Washington			•
West Virginia			•
Wisconsin	•		
Wyoming	•		
<b>Total = 48</b>	<b>27</b>	<b>1</b>	<b>20</b>
<b>Gray Box = State does not satisfy category requirement</b>			
<b>SOURCE: GWU/SPHHS/CHSRP Analysis of Medicaid Adult Immunization Coverage, 2003</b>			

**Copayments Vary According to the Type of Service:** Under Medicaid rules, different copayment amounts apply to immunizations, and depend on which type of provider performs the service, and under which service category. The payments range from a low of \$.50, up to \$6.00, with most states charging between \$1.00 - \$3.00. An example from Montana is provided:

**Montana**

**VII. Copayments**

Copayments are required of both categorically and medically needy individuals with the following exceptions: (a) individuals under age 21; (b) pregnant women; (c) patients in a nursing home or other medical institution who are required to spend all but their personal needs allowance for their care; (d) individuals who are health maintenance organization enrollees; and (e) individuals receiving hospice care. Emergency and family planning services are also excluded from the requirement. Providers are responsible for collecting cost sharing charges from individuals; however, services may not be denied because the recipient cannot pay.

The copayments according to service are . . .

- 2. *Outpatient hospital services:* \$1.00 per service.
- 3. *Physicians' and podiatrists' services:* \$2.00 per service . . .
- 6. *Clinic services:* \$1.00 per visit . . .
- 8. *Prescribed drugs:* \$1.00 per generic prescription; \$2.00 for name brand drugs . . .
- 11. *Rural health clinic, federally qualified health center, and freestanding dialysis clinic services:* \$2.00 per unit. .
- 13. *Mid-level practitioners' services:* \$2.00 per unit . . .

**Prohibition of Copayment:** As stated above, Florida is the only state that limits adult immunization services to beneficiaries who are institutionalized and also do not have Medicare coverage. Since this group of individuals is statutorily exempt from any form of cost sharing, Florida is prohibited from levying any copayments for the service under Medicaid.

**Upper Limit Restrictions on Cumulative Copayment:** Colorado, Maine, Pennsylvania and Wisconsin are the 4 states that instituted a ceiling on the maximum permissible out-of-pocket expenses. These limitations are outlined below:

**Colorado**

Individuals whose copayments reach \$150 in a calendar year are exempt from further copayments during that year.

**Maine**

[T]otal charges limited to no more than four copayments per month or eight per family. *Note that this limitation refers to copayments applicable to drugs.*

**Pennsylvania**

The program reimburses the recipient for copayment exceeding \$90 in a six-month period.

**Wisconsin**

The maximum copayment required of a recipient is \$30 per calendar year . . .

Arizona permits the application of a \$1.00 copayment for a doctor's visit, but excludes the copay for the biologicals that comprise an immunization:



## **Arizona**

### **V. Copayments . . .**

The following copayments are required from categorically needy recipients: (a) \$1.00 for each doctor's office or home visit and all diagnostic and rehabilitative X-ray and laboratory services associated with such visit . . . The following are excluded from copayment requirements . . . (d) visits scheduled by a primary care physician or practitioner not at the recipient's request; (e) drugs and biologicals.

## **4. Medicaid Payment Policy for Adult Immunizations furnished in Non-Institutional Settings**

The Medicaid provider reimbursement policies for the states that provide immunizations are outlined in the state Medicaid Provider Manuals, and are summarized in Table 4 below.<sup>17</sup>

***Reimbursement for cost of vaccine:*** Three states permit full provider reimbursement for the cost of vaccines. Thirty-two states explicitly deny full reimbursement (utilizing another method of payment), while 8 states are silent on the issue. Researchers were unable to obtain reimbursement information about 5 jurisdictions.

***Administration:*** As illustrated on Table 4, 26 states allow a provider to bill for a separate administration fee. Virginia is the only state that explicitly prohibits a separate fee. Fifteen states are silent on the issue, because these states utilize a fee schedule which assumes inclusion of an administration fee. For six states, researchers were not able to obtain information regarding administration fees.

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<sup>17</sup> Provider reimbursement policies have been provided in Appendix III of this report.

**TABLE 4 – Medicaid Reimbursement Policy for Adult Immunizations**

STATE	STATE REIMBURSES COST OF VACCINE				STATE REIMBURSES PROVIDER FOR VACCINE ADMINISTRATION			
	<i>Yes</i>	<i>No</i>	<i>Silent</i>	<i>N/A</i>	<i>Yes</i>	<i>No</i>	<i>Silent</i>	<i>N/A</i>
Alabama		•			•			
Arizona		•					••	
Arkansas				•				•
California	•				•			
Colorado		•			•			
Connecticut		•					••	
Delaware				•				•
Florida		•					••	
Georgia			•		•			
Hawaii			•		•			
Idaho		•			•			
Illinois		•					••	
Indiana		•			•			
Iowa		•			•			
Kansas		•			•			
Kentucky		•					••	
Maine		•			•			
Maryland				•				•
Massachusetts			•		•			
Michigan		•			•			
Minnesota		•			•			
Mississippi			•		•			
Missouri		•			•			
Montana		•					••	
Nebraska		•						•
Nevada		•					••	
N. Hampshire		•			•			
N. Jersey		•			•			
N. Mexico		•					••	
N. York	•				•			
N. Carolina		•					••	
N. Dakota				•				•
Ohio		•			•			
Oklahoma			•		•			
Oregon		•					••	
Pennsylvania		•					••	
Rhode Island		•			•			
S. Carolina		•					••	
S. Dakota		•			•			
Tennessee				•				•
Texas		•					••	
Utah			•		•			
Vermont		•					••	
Virginia	•					•		
Washington		•			•			
W. Virginia		•					••	
Wisconsin			•		•			
Wyoming			•		•			
<b>Total = 48</b>	<b>3</b>	<b>32</b>	<b>8</b>	<b>5</b>	<b>26</b>	<b>1</b>	<b>15</b>	<b>6</b>
<b>Gray Box = State does not satisfy category requirement</b>								
<b>NOTE: Each side of the table totals 48</b>								
<b>NOTE: N/A indicates that researchers were unable to obtain reimbursement information</b>								
<b>•• State utilizes a Fee Schedule which assumes administration is inclusive and prohibits separate billing.</b>								
<b>SOURCE: GWU/SPHHS/CHSRP Analysis of Medicaid Adult Immunization Coverage, 2003</b>								

**Full vaccine replacement:** As noted above, California, and New York provide full vaccination replacement to providers furnishing immunizations to adults. Virginia reimburses under limited circumstances for a particular category of beneficiary, as the following excerpts show:

**California**

This section outlines policy related to billing injection services, including immunizations . . . Reimbursement is determined by the cost of the injection, plus the physician's administration fee. Only one administration fee will be reimbursed per injection regardless of the quantity reflected on the claim line . . .

**New York**

Immunization procedures include reimbursement for the supply of materials and administration.

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the current acquisition cost of the antigen.

Reimbursement for drugs (including vaccines and immune globulins) furnished by practitioners for their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient . . .

**VIRGINIA**

Vaccines Not Available Under VFC . . .

Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for Dialysis Patients . . . Medicaid will reimburse for the acquisition cost for these vaccines. . . . No administration fee will be reimbursed under . . . since this vaccine is not available under VFC.

**Separate administration fee permitted:** Twenty-six states (AL, CA, CO, GA, HI, ID, IN, IA, KS, ME, MA, MI, MN, MS, MO, NH, NJ, NY, OH, OK, RI, SD, UT, WA, WI, WY) will pay for separate billing of an administration fee. Alabama and Georgia provide examples of general and then more specific language regarding the billing of separate administration fees for immunizations:

**Alabama**

**Adult Immunizations**

. . . The administration fee (procedure code Z4998) may be billed separately if an office visit is not billed.

**Georgia**

**903.7 Immunizations**

Diagnostic, Screening and Preventive Services (DSPS) providers may bill under code 99211 for a clinic visit associated with the administration of covered immunizations given to members over 21 years of age . . .

**Silence:** Fifteen states (AZ, CT, FL, IL, KY, MT, NV, NM, NC, OR, PA, SC, TX, VT, and WV) do not provide explicit language to indicate that administration fees are covered, but they do imply that the administration fee is considered as part of the total reimbursement to providers according to a fee schedule.

**Montana**

**90632** HEP A Vaccine, Adult IM Fees Office \$57.59 Facility \$57.59

**90659** FLU Vaccine, Whole, IM Fees Office \$0.00 Facility \$0.00

**90707** MMR Vaccine, SC Fees Office \$27.28 Facility \$27.28

**90716** Chicken Pox Vaccine, SC Fees Office \$44.12 Facility \$44.12

**90718** TD Vaccine > 7, IM Fees Office \$10.26 Facility \$10.26

**90732** Pneumococcal vaccine, Fees Office \$9.42 Facility \$9.42  
**90733** Meningococcal vaccine, SC Fees Office \$63.98 Facility \$63.98  
**90746** HEP B Vaccine Adult IM Fees Office \$50.14 Facility \$50.14 . . .

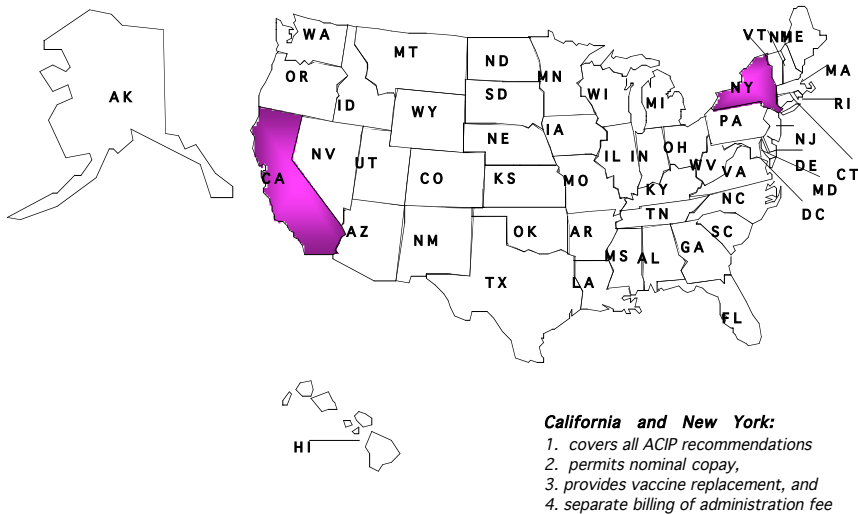
**South Carolina**

**90632** Payment \$40.18 . . . **90659** Payment \$4.92 . . . **90732** Payment \$11.19 . . . **90733**  
 Payment \$47.65 . . . **90746** Payment \$40.22 . . .

**5. Synthesis of Findings**

Taking our individual findings, we sought to present an overall portrait of comprehensiveness of immunization policy. For this study we defined “comprehensive” as coverage of all ACIP recommended vaccines, elimination of copayment requirements, a replacement policy for vaccine, and payment of a separate administration fee. No state met this standard. By modifying our description to permit nominal copayments meeting federal standards, we found that two states (NY and CA) meet the test. The results are set forth on the accompanying map.

States with Most Comprehensive Medicaid Adult Immunization Policy: Composite 2  
 (n = 2)



Source: GWU/SPHHS/CHSRP Analysis of Medicaid Adult Immunization Coverage 2003

**Conclusion**

Coverage of immunizations and their administration at ACIP recommended levels for the entire population has grown in importance as a health policy matter given the growing attention to both manmade and naturally occurring public health threats, recognition of the value of immunization to society, and the relatively high cost of at least certain immunization services in relation to personal income. No population stands to benefit more from comprehensive immunization coverage than low income persons. While Medicaid coverage for children under 21 is comprehensive, very little is known

about adult coverage. Studies suggest that adult immunization status is particularly low, and that financial barriers play a role, especially for low income persons.

The findings from this study suggest that nearly all state Medicaid programs appear to furnish at least some immunization coverage and payment for adult immunizations in the case of non-institutionalized adult beneficiaries. Two-thirds of those offering any coverage do so at ACIP standards, with the most commonly excluded vaccines being Hepatitis A and meningococcal vaccine.

However, while coverage and payment are common features, so are certain limitations. Cost sharing is virtually universal, vaccine replacement programs are almost non-existent, and there is great variation in the extent to which states will pay a separate administration fee or even assume the existence of a fee for administration as part of their rate setting methods. Furthermore, all states prohibit any payment to the extent that immunizations are offered free of charge. In our discussions with state Medicaid officials, it became evident that there was relatively widespread assumption that vaccines for adults can be secured free of charge and that coverage and payment are not an issue. Two states – Alaska and Louisiana – exclude coverage and payment entirely on the basis of this assumption.

In our first study in this series we outlined a technical assistance effort aimed at expanding state insurance laws regulating immunization coverage. A similar effort is well worth considering here. The gap between practice and standards is significant, particularly with respect to certain specified vaccines and in the area of financing. Without a replacement program and at least some level of administration fee (separate or weighted additional payment as part of an office visit) the gap between ACIP-recommended adult immunization standards and actual practice may remain considerable for low income adult Medicaid beneficiaries. Furthermore, it is not clear how many state Medicaid programs are excluding payments on the ground that vaccines are free when in fact they are not as a result of §317 shortages for adults.

Follow-up work could be considered for both state Medicaid programs (configuration of coverage and payment) as well as public health agencies (ensuring that the billing obligations imposed under the Medicaid free care standard are satisfied). As we have recommended for the state-regulated insurance project, such follow up could consist of tailored analyses for each state, targeted efforts to improve coverage levels as well as payments for replacement and administration. In this regard, cost estimates related to the New York and California replacement programs might help induce other states to adopt such an approach, as would estimates of the extent to which the payment of a fee for administration is related to provider participation in adult immunization efforts. We also believe that ensuring that public health agencies understand the Medicaid billing requirements is essential, since the revenues generated through adult vaccine billing could be considerable in those states with relatively high Medicaid eligibility levels.

**APPENDIX I – ADULT IMMUNIZATION COVERAGE PROVISIONS  
Provider Manuals, Medicaid Materials**

**Alabama**

Flu Vaccination

Flu vaccination procedure code 90659 is a covered service regardless of age.

Adult Immunizations . . .

Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service. Immunizations that are provided to Medicaid eligible recipients 19 years old and older must submit a claim for the appropriate CPT code. Vaccines are reimbursable on a fee-for-service basis. The administration fee (procedure code Z4998) may be billed separately if an office visit is not billed...p. H-3

Payments for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service... **p 28-7**

Covered CPT Codes

90659 . . . 90707 . . . 90716 . . . 90718 . . . 90746 . . . 90733 . . . 90732 . . .

**Alaska**

Services not covered by Medical Assistance

In general, Alaska Medical Assistance does not cover the services listed below . . . . immunizations for adult recipients (21 years of age or older). **p 2**

Immunizations. Reimbursement is made for injections and immunizations; however, immunizations are authorized only for recipients under age 21. **Physician Manual p I-9**

2003 Medical Assistance Physician Fee Schedule

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90746.

(NOTE that 90733 is not covered for the under 21 age group).

**These codes provide coverage for ages 18-20 only.**

**There is no adult coverage because the state Health Department provides adults with free immunizations.**

**Meningococcal is not covered by Medicaid or Health Department for any age group.**

**Arizona**

Immunizations . . . **Description.** AHCCCS covers immunizations as appropriate for age, history and health risk, for adults and children...Covered immunizations for adults include, but are not limited to: 1. Diphtheriaptetanus, 2. Influenza, 3. Pneumococcus, 4. Rubella, 5. Measles, 6. Hepatitis-B . . .

**Amount, Duration, and Scope.** Immunizations for passport or visa clearance are not covered by AHCCS. AHCCCS Office of Medical management does not require prior authorization for medically necessary immunization services performed by fee-for-service providers. **Arizona Health Care Cost Containment System AHCCCS Medical Policy Manual p310-23**

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.  
**2003 Rate Codes – Drugs & Injections**

### **Arkansas**

Arkansas Medicaid Manual: Program Coverage . . .

244. Injections. The Arkansas Medicaid program provides coverage . . . for immunization against many diseases . . . The following list includes the types of injections covered . . . D. Immunizations, childhood immunizations and those covered for adults . . . E. Other covered injections . . . 11. Hepatitis B Immune Serum Globulin (ISG) . . . 12. Hemophilis influenza b virus vaccine . . . 15. Influenza virus vaccine . . . 17. Maternal measles/mumps/rubella (MMR) when provided to women of childbearing age (ages 21 through 44) who may be at risk of exposure to these illnesses . . . 19. Pneumococcal polysaccharide vaccine 23-valent, adult dosage, is payable for eligible recipients age 12 and over. Recipients who are age 21 and older and receive this injection should be considered by the provider as high risk. All recipients over age 65 may be considered high risk . . . 21. Rabies vaccine when provided to eligible recipients of all ages . . . 23. Tetanus toxoid, in conjunction with trauma or injury, for all ages . . . **p. II-46**

### **California**

MEDI-CAL UPDATE, Outpatient Services Bulletin 344, Billing and Policy . . .

Immunization services rendered on or after September 22, 2003 must be billed using the appropriate CPT-4 code from the following list: 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.

MEDI-CAL UPDATE, Outpatient Services Bulletin 344, Billing and Policy . . .

Hepatitis A Vaccine. The Hepatitis A vaccine is reimbursable for the following HCPCA codes . . . X5336 Hepatitis A vaccine, adults . . . **p. inject 11**

Medical Necessity. When billing code X5336 or X5338, providers must document medical necessity in the Remarks area/Reserved For Local Use field (Box 19) of the claim, or as an attachment, as defined by any of the following conditions. If the recipient:

Is a Native American Indian or Native Alaskan (Eskimo).

Is receiving clotting factor concentrates, especially solvent-detergent treated preparations.

Has chronic liver disease.

Is a user of illicit injectable or non-injectable “street” drugs.

Is a male having sex with other males.

Resides in a high-rate hepatitis A community (epidemic occurs every 5-10 years, the epidemic lasts for several years, and rates of disease exceeds 700 cases a year per 100,000 population during the outbreaks, and a few cases occur among persons over 15 years of age).

Resides in an intermediate rate hepatitis A community (epidemics often occur at regular intervals and persist for several years with rates in excess of 50 cases a year per 100,000 population) . . . **p. inject 11**

Eligibility Requirements. Codes X5336 and X5338 are reimbursable only if the recipient meets one of the following conditions . . .

Recipients are 19 years of age or older . . . **p. inject 12**

Hepatitis B Immunization Schedules. The Department of Health Services recommends the following hepatitis B immunization schedule, and vaccine (HBVac) and immune globulin (IG) dosages . . . The Department of Health Services recommends the following hepatitis B immunization schedule, and vaccine (HBVac) and immune globulin (IG) dosages . . . The Department of Health Services (DHS) Immunization Branch has adopted new hepatitis B immunization policy recommendations pertaining to alternative dosing. The first recommendation is that the hepatitis B vaccine is always give Intramuscularly (IM), generally in the deltoid muscle for adults . . . The second recommendation is the recent United State Public Health Services Advisory Committee (ACIP) approval of Merck Vaccine Division (new alternative for adolescents only) age 11 to 15 years regimen that consists of two doses of the current adult formulation of 10 mcg/1.0 ml of Recombivax HB. The first dose is administered at the first visit and the second dose is administered four to six months later. This regimen is an alternative to the existing three-dose regimen using 5 mcg/0.5 ml . . . **p. inject 12**

#### MMR Vaccinations

The use of MMR . . . is medically justifiable only for . . . an adult who is known to be immune to the other two diseases. **P inject 25**

### Colorado

Medicaid Bulletin Colorado Title XIX April 2002

Immunizations for adults . . .

Immunizations for adults (age 21 and older) are a Medicaid benefit when medically necessary or when needed to enter the work force or to attend school . . . **p 1**

Influenza Vaccine—Special billing information. . .

. . . Strongly recommended for individuals who are six months of age or older and because of age or underlying medical conditions are at increased risk for complication of influenza. Health care workers and other contacts . . . should be vaccinated. . . persons 65 years of age or older. . . residents of nursing homes . . . adults and children with chronic pulmonary or cardiovascular disorders. . . adults and children who have required hospitalization in the preceding year. . . Flu vaccine may also be administered to individuals who wish to reduce the chance of becoming infected with influenza

Claims should be billed using procedure code . . . 90659. . . **p 3-4**

Hepatitis A & B Vaccines – Special Billing Information

HAV and HBV immunizations must be identified by age-specific procedure codes . . . 90632. . . 90746 . . . . **p 4**

Immunization Coding Quick Reference

. . . 90632. . . 90659 . . . 90707 . . . 90716 . . . 90718. . . 90732 . . . 90733 . . . 90746 . . . **p 8**

### Connecticut

III. Services Not Covered . . .

c. Any immunizations, biological products and other products available to the clinic free of charge from the Connecticut State Department of Public Health . . . **p 46**



Medical Assistance Medical Procedures Fee Schedule, Description of Service . . . 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p 22 – 24**

**Delaware**

13.0 Specific Criteria For Federally Qualified Health Centers (FQHCs). 13.1 General Information . .

. 13.2.5.2 Preventative primary services which may be paid for when provided by FQHCs are the following . . . 13.2.5.2.8 Immunizations, including tetanus-diphtheria booster and influenza vaccine . . .

EDS manages the state’s Medicaid system. All pertinent CPT codes are covered. **Phone call with EDS on 9/11/03 with Christy C.**

**Florida**

Immunization Services

Description

Immunization services provide vaccines to induce a state of being immune to or being protected from a disease. Medicaid reimburses for these services for recipients from birth through 20 years of age. . . . Medicaid does not reimburse for immunization services for recipients who are 21 years of age and older. **Physician Coverage and Limitations Handbook, p 2-41**

Coverage and Limitations for Institutionalized Recipients . . .

The Medicaid prescribed drug services program policies described in this section apply to Medicaid recipients in nursing homes and intermediate care facilities for the developmentally disabled (ICF-DD). . . . Medicaid reimburses for influenza and pneumococcus vaccines for institutionalized recipients who do not have Medicare benefits. Influenza vaccine is limited to one per year per recipient. Pneumococcus vaccine is limited to one per lifetime per recipient. **Prescribed Drug Coverage, Limitations and Reimbursement Handbook, p 9-11**

Summary of Services . . . Prescribed Drug Services . . .

Medicaid does not reimburse pharmacies for the following products: . . . Immunizations for non-Child Health Check-Up 221 recipients 21 years of age and older, except for influenza and pneumococcus vaccines for institutionalized recipients. **p 71, 72.**

Federally Qualified Health Centers . . .

Medicaid reimbursement to FQHCs includes: . . . Adult health screening services. **p 4**

Rural Health Clinic Services . . .

RHCs provide . . . preventive health care. . . Medicaid reimbursement to RHCs includes . . . Adult health screening services. . . **p 76**

Hospital Services Outpatient . . .

Outpatient hospital services are preventive . . . service items provided to an outpatient. The services must be provided under the direction of a licensed physician. . . . Medicaid reimburses for outpatient hospital services for all Medicaid recipients. . . . **p 58**

## Georgia

Non-Covered Emergency Room and Outpatient Services . . .

h) Services provided free-of-charge to the public by the hospital, County Health Departments, State Laboratory or other state agencies; i.e. immunizations, . . . **p IX-28**

905. Non-Covered Services . . .

. . . The services and procedures listed below are non-covered by the Division under the Physician Program . . . b.) immunization Injections for members aged twenty-one or older . . . d) therapeutic injections *except* those contained in the Division's Physicians' Injectable Drug List. **p IX-54**

Physician's Injectable Drug List . . .

The injection must be reasonable and necessary for diagnosis or effective treatment of a specific illness or injury based on accepted standards of medical practice. Therapeutic injections should be utilized only if equally effective oral medications cannot be prescribed without significant or increased side effects. **p 1**

Only the codes listed in this drug list are covered by Georgia Medicaid for injectable drugs. . . 90632 . . . 90658 (Influenza 12 yrs. and older) . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p 2, 7-10**

## Hawaii

Chapter 6, Medical/Surgical Services . . .

Medicaid covers immunizations and the administrative costs of the immunization for adults. . . . a) Covered immunizations for adults include:

Tetanus-diphtheria (Td) booster; Influenza and pneumococcus in high risk groups; Rubella if there is no evidence of immunity for women of childbearing age; Hepatitis B in high risk groups – household and sexual contacts of HBsAg positive persons. . . .

Exclusions – a) Immunizations for travel or work are not covered by Medicaid; b) Pneumococcal and annual influenza vaccines provided to nursing home residents who are Medicare beneficiaries will not be covered as Medicare covers 100 percent of the reasonable cost of these vaccines.

Medicaid Fee Schedule; Effective Date: April 1, 2003 . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p 141, 142**

## Idaho

3.19.6.1 Administration Only of an Injectable and/or Adult Vaccine . . .

When a provider purchased injectable is administered (all ages) and/or adult vaccine is administered (21 years of age or older), Medicaid will pay an injected plus the Estimated Acquisition Cost (EAC) for the injectable/vaccine. . . **p. 3-58**

3.19.6.3 Administration of Childhood Vaccine With or Without an Evaluation and

Management Visit. When an injection or adult vaccine is administered in conjunction with an Evaluation and Management visit, Medicaid will pay only for the Evaluation and Management visit and the EAC . . . **p. 3-58**

Idaho Medicaid Fee Schedule . . . 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . .  
90732 . . . 90733 . . . 90746. **p. 128 – 129**

### **Illinois**

A-221.5 Non-Covered Pharmacy Items . . .

Pharmacy items which may not be covered by the Department are . . . A vaccine, drug, or serum which is provided primarily for preventative purposes . . . This exclusion does not apply to items for clients covered under the Maternal and Child Health Program which are not supplied to the physician by the Vaccine for Kids program . . . **p. II-A-24**

FY2003 Physicians Fee Schedule Key . . . Medicaid-covered services . . . 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p. 181, 182**

### **Indiana**

Indiana Health Coverage Programs Fee Schedule . . .

90632 Hep A Vaccine Adult . . . 90659 Flu Vaccine . . . 90707 MMR . . . 90716  
Varicella . . . 90718 T-D . . . 90732 Pneumococcal . . . 90733 Meningococcal . . . 90746  
Hepatitis B Adult.

### **Iowa**

Procedure Codes and Nomenclature . . .

A. Injections

Physicians are reimbursed separately for injections and for the administration of injections. . . . Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, you may list a minimal service in addition to the injection. Immunization procedures include the supply of related materials.

You must provide Medicaid immunizations under the Vaccines for Children program (VFC). Vaccines available through the VFC program are: 90707 . . . 90718, 90716. When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement. Bill code 90471 or 90472 for vaccine administration in addition to the CPT code. **Pp E-99- E-101.**

Fee Schedule effective 07/01/01 . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.

### **Kansas**

Service, Local Health Department Services: Are covered for both Title XIX and MediKan consumers. Services include . . . immunization. **Medicaid Information Sheet**

Immunization Administration by Certified Pharmacists:

Pharmacy providers certified to administer vaccine to adults, in accordance with K.S.A. 65-1626, will be allowed to bill Medicaid for vaccine administration. . . . Refer to Section 7020 of the DME Provider Manual for a list of procedure codes that are covered. . . . Benefit Limitations: . . . Influenza Treatment: Prescription drug claims for . . . will be paid for dates of service during the influenza (flu) season only (October 1 through April 30) and will be limited on one course of therapy per beneficiary per flu season.

**Pharmacy Provider Manual 03/02 p.8-5, 8-8.**

## Adult Immunization Administration

Reimbursement for adult (non-VFC) immunization administration is included in the total cost: i.e., providers are reimbursed one rate for the vaccine and the administration. . . . 90707 MMR Virus, live . . . 90716 Immunization, active, varicella (chicken pox); 90718 Tetanus and Diphtheria Toxoids (TD) . . . 90632, Hepatitis A Vaccine adult dosage . . . 90746 Hepatitis B Vaccine, Adult dosage . . . 90659 Influenza Virus Vaccine . . . 90732, pneumococcal vaccine . . . **Professional Services Provider Manual, Appendix I.**

## Kentucky

2003 Physicians, Resource Based Relative Value Scale . . .  
90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90746. **p 225.**

## Louisiana

Services . . .

Physician/Professional Services . . . Immunizations are covered for recipients under age 21 through the physicians program . . . Rural Health Clinics . . . Immunizations are covered for recipients under age 21. **Services Fact Sheet.**

## Maine

Maine Medical Assistance Manual Chapter III Allowances for Physician Services, Section 90

This section is intended to inform providers . . . in the reimbursement process, coding system and billing mechanism for . . . Maine Medicaid recipients. **p. 1**

### 8. Immunizations, Therapeutic Injections, Hyposensitization

a. Immunizations: all immunization codes include both the administration and the immunological material. The maximum allowance . . . is adjusted monthly. . . Providers should report the size of the dosage when billing for immunizations. Any vaccine distributed by the State Immunization Program is not reimbursable, e.g. MMR. However a \$5.00 reimbursement amount will be made for the administration of such a vaccine. **p 10**

Maine Medicaid 90000 Series . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **State of Maine Medicaid Physician Codes.**

## Maryland

.01 Definitions . . . (9) "Drugs" means legend drugs (those requiring a prescription under federal or State law).

.04 Benefits – Pharmacy Services.

A. An MCO shall provide to its enrollees all medically necessary and appropriate pharmaceutical services and pharmaceutical counseling, including but not limited to: (1) Legend drugs.

## Massachusetts

(C) Service Limitations . . .

(2) The Division does not pay for the following types of drugs or drug therapy without prior authorization (a) immunizing biologicals . . . that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH) . . . **p. 4-7**

603 Codes That Have Special Requirements or Limitations

The following service codes are payable by MassHealth . . . but have . . . specific instructions or limitations . . . IC: Claim requires individual consideration . . . 90632 . . . 90707 . . . 90716 . . . 90732 . . . 90733 . . . 90746 . . . **Massachusetts Provider Manual p. 6-4, 6-9.**

433.406: Individual Consideration

(A) The Division has designated certain services . . . as requiring individual consideration. This means that the Division will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The Division does not pay claims for services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. . . .

(B) The Division determines the appropriate payment for a service requiring individual consideration in accordance with the following standards and criteria:

- (1) the amount of time required to perform the service;
- (2) the degree of skill required to perform the service;
- (3) the severity and complexity of the member's disease, disorder, or disability;
- (4) any applicable relative-value studies;
- (5) any complications or other circumstances that the Division deems relevant;

and

- (6) the policies, procedures, and practices of other third-party insurers. . . .

**Massachusetts Provider Manual p. 4-7.**

602 Nonpayable Codes

The Division does not pay for services billed under the following codes . . . 90659 . . . 90718. **Massachusetts Provider Manual p. 6-1, 6-2.**

## Michigan

Immunizations . . .

Vaccines and toxoids (immunizations) are covered when given according to ACIP (Advisory Committee on Immunization Practices) recommendations ... In addition, Michigan offers a similar program for Medicaid adults 19 years old and older called the MI-CRP (Michigan Replacement Program). Td, MMR, and Hepatitis B for adults are available from the local health department at no cost to the provider. . . . **p. 30 effective 10/1/03**

## **Minnesota**

Physician and Professional Services . . . Immunizations and/or Vaccinations . . .

MHCP covers only the administration fee for vaccines and toxoids provided free by the Minnesota Vaccines for Children (MnVFC), available through the Minnesota Department of Health (MDH). Most routine childhood vaccines and some adult vaccines are available through MNVFC program. Refer to the Immunization section of the Children's Services chapter (Ch. 9). . . . **p 8**

Immunizations . . . Covered Services

Administration of vaccines and toxoids to MHCP enrolled infants, children, and adults is covered. Clinic, physician, C&TC, outpatient hospital, certified nurse-midwife, certified family and certified pediatric nurse practitioner, home health agency, public health clinic, and public health nursing clinic providers may bill for immunizations. Pharmacies may also provide vaccines to long-term care facilities . . . **p 17**

Covered Services for MA Recipients . . .

MA coverage for FQHC's/RHCs has been mandated for the following . . . Vaccines (e.g., pneumococcal, influenza, and hepatitis B) . . . **p 9**

Minnesota Health Care programs Fee Schedule . . . 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p 198, 199**

## **Mississippi**

34.05 Mississippi Division of Medicaid (DOM) covers immunizations for adults that are related to the treatment of injury or direct exposure to a disease such as rabies or tetanus . . . Influenza and pneumococcal vaccinations are covered services for Medicaid beneficiaries 19 years of age or older . . . **p 1.**

Procedure Code Fee Schedule Index . . .

90659 . . . 90732. **p 41**

## **Missouri**

13.13.A(2) Immunizations Outside VFC Guidelines

If an immunization is given to a Medicaid recipient who does not meet the VFC guidelines, use the standard procedure for billing injections. Physicians, clinics and advanced practice nurses should bill on the pharmacy Claim form using the national drug code (NDC). **p 144**

13.21.A Limitations to Office/Outpatient Services

Office/outpatient services are to be used for . . . preventive medicine . . . . An office/outpatient physician visit includes, but is not limited to, the following: . . . administering injections. **p 153-154**

13.24.B Injections and Immunizations

Injections are covered only if administered by a physician, advanced practice nurse or by a nurse under the physician's supervision. Injections that are not considered by accepted standards of medical practice to be a specific or effective treatment for the particular diagnosis for which they are given are not covered.

Injections that exceed the frequency or duration indicated by accepted standards of medical practice and are not justified by extenuating circumstances are not covered.

If the physician is on the premises, a minimal physician visit may be billed in addition to the injection. . . .

When vaccines are furnished at no cost to the practitioner by the Department of Health and Senior Services, Centers for Disease Control and Prevention, the vaccines cannot be billed to Medicaid. **p 157**

New Procedure Codes . . . 90632 . . . 90659 **1999 CPT and HCPCS Conversion p 11-12**

### **Montana**

Montana Medicaid – Fee Schedule – Physician . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p 203, 204**

### **Nebraska**

There is no specific policy addressing adult immunizations. Services must be medically necessary to be covered and “items not necessary for the diagnosis and treatment of illness or injury,” are not covered.

HHS Finance and Support Manual Rev. July 1, 2001; Manual Letter #46-2001 . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **p 123, 124**

### **Nevada**

Procedure codes that have no unit value may be non-covered services, or payment is based on a report or invoice [thus the following codes are covered]: 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. **Fee Schedule**

### **New Hampshire**

Covered Physician Services . . .

#### **E. Injections**

NH Medicaid reimburses for the administration of injections when provided as part of an examination and/or treatment in accordance with the following guidelines:

1. HCPCS Codes J0110 – J7350 include the administration cost as well as the cost of the drug. In this case, injections may be billed separately or in conjunction with an office visit. NOTE: Immunizations . . . are billed according to HCPCS codes for the complete service. These services will be reimbursed at a global fee. . . .
1. Some vaccines are available free of charge from the New Hampshire Division of Public Health. They are not reimbursable by the NH Medicaid Program. However, the cost of administering the vaccines may be billed using HCPCS code 990070. **New Hampshire Medicaid Billing Manual**

\* \* \*

2002 NH Medicaid Fee Schedule – Covered Procedures . . . 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.

## **New Jersey**

Physicians Services Manual . . .

(i) Hepatitis B Vaccine: Coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with the criteria defined by the CDC. In all such cases, the need for this vaccination must be fully documented in the recipient's medical record. In order to facilitate reimbursement for Hepatitis B immunoprophylaxis for high risk individuals, manufacturer, age, and dose specific procedure codes have been developed for use by physicians and independent clinics providing this service. . . . W9099 – Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age. \$63.57. . . . W9335 – Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age. \$62.09. **p 469.**

To report, use code 90746 (For age 19 and over).

Reimbursement for measles, Mumps and Rubella (MMR) Immunizations . . . Providers will be reimbursed for immunization against measles, mumps, and rubella only when delivering this immunization as MMR identified on the claim form by . . . 90707 procedure code. ***NJ Physician Manual Newsletter Vol 3, No. 58, 11/93.***

\* \* \*

HCPCS procedure code numbers and maximum fee allowance schedule . . .  
90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733. ***Certified Nurse Practitioner/Clinical Nurse Specialist Manual, May 21, 2002.***

## **New Mexico**

713.35 Preventative Services . . .

A. Preventative primary services that an FQHC may provide are those services as defined in the 42 CFR 405.2448 and include . . . 6. Immunizations for children and adults, including tetanus-diphtheria booster and influenza vaccine . . .

Covered CPT Codes: 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. ***New Mexico.***

## **New York**

Immunization Injections

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746. ***Physician Services Manual.***

## **North Carolina**

End-dated Codes for Injectable Drugs

The following codes will be end-dated from the Physician's Drug Program effective with date of service September 30, 2002. Vaccine codes are being end-dated in accordance with information obtained from the drug manufacturers and the Centers for Disease Control. These vaccines are no longer manufactured or available in the United States or are no longer recommended. . . .90659; Influenza virus vaccine, whole virus, for intramuscular or jet injection use.



## Injectable Drugs

The following FDA-approved drugs, immune globulins, and vaccines/toxoids should be added to the list published in the June 2002 general Medicaid bulletin. This completes the list of injectable drugs covered by the N.C. Medicaid program when provided in a physician's office for the FDA-approved indications. . . .90632; Hepatitis A vaccine, adult dosage, for intramuscular use . . . 90707; MMR . . . 90716; Varicella virus vaccine, live . . . 90718; Td adsorbed for use in individuals seven years or older . . . 90732; Pneumococcal polysaccharide vaccine . . . 90733; Meningococcal . . . 90746; Hepatitis B vaccine, adult dosage. **p. 9 – 14, EDS, fiscal agent for the NC Medicaid Program Medicaid Bulletin, August 2002**

## North Dakota

The state is updating their manual. The state has confirmed coverage of the pertinent CPT codes for adults.

NOTE: A provider must indicate medical necessity of all hepatitis immunizations. **Email from Medicaid administrator**

## Ohio

5101:3-4-28 Noncovered services . . .

The following physician services are noncovered . . . (2) Immunizations. . **p 1**

5101:3-9-03 Covered drugs and associated limitations...

(H) Vaccines, inoculations, and immunizations are covered as a pharmacy benefit only for residents of long term care facilities; otherwise these services will be reimbursed as physician services . . . **p. 4**

\* \* \*

Immunization codes changes –

In preparation for HIPAA, the Department is discontinuing the following local level codes for immunizations nor nondesignated vaccines for adults and will begin using the CPT codes for the vaccine effective for dates of services on and after July 1, 2003: . . . 90718 . . . Effective for dates of services on and after July 1, 2003, codes . . . 90718 . . . will be reimbursed at the lesser of the provider's billed charge or the Medicaid maximum for these vaccines provided to adults over eighteen. **Ohio Medicaid Provider Handbook Advanced Practice Nurse Services, p. 3 – 4**

\* \* \*

Immunizations . . .

### General Information

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, the lowest level of office visit (evaluation and management code) may be billed in addition to the immunization procedure code. Immunization procedure codes include the supply of materials and the provision of the vaccine.

(A) As of January 1, 2001, the term "Designated Free Vaccine(s)" shall mean: . . . 90707 . . . 90716 . . . 90718. . . .

### Active Immunizations

(A) The active immunizations specified in proceeding paragraphs are covered by the department when administered in accordance with the "Advisory Committee on Immunization Practices" (ACIP) . . . or the "Centers for Disease Control" (CDC)

recommendations. Additional coverage limitations are specified for hepatitis B vaccines. . . . (1) All the designated free vaccines . . . (2) All the following nondesignated vaccines . . . 90632 . . . 90659 . . . 90732 . . . 90733 . . . 90746 . . . . Hepatitis B vaccines administered to individuals nineteen years or older are not provided free and must be billed using code 90746. . . . (D) Active immunizations identified with a (\*\*) [Meningococcal] are covered on a case-by-case basis and only if determined by ODJFS as medically necessary.

Reimbursement . . . Effective July 1, 2003, the codes . . . 90718 . . . for adults over eighteen years of age . . . will be reimbursed at the lesser of the provider's billed charge or the Medicaid maximum. **Ohio Medicaid Provider Handbook Advanced Practice Nurse Services, pp. 22 – 25, 27**

### **Oklahoma**

317 : 30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for Medicaid. OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The Authority covers any drug for its approved purpose that has been approved by the Food and Drug Administration (FDA). Administration of injections is paid in addition to the medication. . . .

(2) Immunizations for adults. Coverage for adults is limited to: (A) influenza immunizations, (B) Pneumococcal immunizations, and (C) Gamma Globulin and Hepatitis A Vaccine when documentation shows the individual has been exposed to Hepatitis.

**Title 317. Oklahoma Health Care Authority, Chapter 30. Medical Providers-Fee For Service**

### **Oregon**

Oregon Health Plan Providers' fee-for-service fee schedule, July 2003

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746

### **Pennsylvania**

Outpatient Fee Schedule . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.

### **Rhode Island**

Pneumonia and Influenza Immunizations/Age 21 and over

Effective immediately, the Department of Human Services will begin reimbursing for the pneumonia and influenza vaccines for fee-for-service recipients age 21 and over.

A. When the vaccine is administered during an office visit, the serum can be billed along with the office visit. The administration of the vaccine, however, is included in the office visit and cannot be billed separately. . . . Pneumonia Vaccine 90732 \$11.74 . . . Pneumonia Vaccine 90732 \$11.74. . . .

When billing . . . other immunization codes (other than the pneumonia and influenza) for recipients over 21 years of age, please follow the policy as outlined in the physician manual on page 300-05-17 . . .

**Immunization codes (90700-90749) are no longer reimbursable through the Rhode Island Medical Assistance Program.** All immunizations are considered to be part of the fee for the office visit at which the immunization was administered. When it is not possible to administer a vaccine as part of the first office visit and the patient must return to the office for a second visit, the office/clinic visit may be billed with procedure code 99211. *Provider Update Newsletter, January 1999, Volume 75.*

### **South Carolina**

Physicians Payment Schedule – Effective 05/09/03 . . .  
90632 . . . 90659 . . . 90732 . . . 90733 . . . 90746.

Medicaid will not directly reimburse pharmacy providers for influenza virus vaccine where the patient is dually eligible for both Medicare and Medicaid coverage. However, for those long term care patients having only Medicaid coverage, Pharmacy services reimburses for the influenza vaccine. *Medicaid Pharmacy Services Provider Manual p 200-23*

### **South Dakota**

South Dakota Administrative Rules . . . .

67:16:01:06:02. Covered services must be medically necessary. Services covered under this article must be medically necessary. To be medically necessary, the covered service must meet the following conditions: . . . (2) It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group. . .

67:16:02:04. Physicians' services covered. Physician's services covered are limited to the following professional services, which must be medically necessary and provided by a physician to a recipient: . . . (4) Drugs and biologicals administered in a physician's office which cannot be self-administered.

67:16:02:03 List of Physician Nonlaboratory Procedures, Appendix A . . .  
90659 . . . 90707 . . . 90716; 90718 . . . 90732; 90733 . . . 90746.

### **Tennessee**

TennCare MEDICAID 2003

The following preventive medical services . . . shall . . . be covered . . . 90700 – 90744, Immunizations. *TennCare Medicaid Preventive Services #A Sheet*

### **Texas**

Appendix A: Medicaid Local Code to National Code Table

Effective for dates of service on or after October 16, 2003, the following Medicaid local codes will be discontinued. Providers must bill using the national codes or revenue codes indicated in the following table . . . 90718 . . . 90632 . . . 90746 . . . 90707 . . . 90632 . . . 90716 . . . 90733. *2003 HIPAA Special Bulletin 71, 87, 92, 113, 117, 119*

HCPCS 2000 Long Description Changes Table . . .  
Hepatitis A Vaccine 90632. *p 40*

## Hepatitis B Vaccine

For claims in process on or after April 1, 2001, the following procedure code is a payable benefit for clients age 19 through 99 only: 1-90746, Hepatitis B vaccine, adult dosage, for intramuscular use. **No. 154, 2001 HCPCS Special Bulletin, p 4**

90718 – Tetanus and diphtheria toxoids (TD) adsorbed for use in individuals seven years or older, for intramuscular or jet injection. **No. 154, 2001 HCPCS Special Bulletin, p 26**

Physician . . . 34.4.21.20 Hepatitis B Vaccine . . . The Texas Medicaid Program covers the hepatitis B vaccine and the hepatitis B immune globulin for those clients who are not otherwise covered by the Texas Vaccines For Children Program . . . Administration of the hepatitis B vaccine is indicated for immunization against infection cause by all known subtypes of the hepatitis B virus. The hepatitis B vaccine is medically necessary for patients who have been exposed to the hepatitis B virus. This vaccine will not prevent hepatitis caused by other agents, such as hepatitis A, hepatitis C, or other viruses known to infect the liver. The Texas Medicaid Program allows coverage of the hepatitis B vaccine for clients who are at high risk of contracting the disease . . . Mentally retarded Medicaid-eligible individuals residing in a private (non-state) institution for the mentally retarded (CF-MR), are classified as at a continuing high risk for hepatitis B with an ongoing exposure potential. When provided and billed by the attending physician, Medicaid will allow coverage of hepatitis B vaccine for all inpatients of an ICF-MR (private) facility . . . When the hepatitis B vaccine is provided to recipients with end stage renal disease who are directly exposed, separate payment may be made as the vaccine and its administration are not included in dialysis services. Hepatitis B immune globulin, I.M. (HBIG), provides coverage for acute exposure to the hepatitis B virus . . . **p. 34-84**

34.4.21.27 Influenza Vaccine. For individuals not covered by THSteps or the TVFC Program, the Texas Medicaid Program will cover the influenza vaccine . . . for patients who are at high risk for influenza-related complications when medically necessary . . . .For all others, the vaccine may be administered one time per influenza season. Influenza vaccine vary each year, based on the anticipated strains, and should be administered to patients at high risk for influenza October through mid-November. Influenza activity peaks between late December and early March . . . The following clients are at high risk for complications of the disease:

Clients age 65 and older

Residents of nursing facilities and other chronic-care facilities that house people of any age who have chronic medical conditions

Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma

Adults and children who have required regular medical follow-up or hospitalizations during the preceding year because of chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medication) . . .

Women who are in the second or third trimester of pregnancy during flu season . .

p. 34-88 - 34-89

34.4.21.39 Pneumococcal Polysaccharide Vaccine. For individuals not covered by the THSteps or the TVFC Program, the Texas Medicaid Program covers 1-90732, Pneumococcal polysaccharide vaccine, 23-valent, adults or immunosuppressed patient dosage for use in individuals age 2 and older . . . Pneumococcal polysaccharide vaccinations are limited to one per client per lifetime unless specific criteria for revaccination are met. The pneumococcal vaccine is indicated for the following conditions when billed with a diagnosis listed in the following table:

All adults age 65 and older

People older than age 2 who have a long term illness such as:

- o Chronic illness
- o Cardiovascular disease (including congestive heart failure and cardiomyopathies)
- o Pulmonary disease (COPD or emphysema, but not asthma)
- o Chronic metabolic disease (including diabetes mellitus)
- o Alcoholism
- o Chronic liver disease (cirrhosis)
- o CSF leaks
- o Functional or anatomic asplenia (sickle cell disease, asplenia or splenectomy)
- o Clients who live in environments or social settings where the risk for invasive pneumococcal disease is increased (such as Alaskan Natives and certain Native American populations)
- o Immunocompromised clients (including those with HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, radiation, chronic renal failure, nephritic syndrome, organ or bone marrow transplant, chemotherapy, long-term systemic corticosteroid treatment) . . .

Revaccination is recommended for high-risk individuals . . . Those older than age 10 may receive it 5 years after the first dose. Revaccination is recommended for clients who are at high risk for pneumococcal disease or complications of the disease including:

Clients age 65 and older who received their first dose before turning 65, if 5 or more years have passed since the first dose was given

Clients age 65 and older who received a 14-valent vaccine

People with the following conditions

- o Damaged spleen or no spleen (asplenic)
- o Sickle-cell disease
- o HIV infection or AIDS
- o Cancer, leukemia, lymphoma, multiple myeloma
- o Kidney failure
- o Nephrotic syndrome
- o Organ or bone marrow transplant recipients
- o Immunosuppressant therapy (chemotherapy or long-term steroids) . . . **p**

**34-98**

34.4.21.47 Tetanus Injections, Acute Care . . . Tetanus toxoid adsorbed and tetanus immune globulin, human are benefits of the Texas Medicaid Program. Tetanus Toxoid is an immunization used to prevent tetanus. It produces immunity to tetanus by promoting antibody production. The tetanus immune globulin provides a passive immunity for injuries that are over 24 hours old, extensively contaminated, and/or for the client who

has had less than two tetanus toxoid injections in a lifetime. Therefore, both of these injections can be given on the same day for the same injury event . . . Tetanus toxoid and tetanus immune globulin injections are covered for injuries, such as puncture wounds, burns, or abrasions . . . p. 34-101

## Utah

3 Limitations. . . Physician services may be provided only within the parameters of accepted medical practice and are subject to limitations and exclusions determined by the Department on the basis of medical necessity, appropriateness, and utilization control considerations ***Utah Medicaid Provider Manual Physician Services p 17.***

2 Scope of Service for the Non-Traditional Medicaid Plan . . . **(NOTE: This is a waiver program focused on working-age adults with children)**

2 – 16 Preventive Services and health Education

1. Covered Services for Preventive Services and Health Education

a. Preventive screening services, including . . . immunizations . . . are covered.

. . .

b. Immunization codes include:

(1) 90471 – 90473 Administration fee

(2) Covered immunization agents:

90740 Hepatitis B vaccine for immunocompromised adult or adult dialysis patient

90746 Hepatitis B adult

90632 Hepatitis A adult

90636 Hepatitis A and Hepatitis B combination for adult

90659 Influenza virus vaccine whole, for IM or jet injection use

90718 Tetanus and diphtheria toxoids (Td)

90703 Tetanus toxoid

90675 Rabies IM for post exposure treatment

90707 MMR vaccine

90716 Varicella for subcutaneous use for varicella exposed person who is not immune, but not for use in immunocompromised patient

90732 Pneumococcal polysaccharide 23-valent vaccine adult or immunosuppressed patient

90665 Lyme disease only if known exposure ***Utah Medicaid Provider Manual Non-Traditional Medicaid Plan p 5, 16, 17***

## Vermont

Vermont Social Welfare . . . Medicaid . . . M610 Physician Services (Medicaid) . . . Routine . . . immunizations . . . are covered . . . Supplies used in connection with a physician's treatment are not subject to separate reimbursement. Some examples of these supplies are tongue depressors, dextrosticks, bandages, antiseptics, and other consumable items . . . ***p 1***

The state covers all pertinent adult immunization CPT codes. ***Documentation from Vermont Medicaid administrator***

## Virginia

Vaccines. For eligible recipients, routine immunizations are routinely covered only under Virginia Medicaid's EPSDT program. Immunizations to all other individuals are limited except for instances when: It is necessary for the direct treatment of injury, or the immunization is a Pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness . . . **p 82, 83**

## Washington

### Immunizations-Adults

(This section applies to clients 21 years of age and older. . . .) Bill administration CPT codes 90471 and 90472 in addition to the immunization materials. . . . Do not bill administration codes 90471 and 90472 as multiple units; or more than once per client, per day. Bill only CPT code 90471 when administering one vaccine. Bill both CPT codes 90471 and 90472 with one unit per code when administering more than one vaccine. . . . 90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.

**Physician-Related Services; Billing Instructions, Revised July 2002**

## West Virginia

Immunizations: Vaccines listed below are covered by West Virginia Medicaid. . . . the CPT codes include the serum and administration. . . . Specific coverage information follows the list of covered immunizations. . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733. **p 50, 51**

2. West Virginia Medicaid will continue to cover necessary vaccines for Medicaid patients over age 18. Providers will need to purchase vaccine for Medicaid patients over age 18 will bill CPT codes 90700 through 90742, as appropriate. **p. 54.**

Hep. A, flu, and Hep. B are covered under the current program. **Interview with program administrator 8/8/03.**

## Wisconsin

### Immunizations

Wisconsin Medicaid covers the immunizations listed in the CPT subsections "Immune Globulins" (procedure codes 90281 – 90399) and "Vaccines, Toxoids" (procedure codes 90476 – 90749). . . . Wisconsin Medicaid's reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes **includes** reimbursement for the administration of the immunization, contrary to CPT's description of the procedure codes. CPT procedure codes for administration (procedure codes 90471 and 90472) are not covered by Wisconsin Medicaid.

Immune globulin procedure codes and the unlisted vaccine/toxoid procedure code are manually priced by Medicaid's pharmacy consultant. To be reimbursed for these codes, physicians must attach the following information to a paper CMS 1500 claim form:

Name of drug; National Drug Code (NDC); Dosage; Quantity. **Physician Services Handbook, p 27. Rev. 3/03**

Physician Maximum Allowable Fee Schedule . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.

## **Wyoming**

Preventive Medicine . . .

EqualityCare does NOT cover other routine services or examination when the procedure is performed in the absence of an illness or complaints. Exceptions to this policy are: . . . immunizations.

Vaccines, toxoids

Procedure codes 90476-90748 identify the vaccine product only and are reported in addition to the immunization administration codes 90471, 90472 unless the VFC program supplies the vaccine. The exact vaccine product administered needs to be reported.

Influenza and Pneumococcal Vaccines

EqualityCare covers influenza vaccine and pneumococcal vaccine for patients considered at risk. When an EqualityCare client is a resident of a long-term care facility, the vaccine and administration are included in the nursing home per diem rate, and not paid separately.

Fee Schedule; as of August 2003 . . .

90632 . . . 90659 . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733 . . . 90746.



## **Appendix II - COPAYMENTS AND DEDUCTIBLES**

### **State Plan Summaries**

#### **Alabama**

##### **VI. Copayment**

The following copayments are required, except for: (a) individuals under age 18; (b) pregnant women; (c) individuals in long-term care facilities; (d) home health services; (e) family planning services; (f) HMO services; and (g) emergency services . . .

Outpatient hospital services--\$3 per nonemergency visit (also applicable to Medicare crossovers).

Physicians' services--\$1 per office visit (also applicable to Medicare crossovers) . . .

Rural health clinic services--\$1 per visit (also applicable to Medicare crossovers).

Federally qualified health center services--\$1 per medical clinic encounter (also applicable to Medicare crossovers).

Certified nurse practitioner services--\$1 per office visit . . .

Drug prescriptions under \$10--50 cents.

Drug prescriptions under \$25--\$1.

Drug prescriptions under \$50--\$2.

Drug prescriptions exceeding \$50--\$3.

Copayment cannot exceed the maximum charge allowed for Medicaid services.

#### **Arizona**

##### **V. Copayments . . .**

The following copayments are required from categorically needy recipients: (a) \$1.00 for each doctor's office or home visit and all diagnostic and rehabilitative X-ray and laboratory services associated with such visit . . . The following are excluded from copayment requirements . . . (d) visits scheduled by a primary care physician or practitioner not at the recipient's request; (e) drugs and biologicals.

#### **Arkansas**

##### **Silent**

#### **California**

##### **VIII. Copayments**

Recipients are subject to a \$5-per-visit copayment for nonemergency services provided in an emergency room, and to a \$1-per-visit copayment for: (a) outpatient hospital services; (b) physicians' services . . . (g) clinic services . . . (m) prescribed drugs . . . (o) physicians' services provided to the medically needy . . . Copayment is not required for: (a) any service costing the program \$10 or less; (b) family planning services; (c) services for an individual 19 or younger; (d) any woman receiving perinatal care; (e) any health facility inpatient; or (f) any child under 21 in a boarding home or foster care institution. A provider may not refuse services solely on the basis of a recipient's inability to copay.

#### **Colorado**

##### **VI. Copayments by Recipients**

The following benefits are subject to copayments by recipients as follows: . . . (b) \$3.00 per outpatient hospital visit; (c) \$2.00 per rural health clinic, federally qualified health center, or public health clinic visit; (d) \$2.00 per physician home or office visit . . . (h)

\$.75 per drug prescription or refill for generic or multi-source drugs and \$3.00 for prescription or refill for single source or name-brand drugs; (i) \$2.00 per brief, individual, group, or partial care community mental health center visit, except for services in the Home and Community Based Services programs. Individuals whose copayments reach \$150 in a calendar year are exempt from further copayments during that year. The following are exempt from copayment: (a) children under age 19 through the eligibility cycle month of their 19th birthday; (b) pregnant women during pregnancy and for six weeks post-partum; (c) patients in NFs or ICFs/MR; (d) patients 65 or older in institutions for mental diseases; (e) patients under 21 in psychiatric facilities; (f) family planning services and supplies for individuals of child-bearing age; (g) HMO services; and (h) emergency services.

**Connecticut**

**VII. Copayments**

Medicaid recipients generally must make a \$1 pharmacy prescription copayment. The copayment applies to each initial and refilled prescription and over-the-counter drug.

**Delaware**

**Silent**

**Florida**

**VI. Copayments . . .**

The following copayments and coinsurance are required: . . . \$2.00 per day for each physician, physician assistant . . . visits. . . . \$3.00 per . . . outpatient hospital visit. . . . Recipients under age 21, pregnant women, institutionalized individuals, HMO enrollees, family planning services, emergency services and hospice patients are exempt from the copayment or coinsurance amounts.

**Georgia**

**VI. Copayments for Recipients**

The following copayments apply:

Outpatient non-emergency visits.--\$3.00 per visit . . .

Physicians, podiatrists, or nurse practitioners evaluation and management office visits.--\$2.00 per visit . . .

Rural health centers and federally qualified health center services.--\$2.00 per visit . . .

Children under age 21, pregnant women, nursing home residents, and hospice care recipients are not required to pay the copayments. Emergency services and family planning services are also exempt from copayments.

**Hawaii**

**Silent**

**Idaho**

**Silent**

## **Illinois**

### **VI. Copayments**

Copayments are required for all recipients, except pregnant women (including post-partum women during the 60-day post-partum period), long-term care facility residents and institutionalized individuals, and children under age 19. . .

A \$1.00 copayments is required for services provided by the following provider types: physician office visits, chiropractor services, podiatric services, vision services, and pharmacy services per prescription.

Copayments will not be assessed for services paid by Medicare, family planning services, certain medications, cancer chemotherapy, radiation therapy, renal dialysis treatment and over the counter drugs.

## **Indiana**

### **VI. Copayments**

*Medicaid recipients must make the following copayments:*

The following copayments are required from all recipients except pregnant women, individuals under age 18, and institutionalized individuals. The following services are also exempt from copayments: emergency ambulance service, family planning services and supplies to individuals of child bearing age, HMO pharmacy services, and emergency pharmacy services . . .

2. Pharmacy services.--\$.50 for each generic drug and brand name drug for which Medicaid pays less than \$10.00. \$1.00 for brand name drugs with costs between \$10.01 and \$30.00; \$2.00 for brand name drugs with costs between \$30.01 and \$55.00 and \$3.00 for brand name drugs that cost over \$55.00.

3. Emergency room services.--\$3.00 for nonemergency services when provided in an emergency room.

## **Iowa**

### **VI. Copayments**

A recipient is subject to copayments of: (a) \$1 per drug prescription or refill . . . A \$1.00 copayment is required for each federal Medicare Part B crossover claim submitted to Medicaid when services have a Medicaid copayment listed above. Copayments are not applicable to (a) individuals under age 21; (b) family planning services or supplies; (c) services provided in a hospital, NF, state mental health institution, or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend, for costs of necessary medical care, all but a minimal amount of income for personal needs; (d) services furnished to pregnant women; (e) Medicare Part B covered services rendered to a Medicare-eligible recipient when the provider is billing the Medicare program for the service as well as Medicaid; (f) services rendered by an HMO in which the recipient is enrolled; and (g) any emergency services provided by hospitals, clinics, physicians, and ambulatory surgical centers.

However, no Medicaid provider may deny care or services because of an eligible individual's inability to pay a copayment.

**Kansas****VI. Copayments**

Medicaid recipients must make the following copayments: . . . (b) hospital outpatient (nonemergency) services--\$1.00 per visit. Copayments for other medical services are based on the following ranges: (a) for services below \$10--\$.50; (b) for services below \$25--\$1; (c) for services below \$50--\$2; and (d) for services \$50 or over--\$3. Other medical services include . . . prescribed drugs (new or refill); physician or physician extender services . . . federally qualified health center services; and rural health clinic services.

Exempt from copayment requirements are: (a) recipients under age 18; (b) pregnancy-related services; (c) individuals in hospitals, nursing homes, or other medical institutions; (d) emergency services; (e) family planning services or supplies; and (f) health maintenance organization enrollees.

**Kentucky**  
**Silent****Maine****VI. Copayments**

Medicaid recipients generally must make the following copayments: . . . (b) pharmacy--initial and refill prescriptions--\$1 for generic and single-source drugs and \$2 for multi-source brand name drugs, with total charges limited to no more than four copayments per month or eight per family . . .

**Massachusetts****VI. Copayments**

The following copayments are required:

\$.50 per day for each prescription for all legend or nonlegend drugs including the original prescription and all refills; and

\$3.00 for nonemergency services provided in a hospital emergency department.

Copayments are not required from members who: (a) are under age 19; (b) are pregnant including during the postpartum period; (c) hospitalized or in nursing facilities; (d) receive family planning services and supplies; (e) receive emergency services; (f) receive hospice care services; and (g) members who receive medical services through the emergency aid to the elderly, disabled and children programs.

**Michigan****VII. Copayments**

The following copayments are required for all recipients, except pregnant women, institutionalized individuals, children under age 21 (EPSDT recipients), and health maintenance organization enrollees. Family planning drugs and supplies and emergency services also are exempt for copayment charges...

6. Pharmacy services - - \$1 per prescription.

**Minnesota**  
**Silent**

## **Mississippi**

### **VI. Copayments**

The following copayments are required from all recipients other than children under age 18, pregnant women, and nursing home patients. Emergency services provided in an emergency room and family planning services also are excluded from the requirement . . .

- Outpatient hospital and emergency room services--\$2 per visit
- Physician office visits--\$1 per visit
- Home health visits--\$2 per visit
- Clinic visits--\$1 per visit
- Rural health clinic--\$2 per visit . . .
- Prescribed drugs--\$1 per prescription or refill . . .

## **Missouri**

### **VI. Copayments by Recipients**

*Prescribed drugs*--A copayment is required of recipients, except as exempted below, for each original or refilled prescription of a Medicaid-covered drug. Copayments are \$.50 for items of service costing \$10.00 or less, \$1.00 for items costing from \$10.01 to \$25.00, and \$2.00 for items costing \$25.01 or more.

*Other services*-- . . . . For outpatient hospital clinic or emergency room services, the copayment per date of service is \$2.00 plus \$1.00 for the physician's services . . .

. . . . Copayments for items of service costing up to \$10.99, \$1.00 for costs up to \$25.99, \$2.00 for costs up to \$50.99, and \$3.00 for costs of \$51.00 or more.

Exempted from the copayment and coinsurance requirements are services to recipients under age 18, institutionalized individuals, services to those having Medicare-Medicaid coverage, certain emergency services, certain types of therapy, services related to family planning or pregnancy, services to foster care children, EPSDT services and services to HMO enrollees.

## **Montana**

### **VII. Copayments**

Copayments are required of both categorically and medically needy individuals with the following exceptions: (a) individuals under age 21; (b) pregnant women; (c) patients in a nursing home or other medical institution who are required to spend all but their personal needs allowance for their care; (d) individuals who are health maintenance organization enrollees; and (e) individuals receiving hospice care. Emergency and family planning services are also excluded from the requirement. Providers are responsible for collecting cost sharing charges from individuals; however, services may not be denied because the recipient cannot pay.

The copayments according to service are . . .

2. *Outpatient hospital services*: \$1.00 per service.
3. *Physicians' and podiatrists' services*: \$2.00 per service . . .
6. *Clinic services*: \$1.00 per visit . . .
8. *Prescribed drugs*: \$1.00 per generic prescription; \$2.00 for name brand drugs . . .
11. *Rural health clinic, federally qualified health center, and freestanding dialysis clinic services*: \$2.00 per unit. .

13. *Mid-level practitioners' services*: \$2.00 per unit . . .

**Nebraska**

**VI. Copayments for Recipients**

The following copayments apply . . .

Prescribed drugs--\$2.00 per prescription . . .

Optometrists' services and physicians' services, including nurse midwives, nurse practitioners, and physician assistants providing primary care--\$2.00 per visit . . .

Outpatient hospital service--\$3.00 per visit.

Copayments do not apply to children under age 18, institutional services, emergency services, family planning services, and HMO services.

**Nevada**

**Silent**

**New Hampshire**

**Silent**

**New Jersey**

**Silent**

**New Mexico**

**Silent**

**New York**

**Silent**

**North Carolina**

**VI. Copayments**

Medicaid recipients generally must make the following copayments . . .

\$3.00 per outpatient hospital visit . . . \$1.00 per generic prescription and \$3.00 per brand name prescription drugs

**North Dakota**

**VI. Copayment**

The following copayments are required, except for: (a) individuals under age 21; (b) pregnant women; (c) inpatients of medical institutions; (d) family planning services; and (e) emergency services:

Physicians' services--\$2 per office visit . . .

Federally qualified health center services--\$2 per visit.

Rural health clinic services--\$2 per visit.

**Ohio**

**Silent**

## **Oklahoma**

### **VI. Copayments**

Medicaid recipients generally must make the following copayments: (a) \$3.00 for each inpatient or outpatient hospital service, organized clinic service, or ambulatory surgical service; (b) \$1.00 for each physician, optometrist, home health agency, rural health clinic, CRNA or federally qualified health center service; and (c) \$.50 per service for all Part B covered services.

## **Oregon**

### **V. Copayments**

Medically needy beneficiaries must make the following copayments: (a) outpatient services--\$3.00 per visit; (b) other medical services--\$3.00 per visit; and (c) prescription drugs--\$2.00 for generic drugs; or \$3.00 for brand name prescriptions.

Exempt from copayment requirements are: (a) recipients under age 19; (b) pregnant women; (c) institutionalized individuals; (d) emergency services; (e) family planning services or supplies; (f) health maintenance organization enrollees; and (g) individuals who receive services through Indian Health Services (IHS)/Tribal Health Facilities.

## **Pennsylvania**

### **VI. Copayments for Recipients**

Recipients must make copayments for Medicaid services except for: (a) individuals under age 18; (b) pregnant women; (c) nursing home patients who must spend all but a minimal amount of their income for medical care; (d) emergency care; (e) laboratory services; (f) the professional component of diagnostic radiology, nuclear medicine, radiation therapy, and medical diagnostic services when the professional component is billed separately from the technical component; (g) family planning services and supplies; (h) HMO services; (i) services furnished or authorized by a health insuring organization; (j) home health agency services; (k) services by a psychiatric partial hospitalization program; (l) services of a funeral director; (m) renal dialysis services; (n) blood and blood products; (o) oxygen; (p) ostomy supplies; (q) drugs specified by the program; (r) rental of durable medical equipment; (s) outpatient services with a fee under \$2.00; (t) medical examinations requested by the program; (u) EPSDT screening; (v) more than one of a series of a specific allergy test provided in a 24-hour period; and (w) targeted case management. These are the copayments:

1. Legend and nonlegend drugs--\$1.00 per prescription or refill . . .
5. Other services in relation to the Medicaid fee amount--(a) \$.50 for \$2.00 through \$10.00; (b) \$1.00 for \$10.01 through \$25.00; (c) \$2.00 for \$25.01 through \$50.00; and (d) \$3.00 for \$50.01 or more.

The program reimburses the recipient for copayment exceeding \$90 in a six-month period. A provider may not deny covered care because of a recipient's inability to copay. However, the provider may attempt to collect copayment. A recipient who believes copayment charges are incorrect must continue to copay until the program determines correctness. Providers may neither waive copayment nor compensate recipients for copayment. Copayment may not exceed Medicaid payment when care is partly covered by a third party other than Medicaid.

**Rhode Island**  
**Silent**

**South Carolina**  
**Silent**

**South Dakota**  
**VI. Cost Sharing by Recipients**

The state's Medicaid program requires the following coinsurance and copayment amounts from recipients age 18 or older who are not inpatients in medical institutions. Exempt from cost-sharing requirements are services related to pregnancy, family planning, and emergency hospital services.

*Coinsurance:* 5% of payment amount for: (a) each nonemergency outpatient hospital service; (b) durable medical equipment; (c) prosthetic devices; and (d) mental health center services.

*Copayments:* \$2 for each of the following: (a) physician services--home visit, office visit . . . (b) rural health clinic visit including hospital based rural health clinics; (c) federally qualified health center visit; and (d) each prescription or refill.

**Tennessee**  
**Silent**

**Texas**  
**Silent**

**Utah**  
**Silent**

**Vermont**  
**VI. Copayments**

A recipient is subject to the following copayments . . . (b) \$3.00 per day for outpatient hospital services . . . and (c) \$1.00 for prescriptions or refills with usual and customary charges not exceeding \$29.99 and \$2.00 for those with usual and customary charges of \$30 or more.

**Virginia**  
**VI. Copayments**

Categorically needy and medically needy individuals must generally pay \$1.00 for each clinic visit . . . drug prescription or refill, or physician visit, and \$3.00 for each outpatient hospital clinic visit . . . . The following are exempt from cost-sharing requirements: (a) individuals under age 21; (b) nursing home patients; (c) women receiving pregnancy-related services; and (d) individuals receiving family planning services.

**Washington**  
**Silent**

**West Virginia**  
**Silent**



## **Wisconsin**

### **VI. Copayments**

*Medicaid recipients must make the following copayments:* The following copayments are required from all recipients except nursing home residents, HMO or PHP members, recipients of EPSDT, pregnant women if service is related to pregnancy, and hospice recipients. Emergency hospital, dental, or transportation services, transportation services provided by specialized medical vehicles or by the County Department of Social Services, AODA day treatment services, respiratory care for ventilator-assisted recipients, community support program services, family planning services and supplies, home health services, personal care services, and case management services are also excluded from the requirement . . .

2. Outpatient hospital services--\$3.00 per visit; 50 cents per day for day treatment . . .
4. Rural health clinic services--\$.50 to \$3.00 per encounter.
5. Physicians' services--\$1.00 per home or preventive medical evaluation . . . \$1.00 to \$2.00 per office or other outpatient visits. Consultation--\$3.00 per service. . . . The maximum copayment required of a recipient is \$30 per calendar year . . .
10. EPSDT--\$1.00 per screening for recipients over age 18 . . .
12. Drugs and disposable medical supplies--\$1.00 per new or refill prescription up to a \$5.00 limit on copayment per recipient per pharmacy each month, and 50 cents per item for each new and refill over-the-counter drug or disposable medical supply; there is no monthly limit on copayment for OTC items or disposable supplies . . .
15. Nurse practitioner services--Same as for physicians' services in 5, above . . .

## **Wyoming**

### **V. Copayments**

The following copayments are required of Medicaid recipients

1. Prescription drugs--\$2 per prescription.
2. Practitioner visits--\$2 for office visits, home visits. . . .
3. Outpatient hospital services--\$6 per non-emergency outpatient clinic. . . .
4. Rural health clinic and federally qualified health center services.--\$2 per encounter.

**APPENDIX III - PROVIDER REIMBURSEMENT**  
**Provider Manuals**

**Alabama**

**Adult Immunizations**

Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service . . . Immunizations are reimbursable on a fee-for-service basis. The administration fee (procedure code Z4998) may be billed separately if an office visit is not billed. ***Provider Manual***

**Arizona**

**90632** Hepatitis A Vaccine, Adult Dosage, For Intramuscular Use; Rate 2003 \$60.24

**90659** Influenza Virus Vaccine, Whole Virus, For Intramuscular Or Jet Injection Use; Rate 2003 \$3.92

**90707** Measles, Mumps, and Rubella Virus Vaccine (MMR), Live, For Subcutaneous or Jet Inj. ; R a t e \$ 3 1 . 7 4

**90716** Varicella Virus Vaccine, Live, For Subcutaneous Use; Rate \$61.70

**90718** Tetanus and Diphtheria Toxoids (TD) Adsorbed For Use In Individuals Seven Years; Rate \$10.35

**90732** Pneumococcal Polysaccharide Vaccine, 23-Valent, Adult Or Immunosuppressed Patient; Rate \$14.68

**90733** Meningococcal Polysaccharide Vaccine (Any group(s)), For Subcutaneous Or Jet Inj.; Rate \$37.25

**90746** Hepatitis B Vaccine, Adult Dosage, For Intramuscular Use; Rate \$52.54

***AHCCCS 2003 Rate Codes – Drugs & Injections***

\*\*\*

. . . AHCCCS Office of Medical Management does not require prior authorization for medically necessary immunization services performed by fee-for-service providers.  
***Arizona Health Care Cost Containment System Medical Policy Manual***

**Arkansas**

No information available.

**California**

This section outlines policy related to billing injection services, including immunizations . . . Reimbursement is determined by the cost of the injection, plus the physician's administration fee. Only one administration fee will be reimbursed per injection regardless of the quantity reflected on the claim line . . . ***Injections, May 2003***

**Colorado**

**Immunizations for Adults**

. . . If immunization is the only service rendered, providers may also submit charges for a minimal Evaluation/Management (E/M) service (CPT code 99211). If additional E/M services are rendered, the reason for care (diagnosis) and appropriate level of service (procedure code) must be recorded on the claim . . . Reimbursement for immunizations to adults is at the Medicaid injectable drug fee schedule rate. The fee schedule amount

includes average wholesale cost. Providers should bill their usual and customary charge . . . **Medicaid Bulletin, April 2002**

**Connecticut**

**90632** Hepatitis A Vaccine, Adult Dosage, For Intramuscular Use; M.P. (Manually Priced By DSS)

**90659** Influenza Virus Vaccine, Whole Virus, For Intramuscular or Jet Injection Use; \$18.95

**90707** Immunization, Active, Measles, Mumps, and Rubella Virus Vaccine, Live; M.P.

**90716** Immunization, Active, Varicella (Chicken Pox) Vaccine; M.P.

**90718** Tetanus And Diphtheria Toxoids (TS) Adsorbed For Use in Individuals Seven Years Or Older, For Intramuscular Or Jet Injection; \$15.00

**90732** Pneumococcal Polysaccharide Vaccine, 23-Valent, Adult or Immunosuppressed Patient Dosage, For Use in Individuals 2 Years Or Older, For Subcutaneous or Intramuscular Use; \$25.00

**90733** Immunization, Active, Meningococcal Polysaccharide Vaccine (Any Group(s)); M.P.

**90746** Immunization, Active, Hepatitis B Vaccine, 20 Years and Above; \$30.00

**Medical Assistance Policy Fee Schedule, Physician**

\*\*\*

**Sec. 17b-442 Services Not Covered**

. . . (b) immunizations . . . available to providers free of charge . . . **Physician Services Regulation/Policy**

**Delaware**

EDS manages the state's Medicaid system. They do not publish a fee schedule. **Phone call with EDS on 9/11/03 with Christy C.**

**Florida**

Reimbursement . . .

Medicaid reimburses the FQHC a clinic-specific, all-inclusive encounter rate for clinic services. Immunizations . . . are reimbursed on a fee-for-service basis. There is a \$3 recipient copayment for FQHC services, per clinic, per day, unless the recipient is exempt. **p 4**

Rural Health Clinic Services . . .

Reimbursement . . . Immunizations . . . are reimbursed on a fee-for-service basis. There is a \$3 recipient copayment for RHC services, per clinic, per day, unless the recipient is exempt. **p 76**

Hospital Services Outpatient . . . Reimbursement . . .

There is a \$3 recipient co-payment for each hospital outpatient department or clinic visit and emergency room visit to receive non-emergency services, unless the recipient is exempt. **p 58**

## Georgia

### 907. Non-Covered Emergency Room and Outpatient Services

h) Services provided free-of-charge to the public by the hospital, County Health Departments, State Laboratory or other state agencies; i.e., immunizations . . . ***Policies and Procedures For Hospital Services***

\*\*\*

### 903.7 Immunizations

Diagnostic, Screening and Preventive Services (DSPS) providers may bill under code 99211 for a clinic visit associated with the administration of covered immunizations given to members over 21 years of age. ***Policies and Procedures For Diagnostic, Screening and Preventive Services***

## Hawaii

### 6.6 Immunizations

6.6.1 Medicaid covers immunizations and the administrative costs of the immunizations for adults and children . . .

#### 6.6.3 Exclusions

b) Pneumococcal and annual influenza vaccines provided to nursing home residents who are Medicare beneficiaries will not be covered as Medicare covers 100 percent of the reasonable costs of these vaccines . . . ***Medicaid Provider Manual; Medical/Surgical Services***

## Idaho

### 3.19.6.1 Administration Only of an Injectable and/or Adult Vaccine

When a provider-purchased injectable is only administered (all ages) and/or adult vaccine is administered (21 years of age or older), Medicaid will pay an injection plus the Estimated Acquisition Cost (EAC) for the injectable/vaccine . . .

### 3.19.6.3 Administration of an Injectable/Adult Vaccine with Evaluation and Management Visit

When an injection or adult vaccine is administered in conjunction with an Evaluation and Management visit, Medicaid will pay only for the Evaluation and Management visit and the EAC . . .

### 3.19.5 State Supplied Vaccines

Medicaid should be billed for the administration of free vaccines according to the service(s) rendered at the time the vaccine(s) was administered . . .

**90632** Hepatitis A Vaccine, Adult Dosage Allowed Amount \$50.50

**90659** Influenza Virus Vaccine, Whole Allowed Amount \$5.09

**90707** MMR Vaccine, Allowed Amount \$30.00

**90716** Immunization, Active; Varicella Allowed Amount \$46

**90718** Tetanus and Diphtheria Toxoid Allowed Amount \$5.00

**90732** Pneumococcal Polyvalent Pneumovax \$13.00

**90733** Meningococcal Polysaccharide Allowed Amount \$55.00

**90746** Immunization, Active Hepatitis Allowed Amount \$52.50 ***Provider Handbook***

## **Illinois**

- 90632 Hepatitis A Vaccine, Adult Dosage, Intramuscular Use Rate \$56.15
- 90659 Flu Virus Vaccine, Whole Virus, Intramuscular/Jet Inject Rate \$5.65
- 90707 Immunization Measles-Mumps-Rub Rate \$39.70
- 90716 Varicella Chicken Pox Vaccine Rate \$46.60
- 90718 Immunization Tetanus-Dip Adult Rate \$2.70
- 90732 Immunization Pneumococcal Vac rate \$14.60
- 90733 Immunization Meningococcal Polysaccharide Vaccine \$85.00
- 90746 Immun. Active Hepatitis B Vaccine Rate \$0.00 *Physicians Fee Schedule*

## **Indiana**

### **Billing for Vaccines and Toxoids**

Reimbursement for vaccines and toxoids, procedure codes 90585-90749, will continue to include the \$2.90 administration fee. Codes 90471 and 90472 are nonreimbursable codes, since the fee for administration of the vaccine or toxoid is included in the procedure code. Providers should not bill any other administration code with these procedure codes. Payments made for additional administration is subject to recoupment. . .

### **Provider Bulletin**

## **Iowa**

### **A. Injections**

Physicians are reimbursed separately for injections and for the administration of injections . . . Immunizations are usually given with a medical service. When an immunization is the only service performed, you may list a minimal service in addition to the injection. Immunization procedures include the supply of related materials . . .

- 90632 Hepatitis A Vaccine, Adult Dosage \$52.94
- 90659 Influenza Virus Vaccine, Whole Virus \$6.11
- 90707 Measles, Mumps, and Rubella Virus Vaccine \$27.65
- 90716 Varicella (chicken pox) Immunization \$44.46
- 90718 Tetanus and Diphtheria Toxoid Absorbed \$6.19
- 90732 Pneumococcal Vaccine Polyvalent 1 Immuni. \$8.19
- 90733 Meningococcal Polysaccharide Vaccine \$11.98
- 90746 Immunization, Active, Hepatitis B \$51.34 *Physician Services*

## **Kansas**

### **Adult Immunization Administration**

Reimbursement for adult (non-VFC) immunization administration is included in the total cost; i.e., providers are reimbursed one rate for the vaccine and the administration.

### **Professional Services Provider Manual**

## **Kentucky**

### **2003 Physicians, Resource Based Relative Value Scale (RBRVS)**

- 90659 Flu Vaccine, Whole, IM Rate Outpatient \$0.00 Professional \$3.30
- 90707 MMR Vaccine, SC Rate \$3.30
- 90716 Chicken Pox Vaccine, SC Rate Outpatient \$0.00 Professional \$3.30
- 90718 TD Vaccine < 7, IM Rate Professional \$3.30
- 90732 Pneumococcal Vaccine Professional \$3.30
- 90746 Hep B Vaccine, Adult, IM Rate Outpatient \$0.00 Professional \$3.30

## **Maine**

### **8. Immunization's, Therapeutic Injections, Hyposensitization:**

**a. Immunizations:** All immunization codes include both the administration and the immunological material. The maximum allowance for immunizations is adjusted monthly, based on the average wholesale price of the serum. Providers should report the size of the dosage administered when billing for immunizations. The charged amount for the immunization by the provider must reflect the acquisition cost of the serum plus the \$2.00 allowance for administration. Any vaccine distributed by the State Immunization Program is not reimbursable, e.g. MMR. However, a \$5.00 reimbursement amount will be made for the administration of such a vaccine . . . ***Maine Medical Assistance Manual: Allowances for Physicians***

## **Maryland**

No information available

## **Massachusetts**

### **Claims That Have Special Requirements or Limitations**

IC: Claim requires individual consideration.

90632 IC . . . 90707 IC . . . 90713 IC . . . 90716 IC . . . 90732 IC . . . 90733 IC . . . 90746 IC

(C) Immunization or Injection. When an immunization or injection is the primary purpose of an office or other outpatient visit, the physician may bill only for the injectable material and its administration. However, when the immunization or injection is not the primary purpose of the office or other outpatient visit, a physician may bill for both the visit and the injectable material, but not for its administration . . . The Division does not pay for the cost of the injectable material if: (1) the Massachusetts Department of Public Health distributes the injectable material free of charge; or (2) the cost to the physician is \$1.00 or less.

***Physician Manual***

## **Michigan**

### **Immunizations (Vaccines and Toxoids)**

. . . Michigan offers a . . . program for Medicaid adults 19 years old and older called the MI-VRP (Michigan Vaccine Replacement Program). Td, MMR, and Hepatitis B for adults are available from the local health department at no cost to the provider. Any local health department in the state can be contacted for specifics about the VFC and MI-VRP program, what vaccines are available, and instructions on enrolling and obtaining vaccines. The Program will not cover vaccine costs for any product available free for Medicaid enrollees.

An administration fee is covered separately for vaccines and toxoids given to Medicaid beneficiaries whether the vaccine is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.

***Michigan Department of Community Health, Notice of Proposed Policy***

## **Minnesota**

### **Immunizations and/or Vaccinations**

MHCP covers vaccines, toxoids, and an administration fee.

MHCP covers only the administration fee for vaccines and toxoids provided free by the Minnesota Vaccines for Children (MnVFC), available through the Minnesota Department of Health (MDH). Most routine childhood and some adult vaccines are available through MnVFC . . .

### **Immunizations**

#### **Covered Services**

Administration of vaccines and toxoids to MHCP enrolled infants, children, and adults is covered. Clinic, physician, C&TC, outpatient hospital, certified nurse-midwife, certified family and certified pediatric nurse practitioner, home health agency, public health clinic, and public health nursing clinic providers may bill for immunizations. Pharmacies may also provide vaccines to long-term care facilities . .

#### **Billing Requirements and Vaccines for Children**

Providers must bill according to the following instructions:

. . . Providers will receive an administration fee for each immunization.

. . . MHCP does not pay for purchase if vaccines available through MnVFC . . . .

For vaccines not available through MnVFC, payment to providers for immunization procedure codes is based on the average wholesale price plus a standard administration fee . . .

In addition to the CPT vaccine codes, usual and customary charges for an office visit associated with the immunization may also be billed . . . ***Physician and Professional Services***

## **Mississippi**

### **Reimbursement**

To receive maximum reimbursement for flu and pneumonia immunizations for adults, providers should bill as follows:

For beneficiaries who come in only for these immunizations, providers may bill E&M procedure code 99211, the vaccine code(s), and the G administration code(s). This E&M procedure code does not count toward the twelve (12) office visit limit for beneficiaries.

For beneficiaries who are seen by the provider for evaluation or treatment and receive these immunizations, the provider may bill the appropriate E&M procedure code, the vaccine code(s), and the G administration code(s). The E&M procedure code billed in this instance will count toward the twelve (12) office visit limit for beneficiaries.

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers will count visits under current procedures. Providers will count or bill visits when the only service involved is the administration of influenza or pneumonia vaccine.

. . . Influenza and pneumococcal vaccines will be reimbursed by the DOM for residents with a payment source of Medicaid only in nursing facilities. The facilities may have the provider come to the facility and administer the injections or may send a resident to the provider's office for the injection. The provider may bill and be reimbursed by Medicaid, or the facility may purchase the vaccine, administer the injection, and claim the cost of the vaccine in the Medicaid cost report for Medicaid residents only. **Provider Policy Manual**

## **Missouri**

### **Immunization Administration Codes (Change in Policy)**

. . . In the past, Missouri Medicaid has allowed providers to bill a minimal office visit when a patient comes into the office to receive and immunization only . . . that will no longer be an option. The provider may bill the appropriate administration code and the drug may continue to be billed . . . If a significant, separately identifiable Evaluation and Management (E/M) service, (Procedure Codes 99201-99215) is performed, the appropriate E/M code may be billed in addition to the administration code . . . The administration procedure codes may not be billed by federally qualified health centers (FQHCs) or rural health clinics (RHCs) as outlined by federal guidelines. The administration of any medications, including immunizations, is included in the encounter rate and additional reimbursement is not allowed. **Missouri Medicaid Bulletin Vol. 21, No. 6, April 1, 1999**

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### **13.24.B Injections and Immunizations**

. . . .When vaccines are furnished at no cost to the practitioner by the Department of Health and Senior Services, Center for Disease Control and Prevention, the vaccines cannot be billed to Medicaid . . .

Reimbursement for injectables billed on the Pharmacy Claim form is made on the basis of the current market price, defined as the current average wholesale price (AWP) for the specific product used . . . A Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) . . . are reimbursed on the basis of the current physician fee schedule . . . **Physician Provider Manual**

## **Montana**

**90632** HEP A Vaccine, Adult IM Fees Office \$57.59 Facility \$57.59

**90659** FLU Vaccine , Whole, IM Fees Office \$0.00 Facility \$0.00

**90707** MMR Vaccine, SC Fees Office \$27.28 Facility \$27.28

**90716** Chicken Pox Vaccine, SC Fees Office \$44.12 Facility \$44.12

**90718** TD Vaccine > 7, IM Fees Office \$10.26 Facility \$10.26

**90732** Pneumococcal vaccine, Fees Office \$9.42 Facility \$9.42

**90733** Meningococcal vaccine, SC Fees Office \$63.98 Facility \$63.98

**90746** HEP B Vaccine Adult IM Fees Office \$50.14 Facility \$50.14 **Montana Medicaid Fee Schedule**

## **Nebraska**

No information available



**Nevada**

. . . To calculate Medicaid’s maximum allowable reimbursement for a specific procedure, multiply the unit value by the unit rate listed for your provider type and procedure code range . . . **Unit Rate Schedule & Procedure Code Value List**

**New Hampshire  
Covered Physician Services**

**E. Injections**

. . .NOTE: Immunizations . . .are billed according to HCPCS codes for the complete service. These services will be reimbursed at a global fee . . .

3. Some vaccines are available free of charge form the New Hampshire Division of Public Health. They are not reimbursable by the NH Medicaid Program. However, the cost of administering the vaccines may be billed using HCPCS code 99070. **New Hampshire Medicaid Billing Manual**

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**90632** Fee \$61.00 . . . **90659** Fee \$3.54 . . . **90707** Fee \$0.01 . . . **90716** Fee \$75.00 . . .  
**90718** Fee \$5.00 . . . **90732** Fee \$16.50 . . . **90733** Fee \$47.50 . . . **90746** Fee \$65.00 . . .  
**2002 NH Medicaid Fee Schedule**

**New Jersey**

**10:58A-4.2 HCPCS procedure code numbers and maximum fee allowance schedule**

(j) Immunizations:

- 90707** \$39.87; Administration of serum only \$2.50
- 90716** \$48.00; Administration of serum only \$2.50
- 90718** \$3.35; Administration of serum only \$2.50
- 90732** \$14.35; Administration of serum only \$2.50
- 90733** \$17.48; Administration of serum only \$2.50

. . .Administration of serum only. These codes shall be reimbursable only for services provided to beneficiaries 19 years of age and older. **Certified Nurse Practitioner/Clinical Nurse Specialist Manual**

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**10:54-4.12 Physician reimbursement in special situations**

. . .1. Reimbursement for immunization services will be based on the formula of Average Wholesale Price (AWP) of the drug plus 15 percent, plus \$2.00 for physician’s cost of dispensing the immunization . . .

**W9099** Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml does. This code applies only to high risk recipients over 19 years of age. \$63.57

**W9335** Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml does. This code applies only to high risk recipients over 11 years of age. \$62.09

**Physicians Services Manual**

**New Mexico**

**90632** \$60.00 . . . **90659** \$16.88 . . . **90707** \$10.00 . . . **90716** \$10.00 . . . **90718** \$10.00 . . .  
. **90732** \$14.00 . . . **90733** \$14.00 . . . **90746** \$58.00

## **New York**

### **Immunization Injections**

If a significantly separately identifiable Evaluation and Management services (eg, office service, preventative medicine services) is performed, the appropriate E/M code should be reported in addition to the vaccine and toxoid codes.

Injections are usually given in conjunction with a medical service. When an immunization is the only service, performed, a minimal service may be listed in addition to the injection. Immunization procedures include reimbursement for the supply of materials and administration.

NOTE: The maximum fees for immunization injection codes are adjusted periodically by the State to reflect the current acquisition cost of the antigen . .

Reimbursement for drugs (including vaccines and immune globulins) furnished by practitioners for their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient . . . **Physician Services**

## **North Carolina**

### **Vaccines/Toxoids**

**90632** Hepatitis A vaccine, adult dosage, for intramuscular use, 1 ml Fee \$57.83

**90707** Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use

**90716** Varicella virus vaccine, live, for subcutaneous use, 0.5 ml Fee \$61.52

**90718** Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular or jet injection, 0.5 ml Fee \$10.35

**90732** Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use, 0.5 ml.

**August 2002 North Carolina Medicaid Bulletin**

## **North Dakota**

No information available

## **Ohio**

### **APN.1104. Immunizations . . .**

#### **APN.1104.1 General Information**

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, the lowest level of office visit (evaluation and management code) may be billed in addition to the immunization procedure code. Immunization procedure codes include the supply of materials and the provision of the vaccine . . .

#### **APN. 1104.7 Reimbursement**

The Medicaid maximum for each designated free vaccine code is limited to the lowest acquisition cost available to providers as determined by the Department plus two dollars twenty eight cents not to exceed the Medicare maximum for the vaccine. The department will pay the lesser of the provider's billed charge or the Medicaid maximum for the vaccine.

As long as the designated free vaccines are available free through an ODJFS/ODH interagency agreement and/or the Vaccines for Children (VFC) program, the provider's lowest acquisition cost for the designated free vaccines is zero and reimbursement for those vaccines will be limited to the maximum.

Effective July 1, 2003, the codes 90658, 90703, 90706, and 90718 . . .for adults over eighteen years of age, the codes will be reimbursed at the lesser of the provider's billed charge or the Medicaid maximum.

Immunizations are reimbursable as a physician or clinic service only if the immunization was provided in a nonhospital setting.

Immunization administered in a hospital setting are reimbursable only to a hospital billing on an institutional claim form/transaction.

Reimbursement is not available for the cost of designated free vaccines obtained from a source other than ODH.

Immunizations prescribed for residents of a Long-Term-Care Facility (LTCF) for subsequent administration by LTCF staff are reimbursable only to a pharmacy participating in the Medicaid program. **Ohio Medicaid Provider Handbook**

## **Oklahoma**

### **317:30-5-14. Injections**

. . .Administration of injections is paid in addition to the medication . . .

## **Oregon**

**90632** Hepatitis A Vaccine, Adult Dosage Pricing/Action Code 3 (Pay the lesser of: OMAP's Level 3 rate, times the quantity, or billed amt.)

**90659** Influenza Virus Vaccine, Whole V. Code 3.

**90707** Immunization Active; Measles, Mumps, Rubella. Code 3.

**90716** Immunization, Active, Varicella, Code 3.

**90718** Tetanus And Diphtheria Toxoids, Code 3.

**90732** Pneumococcal Polysaccharide Vacc, Code 3.

**90733** Immunization Active; Meningococ, Code 3.

**90746** Immunization, Active Hepatitis, Code 3. **Fee Schedule**

## **Pennsylvania**

**90632** Hepatitis A Vaccinem Adult Dosage Fee \$10.00

**90659** Influenza Virus Vaccine Fee \$10.00

**90707** Measles, Mumps, and Rubella Virus Vaccine (MMR) Fee \$10.00

**90716** Varicella Virus Vaccine Fee \$10.00

**90718** Tetanus and Diphtheria Toxoids Fee \$10.00

**90732** Pneumococcal Polysaccharide Vaccine Fee \$10.00

**90733** Meningococcal Polysaccharide Vaccine Fee \$10.00

**90746** Hepatitis B Vaccine Fee \$10.00

**Rhode Island**

**Pneumonia and Influenza Immunizations/Age 21 and over . . .**

A. When a vaccine is administered during an office visit, the serum can be billed along with the office visit. The administration of the vaccine, however, is included in the office visit and cannot be billed separately . . .

B. If the recipient is only receiving the vaccine, without an office visit, both the vaccine and the administration can be billed. When billing for the vaccine . . .

. . . Immunization codes (90700-90749) are no longer reimbursable through the Rhode Island Medical Assistance Program. All immunizations are considered to be part of the fee for the office visit at which the immunization was administered. When it is not possible to administer a vaccine as part of the first office visit and the patient must return to the office for a second visit, the office/clinic may be billed with procedure code 99211.

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**South Carolina**

**90632** Payment \$40.18 . . . **90659** Payment \$4.92 . . . **90732** Payment \$11.19 . . . **90733** Payment \$47.65 . . . **90746** Payment \$40.22 ***Medicaid Payment Schedule – Physicians***

**South Dakota**

**90471** Immunization Administration (Includes Percutaneous, Intradermal, Subcutaneous, Intramuscular, and Jet Injections and/or intranasal or oral administration); One vaccine (single or combination vaccine/toxoid) . . . \$7.00

**90472** Immunization Administration (Includes Percutaneous, Intradermal, Subcutaneous, Intramuscular, and Jet Injections and/or intranasal or oral administration); One vaccine (single or combination vaccine/toxoid); Each additional vaccine (single or combination/vaccine/toxoid) (List separately in addition to co . . .) . . . \$7.00

**90645** Hemophilus Influenza B Vaccine (HIB), HBOC Conjugate (4 does schedule) . . . \$7.00

**90646** Hemophilus Influenza B Vaccine (HIB), PRP-D Conjugate, For Booster . . . \$7.00

**90647** Hemophilus Influenza B Vaccine (3 does schedule) . . . \$7.00

**90648** Hemophilus Influenza B Vaccine (4 dose schedule) . . . \$7.00

**90658** Influenza Virus Vaccine, Split Virus, 3 Years and Above Dosage . . . \$9.00

**90659** Influenza Virus Vaccine, Whole Virus . . . \$9.00

**90700** Diphtheria, Tetanus Toxoids, and Acellular Pertussis Vaccine (DTAP) . . . \$7.00

**90701** Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis Vaccine (DTP) . . . \$7.00

**90704** Mumps Virus Vaccine, Live . . . \$7.00

**90705** Measles Virus Vaccine, Live . . . \$7.00

**90706** Rubella Virus Vaccine, Live . . . \$7.00

**90707** Measles, Mumps, and Rubella Virus Vaccine (MMR), Live . . . \$7.00

**90710** Measles, Mumps, Rubella, and Varicella Vaccine (MMRV), Live . . . \$7.00

**90716** Varicella Virus Vaccine, Live . . . \$44.68

**90718** Tetanus and Diphtheria Toxoids (TD) . . . For use in individuals seven years or older . . . \$7.00

**90719** Diphtheria Toxoid . . . \$7.00

**90720** Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis Vaccine And Hemophilus Influenza B Vaccine (DTP-HIB) \$7.00

**90721** Diphtheria, Tetanus Toxoids, And Acellular Pertussis Vaccine and Influenza B Vaccine (DTAP-HIB) \$7.00  
**90732** Pneumococcal Polysaccharide Vaccine . . .Adult or Immunosuppressed Patient Dosage . . . \$20.00  
**90733** Meningococcal Polysaccharide Vaccine (Any Group(s)) . . . \$54.60  
**90746** Hepatitis B Vaccine, Adult Dosage . . . \$34.28  
**90747** Hepatitis B Vaccine, Dialysis or Immunosuppressed Patient Dosage (4 dose schedule) . . . \$7.00  
**90749** Unlisted Vaccine/Toxoid \$7.00

### **Tennessee**

No information available

### **Texas**

**90659** Flu Vaccine, Whole . . .Access Based or Whole Fee \$4.01  
**90732** Pneumococcal Vaccine . . .Access Based or Whole Fee \$11.81  
**90746** Hep B Vaccine, Adult, IM . . .Access Based or Whole Fee \$57.99

### **Utah**

. . .b. Immunization codes include:

(1) 90471-90473 Administration fee

(2) Covered immunizations agents . . . ***Utah Medicaid Provider Manual***

### **Vermont**

Vermont Social Welfare . . . Medicaid . . . M610 Physician Services (Medicaid) . . .

Payment for a service rendered by a physician (M.D. or D.O.) will be made at the lower of: The actual charge for the service; or the Medicaid reimbursement rate on file.

Routine . . . immunizations . . . are covered . . . Supplies used in connection with a physician's treatment are not subject to separate reimbursement. Some examples of these supplies are tongue depressors, dextrosticks, bandages, antiseptics, and other consumable items . . . ***Physicians Services (Medicaid) Bulletin No. 91-31. p 1***

### **Virginia**

Vaccines Not Available Under VFC . . .

Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for Dialysis Patients . . . Medicaid will reimburse for the acquisition cost for these vaccines. . . . No administration fee will be reimbursed under . . . since this vaccine is not available under VFC.

### **Washington**

#### **Immunizations-Adults**

. . . Immunizations materials are reimbursed at MAA's established Maximum Allowable Fee (MAF). Bill administration CPT codes 90471 and 90472 in addition to the immunization materials.

Do not bill and E&M procedure with an administration unless there is a separate identifiable diagnosis from the administration . . .

. . .MAA will reimburse a maximum of \$8.00 when: More than one vaccine is administered and Both CPT codes 90471 and 90472 are billed . . . ***Physician-Related Services***

### **West Virginia**

Immunizations: Vaccines listed below are covered by West Virginia Medicaid. . . . the CPT codes include the serum and administration. . . . Specific coverage information follows the list of covered immunizations. . . . 90707 . . . 90716 . . . 90718 . . . 90732 . . . 90733. ***p 50, 51***

### **Wisconsin**

. . .Wisconsin Medicaid's reimbursement for . . .immunizations . . .includes reimbursement for the administration of the immunizations . . . ***Physician Services Handbook***

### **Wyoming**

#### **Vaccines, Toxoids – 90471-90749**

Procedure codes 90476-90478 identify the vaccine product only and are reported in addition to the immunization administration codes 90471-90472 . . . ***Medical Services Covered Services and Limitations Module, June 2002***

**APPENDIX IV - ACIP RECOMMENDED IMMUNIZATIONS:  
CPT CODES AND DESCRIPTIONS**

90632	Hepatitis A vaccine, adult dosage for intramuscular use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
90707	Measles, mumps and rubella virus vaccine (MMR) live, for subcutaneous or jet injections use
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals seven years or older, for intramuscular or jet injection
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older,
for	subcutaneous or intramuscular use.
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injection use
90746	Hepatitis B vaccine, adult dosage for intramuscular

## APPENDIX V – ACIP LIMITATIONS

### 1) Tetanus-Diphtheria

- a) No limitations identified
- b) 1 dose every 10 years for all age groups

### 2) Influenza

- a) Ages 19—49 Limitations
  - i) Medical
    - (1) Disorders of cardiovascular system
    - (2) Diabetes
    - (3) Renal dysfunction
    - (4) Immunosuppression
    - (5) Women in 2-3 trimester of pregnancy during flu season
  - ii) Occupational
    - (1) Health care workers
    - (2) Residents of nursing homes and other long-term care facilities
    - (3) Persons who are likely to transmit to those who are at high-risk
    - (4) Anyone who wishes to be vaccinated
- b) Ages 50 +
  - i) No limitations identified
  - ii) 1 dose every year

### 3) Pneumococcal

- a) Ages 19-64
  - i) Medical indications
    - (1) Disorders of cardiovascular system (excluding asthma)
    - (2) Diabetes
    - (3) Liver disease as the result of alcohol abuse
    - (4) Asplenia
    - (5) Immune-suppression
  - ii) Geographic
    - (1) American Indian/Alaska Native
  - iii) Occupational
    - (1) Residents of nursing homes and other long-term care facilities
  - iv) Revaccination: one-time after 5 years with medical indications
- b) Ages 65+
  - i) One dose for unvaccinated person
  - ii) One dose revaccination (if vaccinated more than 5 years before)

### 4) Hepatitis B

- a) All Adult Age groups
  - i) 3 doses for all persons with medical, behavioral, occupational or other indications
    - (1) Medical
      - (a) Hemodialysis patients
    - (2) Behavioral
      - (a) Injection-drug user
      - (b) Persons with >1 sex partner during last 6 months
      - (c) Recently acquired STD's
      - (d) All clients in STD clinics
      - (e) MSM



- (3) Occupational
  - (a) Health care and public safety workers
  - (b) Persons in training schools for medicine
  - (c) Dentistry, nursing, lab techs
  - (d) Allied health professionals

## 5) Hepatitis A

- a) All Adult Age groups
  - i) 2 doses for persons with medical, behavioral occupational or other indications
    - (1) Medical
      - (a) Clotting factor disorder or chronic liver disease
    - (2) Behavioral
      - (a) MSM
      - (b) Drug users
    - (3) Occupational
      - (a) Persons working with Hep. A infected primates
    - (4) Other
      - (a) Traveling or working in countries that have high endemic rates

## 6) MMR

- a) Ages 19-49 (catch up on childhood vaccines.) Not required for 50+
  - i) 1 dose if MMR vaccine is unreliable
  - ii) 2 doses for persons with occupational, geographic, other indications
    - (1) Occupational
      - (a) Health care workers
    - (2) Geographic
      - (a) Travelers to countries in which measles is endemic
    - (3) Other
      - (a) Pregnant and susceptible—vaccinate early in postpartum period as possible

## 7) Varicella

- a) All adult age groups
  - i) 2 doses for persons who are susceptible
    - (1) No history of varicella
    - (2) Health care workers
    - (3) Family contacts
    - (4) Immune-suppressed
    - (5) Environments in which infection likely (teachers, college students, inmates, etc.)
  - ii) Do not vaccinate pregnant women or those wanting to get pregnant in next 4 weeks

## 8) Meningococcal

- a) All adult age groups
  - i) 1 dose for persons with medical or other indications
    - (1) Asplenia
    - (2) Travelers to countries where endemic
    - (3) Counsel college freshmen about getting vaccination