WASHINGTON STATE CVP
Childhood Vaccine Program
Office of Immunization | (360) 236-2829 | doh.wa.gov/cvp | wachildhoodvaccines@doh.wa.gov

Washington State Department of HEALTH

Childhood Vaccine Program Training Series | Eligibility & Billing Q&A March 27, 2025

General

How can I request one-on-one assistance with billing issues or questions?

Contact the Childhood Vaccine Program (CVP) at WAChildhoodVaccines@doh.wa.gov or (360) 236-2829. Depending on the type of question or issue, we may refer you to Medicaid or the Washington Vaccine Association for additional assistance.

Eligibility Screening

How can staff differentiate between traditional Medicaid/Medicaid Managed Care and CHIP/CHP coverage & what codes identify a child enrolled in CHIP or CHP?

Verifying the child's coverage in the ProviderOne billing system is the best way to determine which Apple Health plan a child is enrolled in. See pg. 4 of the CVP Eligibility Guide for instructions on how to identify patients enrolled in CHIP or CHP.

Identify insurance type by their Recipient Aid Category (RAC) code and ACES Coverage Group code. See table below for CHIP/CHP RAC and ACES codes.

RAC Code	ACES Coverage Group Code	Description
1206, 1207	N13	Child is less than 19 years old, and is in Children's Health Insurance Program (CHIP)
1211, 1212, 1213	N31, N33	Child is less than 19 years old, and is in Washington State Child Health Insurance Program (CHP)

What eligibility status should be documented when a patient has dual insurance coverage (e.g. Private Insurance and Medicaid)?

When a patient has private/commercial insurance and Medicaid, the eligibility status should be documented as Private Insurance and a dosage-based assessment (DBA) should be submitted the insurer, payable to the Washington Vaccine Association (WVA).

If coverage is denied, then Medicaid can be billed as the secondary insurance following Medicaid guidelines (see the most current EPSDT billing guide, section titled *"How do I bill for free vaccines for clients age 18 and younger?"*).

What eligibility status should be documented for patients under 19 with TRICARE coverage?

The eligibility status should be documented as Private Insurance, and a DBA should be submitted.

Is First Choice a Medicaid Managed Care Plan (i.e. state insurance) or Private Insurance?

First Choice is considered a private/commercial insurer. They are not a contracted Medicaid managed care plan. For patients under 19 enrolled in a First Choice plan, document their eligibility status as Private Insurance and submit a DBA to the insurer.

A list of Medicaid Managed Care Plans is in the CVP Eligibility Guide (see pg. 1 under Medicaid).

Private Insurance & Dosage-Based Assessments

Is a provider still required to submit dosage-based assessments (DBAs) to TRICARE, even when out-of-network?

Yes, DBAs must be submitted when a patient under 19 is enrolled in TRICARE or another private/commercial insurance and receives vaccine supplied through the Childhood Vaccine Program, even when the provider is out-of-network with the patient's insurer.

If a provider is out-of-network with the patient's insurer, should the patient be charged out-of-pocket for vaccine administration and then bill the DBA?

If the patient's commercial insurance does not cover the vaccine administration fee due to a deductible or out of network provider, the patient can only be billed up to $23.44 per vaccine out-of-pocket for the administration fee. The patient can only be billed once within 90 days of service and any unpaid administration fees cannot be sent to collections.

The vaccine DBA should still be submitted to the insurer in this case. However, it may help to notify patients with out-of-network coverage that they are not responsible to pay any portion of the vaccine-specific costs on a DBA if the insurer denies payment.

What administration code(s) should be billed when counseling is provided?

When billing private/commercial insurers for vaccine administration with counseling, providers should bill CPT code 90460 for the first vaccine or component of a combination vaccine administered. CPT code 90461 should be billed for additional components of a combination vaccine administered during the same encounter.

Additional administration codes:

- 90480: Administration of COVID vaccine
- 96380: Administration of RSV, monoclonal antibody, with counseling
- 96381: Administration of RSV, monoclonal antibody

Remember: The 90460-90461 administration codes cannot be billed to Medicaid. Providers can only bill Medicaid for administration CPT codes 90471-90474 and the additional codes listed above for COVID and RSV (Nirsevimab) administration.

Medicaid/Medicaid Managed Care Billing

What changed with Medicaid billing as of July 1, 2024?

Effective July 1, 2024, Medicaid started requiring providers to bill administration codes (e.g. 90471), along with the vaccine CPT code and SL modifier to receive full reimbursement of administration and administrative costs related to vaccines supplied through the Childhood Vaccine Program.

Previously, Medicaid only required providers to bill the vaccine CPT code along with the SL modifier.

Can a provider bill the 90461 & 90462 administration CPT codes to Medicaid?

No. Providers receiving vaccines through the Childhood Vaccine Program are not allowed to bill these administration codes to Medicaid.

See section titled *"How do I bill for stand-alone vaccine counseling?"* in the Medicaid EPSDT guide for instructions on billing for vaccine counseling. Vaccine counseling cannot be billed on the same date of service as an EPSDT well-child visit.

When should a provider bill administration CPT code 90471 vs 90473?

Typically, the 90471 CPT code is billed for the first vaccine administered, then 90472 for each additional vaccine given during the encounter.

90473 should only be billed when administering an oral (e.g. Rotavirus) or intranasal (e.g. FluMist) vaccine.

Are providers required to bill Medicaid a set fee amount for administration CPT codes?

Sites can bill administration fees to Medicaid based upon their general fee schedules. However, Medicaid will only pay up to their allowed amount for vaccine administration. Any remaining balance must be written off and cannot be billed to the patient.

See Medicaid's current Enhanced Pediatric Fee Schedule for the maximum allowed amounts for administration and vaccine CPT codes billed with the SL modifier. See the heading titled *"Enhanced Pediatric Fee Schedule"* under Physician-Related/Professional Services at the link above to locate the current fee schedule.