# Update on Billing and Coding Task Group

May 1, 2025



### Introduction

- Billing and coding task group met at August 2024 NAIIS in-person meeting
- Identified priority areas impacting providers' ability to implement CDC vaccine recommendations and challenges with respect to payment
- Meet monthly to discuss priorities for the task group
- Tools developed/updated at <a href="www.izsummitpartners.org/naiis-workgroups/billing-coding-payment-taskgroup/">workgroups/billing-coding-payment-taskgroup/</a>.



### Billing and Coding Task Group Members

- Mitchell Finkel
- Carolyn Bridges
- Mitch Rothholz
- Abby Bownas
- Lisa Foster
- Alessandra Fix
- Jon Pohlers
- Brigid Grover
- Mary Soliman
- LJ Tan
- Katheryne Murray

- Jennifer Tinney
- June Fisher
- Sri Parajuli
- Amy Walker
- Katie Pischke
- Jenny Galbraith
- Heather Richmond
- Emman Parian
- Jacqueline Doyle
- Katie Mahuron
- Becky Neudecker
- Kate Mehring
- Leena Scaria

- Eric Crumbaugh
- Elizabeth Sobczyk
- Sarah Price
- Lana Hudanick
- Carolina LeCours
- Lisa Robertson
- Thomas Acciani
- Tiffany Tate
- Erica DeWald
- Michelle Fiscus
- Carolyn Parry
- Ronald Balajadia
- Karyn Lyons



### Challenges and Gaps Identified in Aug 2024

- Declines in confidence by providers that payments for vaccines and vaccine administration or dispensing fees will cover costs
  - May be leading to fewer providers offering vaccines and reducing access
  - Lack of transparency regarding costs and payments
  - Administration fees / dispensing fees vary widely
  - Clawbacks reported
- Pharmacy benefits management organizations (PBMs) increasingly lowering payments to pharmacists for vaccines and dispensing
  - Already resulting in decreased hours of operation or closing of some pharmacies
- Delays in updates to vaccine payments with new vaccines or new formulations
- Challenges with LTCF patient and staff vaccination after COVID, esp. Part A stay patients and uninsured staff
- Continued challenges with Medicare B vs D vaccines depending on setting
- Lack of CPT code for vaccine counseling for adults when no vaccine administered



### Actions of Billing and Coding WG and Partners

- Updates made to pharmacy and medical billing guidance on website
- Algorithms and guidance updated to emphasize
  - Need to work with in-network providers
  - Hepatitis B vaccine now in part B
  - Contacting manufacture assistance programs
- White paper on billing and payment issues for Community Health Centers/FQHCs updated from 2017 led by Sarah Price and NACHC and published in January 2024.
   <a href="https://www.izsummitpartners.org/content/uploads/2024">www.izsummitpartners.org/content/uploads/2024</a> Adult Immunization White Paper Updated.pdf.
- White paper on billing and payment issues facing LTCF for staff and residents in progress
  - Work led by Elizabeth Sobczyk at PALT-MED
- Collecting additional data on main reasons for claims rejection
  - Jennifer Tinney and TAPI
  - Mitchell Finkel at Avalere Health
- New pilot project on NAIIS website to receive and have WG review reports of vaccine payment issues.

## Jennifer Tinney – Update on Common Reasons for Claims Rejection





- 1. Advocate for inclusion of local health departments as in network providers
- 2. Monitor private/public vaccine reimbursement for all vaccines and providers.

Jennifer Tinney, TAPI

### vaccine payment challenges





Medicare Part A, B, D & who can vaccinate where?

(Non-traditional billing systems dental, LTC)



### Plan specific snags

(Combo vaccines,
Preauth, coordination of
benefits, age, shared
clinical, Federal to
private)



# Low margins on private vaccines

(Lower for NP's, pharmacy)



### New vaccine payment lag

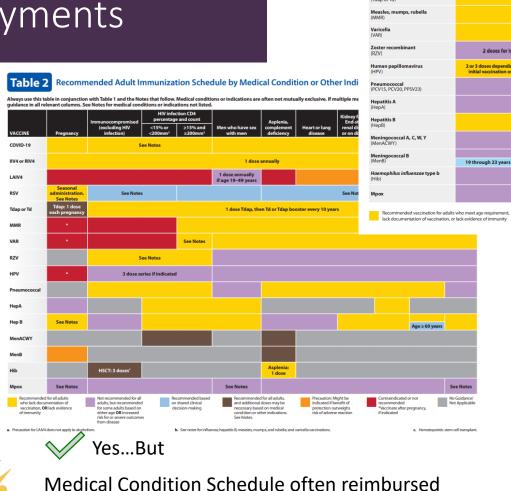
(ACA 1 year+, typically 6 months for code changes)



### Limited networks

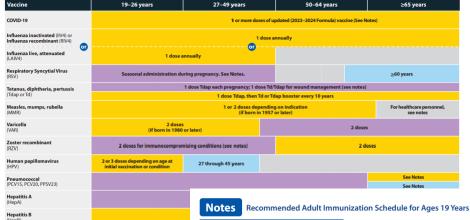
(Few PCP's that carry vaccines. Out of network payments. Even Medicare)

### footnotes, algorithms & payments



but requires additional documentation.

Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2024





Age-Based Schedule usually reimbursed by most plans.

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2024

#### laemophilus influenzae type b vaccination

#### Special situations

- Anatomical or functional asplenia (including sickle cell disease): 1 dose if previously did not receive Hib vaccine: if elective splenectomy, 1 dose preferably at least 14 days before splenectomy.
- · Hematopoietic stem cell transplant (HSCT): 3-dose series 4 weeks apart starting 6-12 months
- after successful transplant, regardless of Hib vaccination history

#### **Hepatitis A vaccination**

· Any person who is not fully vaccinated and requests

vaccination (identification of risk factor not required) 2-dose series HepA (Havrix 6-12 months apart or Vaqta 6-18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months)

#### Special situations

- · Any person who is not fully vaccinated and who is at risk for hepatitis A virus infection: 2-dose series HepA or 3-dose series HepA-HepB as above. Risk factors for hepatitis A virus infection include
- Chronic liver disease (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)

#### - HIV infection

- Men who have sex with men Injection or noninjection drug use
- Persons experiencing homelessness
- Work with hepatitis A virus in research laboratory or with nonhuman primates with hepatitis A virus infection

#### Travel in countries with high or intermediate endemic hepatitis A (HepA-HepB [Twinrix] may

- be administered on an accelerated schedule of 3 doses at 0. 7, and 21-30 days followed by a booster dose at 12 months)
  - Close, personal contact with international adopted (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before
  - adoptee's arrival) Pregnancy if at risk for infection or severe outcome from infection during pregnancy
  - Settings for exposure, including health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

#### lepatitis B vaccination

#### **Routine vaccination**

- Age 19 through 59 years: complete a 2- or 3- or 4-dose series
- 2-dose series only applies when 2 doses of Heplisav-B\* are used at least 4 weeks apart
- 3-dose series Engerix-B, PreHevbrio\*, or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks])
- 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2:
- 4 weeks / dose 2 to dose 3: 5 months] 4-dose series HepA-HepB (Twinrix) accelerated
- schedule of 3 doses at 0, 7, and 21-30 days, followed by a booster dose at 12 months
- \*Note: Heplisav-B and PreHevbrio are not recommended in pregnancy due to lack of safety data in pregnant persons.

- Age 60 years or older without known risk factors for hepatitis B virus infection may receive a HepB vaccine series.
- · Age 60 years or older with known risk factors for henatitis B virus infection should receive a HenR vaccine series
- · Any adult age 60 years of age or older who requests HepB vaccination should receive a HepB vaccine

#### Risk factors for hepatitis B virus infection include:

· Chronic liver disease e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase (ALT) or aspartate aminotransferase (AST) level greater than twice the upper limit of normal

#### **HIV** infection

- Sexual exposure risk e.g., sex partners of hepatitis B surface antigen (HBsAg)-positive persons, sexually active persons not in mutually monogamous relationships, persons seeking evaluation or treatment for a sexually transmitted infection men who have sex with men
- Current or recent injection drug use

#### Percutaneous or mucosal risk for exposure

- to blood e.g., household contacts of HBsAgpositive persons, residents and staff of facilities for developmentally disabled persons, health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; persons on maintenance dialysis (including in-center or home hemodialysis and peritoneal dialysis), persons who are predialysis, and patients with diabetes\*
- Incarceration Travel in countries with high or intermediate endemic hepatitis B
- \*Age 60 years or older with diabetes: Based on shared clinical decision making, 2-, 3-, or 4-dose series



Footnotes rarely get through algorithms. 2 Require appeals for payments 128 months fix.9

### Mitchell Finkel – Updates to Medical Coding

- 1. Avoid Common Errors
- 2. Coding for Time for Vaccine Counseling

#### **Avoiding Common Errors:**

www.izsummitpartners.org/content/uploads/NAIIS Top-10-questions 2025.pdf

#### **CPT Scenarios:**

www.izsummitpartners.org/content/uploads/CPT ScenariosUpdate 2023.pdf/.



### **Avoiding Common Errors**

 Updated led by Mitchell Finkel, June Fisher, and Jennifer Tinney



### Top Questions for Medical Benefit Coding and Billing for Vaccines: Avoiding Common Errors

The Summit has compiled billing issues from partners and reviewed publications on adult vaccine billing to develop the following Top Questions associated with coding and billing for adult vaccines. Some pediatric vaccine billing information is also included. An algorithm describing overall vaccine coverage by insurance type, additional information on CPT coding for vaccine counseling, and detailed information regarding U.S. vaccine insurance coverage policy and reimbursement policy are available.

2. What is the CPT code for vaccine "x"? What is the correct NDC for vaccine "x"? How should the claims form be completed?

#### A. BILLING FOR VACCINE ADMINISTRATION:

Proper Current Procedural Technology (CPT) codes for the vaccines administered, as well as for the vaccine administration service, must be used on claim forms. The vaccine CPT codes can be found on the <a href="CDC">CDC</a> website.



### **CPT Coding Case Scenarios**

Developed in 2021
 with AMA when
 physician fee schedule
 was updated. Includes
 information on
 medical billing for
 prolonged visits that
 may include vaccine
 counseling.

### Adult Current Procedural Terminology® Coding Case Scenarios¹



#### Background

This document provides case studies designed to help providers, who use the CMS 1500 form or the electronic equivalent, with appropriate coding and billing of vaccinations for adult patients for a range of scenarios.

Billing and coding for vaccine counseling for people 18 years and older differs from those less than 18. When a qualified healthcare provider (QHP) counsels a patient younger than 18 years of age, the counseling time is incorporated into the immunization administration code (e.g., 90460). When a QHP counsels a patient age 18 years or older, the counseling time needs to be coded separately.

In an effort to address the continuing problem of administrative burden for physicians in nearly every specialty, recent changes to the Evaluation and Management (E/M) office visit Current Procedural Terminology (CPT®)<sup>2</sup> codes (99201-99215) code descriptions and documentation standards have been approved for use by the American Medical Association (AMA) and were finalized in the 2020 Medicare Physician Fee Schedule Final Rule, effective 2021. These new codes, effective January 1, 2021, are designed to be more intuitive and reduce administrative burden by removing complex counting systems for history, exam and data.<sup>3</sup> A chart of the codes prior to the change relative to the current change is provided in *Appendix* 1.



### Pharmacy Billing

 Updates to pharmacy billing and algorithm led by Eric Crumbaugh.

www.izsummitpartners.org/content/uploads/NAIIS Pharmacy-Billing.pdf.



#### **Summary of Vaccine Coverage Through the Pharmacy**

Insurer	Vaccine Type	Bill to Medical or Pharmacy Benefit	Notes
Medicare Part B	Influenza	Medical	
	Pneumococcal	Medical	
	COVID-19	Medical	
	Hepatitis B	Medical	Starting January 1, 2025, Part B will cover hepatitis B vaccination for those without a completed hepatitis B vaccination series or whose vaccination history is unknown. A physician's order will no longer be required for hepatitis B vaccination under Part B, which will facilitate roster billing by mass immunizers.
Standalone Medicare Part D Plan	All ACIP-recommended vaccines (covered with no cost-sharing to the patient) except those covered by Medicare Part B (influenza, pneumococcal, COVID-19, and hepatitis B vaccines administered by in-network providers.	Pharmacy	Medicare Part D covers ACIP-recommended vaccines not covered by Part B, including shingles vaccine, and Td/Tdap vaccines for prevention. Td/Tdap vaccine for wound management is covered by Medicare Part B.
Medicare Advantage Plans with Part D Benefits (MAPD)	All ACIP-recommended vaccines covered with no cost-sharing to the patient when administered by an in-network providers.	Pharmacy or Medical	Depending on MAPD, vaccine claims may be submitted via:  • pharmacy claim (Part D or similar plan)  • medical plan (not the traditional Part B roster billing)
State Medicaid Plans	Effective October 1, 2023, all ACIP-recommended vaccines must be covered with no cost-sharing to the patient when administered by an in-network providers.	Medical or Pharmacy	Depending on the state, the Medicaid plan may either be administered by the state (FFS) or a private plan (Managed Care). FFS and Managed Care Medicaid plans may have different policies about whether a pharmacy can bill for vaccines and vaccinations and if they are covered under the medical benefit, pharmacy benefit, or both.  If vaccines are only covered under the medical benefit, pharmacists may need to be credentialed as providers (this includes FFS and Managed Care plans).
Commercial/ ACA/Employee- Sponsored Plans <sup>1</sup>	All ACIP-recommended vaccines, with no cost-sharing for the patient when administered by in-network providers.	Medical or Pharmacy	Some plans allow vaccines to be billed as a prescription; however, some limit this benefit to medical plans only.
Selected National Health Plans			
Tricare	All ACIP-recommended vaccines, with no cost-sharing for the patient	Medical or Pharmacy	
Federal Blue Cross Blue Shield	All ACIP-recommended vaccines, with no cost-sharing for the patient	Medical or Pharmacy	

ACA requirements do not apply to "grandfathered" plans and therefore covered individuals may have cost sharing for recommended vaccines.

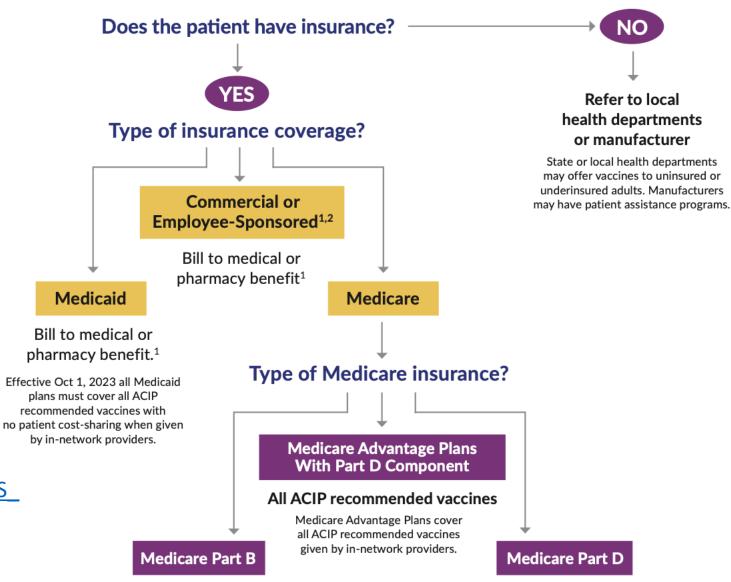
### Billing Algorithm

 Updates to remove references to COVID-19 Bridge Program, and move hepatitis B all to Part B.

www.izsummitpartners.org/content/uploads/NAIIS\_ Vaccine-insurance-coverage-2024-2025.pdf.



#### PATIENT NEEDS VACCINE



### Influenza, pneumococcal, COVID-19, Hepatitis B

Tetanus (Td or Tdap) vaccines are covered under Medicare Part B only for wound management.

Influenza, pneumococcal, COVID-19, and hepatitis B vaccines are eligible for roster billing.

### All ACIP recommended vaccines except those covered by Part B

Medicare part D also covers Td/Tdap vaccines not for wound management.

### Vaccine Payment Challenges Reports - Pilot Project

- Provider payment challenges often reported anecdotally
- Recently, change from QIV to TIV influenza vaccine formulations, introduction of RSV vaccines, and newly approved or expanded indications for some vaccines brands further highlighted challenges with claims denials and long delays after ACIP vaccine recommendations and FDA approvals for vaccines included in existing ACIP recommendations

#### Report Vaccine Payment Challenges

The NAIIS Billing and Coding Work Group is seeking information regarding vaccine billing challenges experienced by providers and their organizations in order to help identify and address payment issues with vaccine providers and payers. This is a pilot project to identify specific examples of payment challenges which the NAIIS work group will review to identify ways in which we can help vaccine providers and work with all partners to reduce payment challenges.

DO NOT REPORT ANY Patient Personal Identifiers (including patient record numbers or contact information).

**Reporting Form** 



### Vaccine Payment Challenges Reports - Pilot Project

#### Issues reported

- Multiple payers/plans denying a second dose of COVID-19 vaccine for persons with eligibility for 2<sup>nd</sup> dose based on CDC clinical considerations. Payer noting that FDA PI does not include twice yearly vaccination.
- Claims denials for hepatitis B vaccination using Part B even though CMS issued a rule in the fall that this change would take place January 1.
- Vaccine payment by insurer is lower than purchase cost, especially when the payer does not update their contract payment amounts in a timely manner. E.g., a state Medicaid agency updates their fee schedule in July 2024. In August 2024, G9 list price increased, but the state Medicaid will not review pricing until July 2025.
- Pneumococcal examples:
  - PCV21 not being covered by a commercial insurer.
    - Delays in paying for pneumococcal vaccine for newly recommended 50-64 age group.

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### Vaccine Coding and Billing Task Group

- Next Steps
  - Task group meeting during NAIIS in-person meeting in breakout session on May 14.
    - Will review activities and learnings over the year
    - Discuss which activities to prioritize in 2025-26
  - Priorities include:
    - Expanding understanding of the many systems, organizations and processes that impact the timeliness for providers to receive payment after administering vaccines in accordance with ACIP recommendations with FDA approved vaccines.
    - Developing templates for providers responding to payment issues when ACIP recommendations have been followed.
- Any NAIIS in-person attendee welcome to join breakout discussion!
  - Will include additional discussion of PBM's, reported billing and coding challenges and responses, and identification of other priority issues.

