American Academy of Pediatrics
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Frequently Asked Questions for the Pediatric Immunization Administration Codes

For information on Coding COVID IA, refer to our COVID Vaccine Resource site

Were codes 90465–90468 replaced? If so, what are the replacement code numbers and descriptors?
Yes, codes **90465–90468** were replaced with codes **90460** and **90461.**

90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

+90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure.)

Code **90460** is reported once for the first component of each vaccine or toxoid administered by any route. The reporting of code **90460** includes counseling for the first vaccine component. Code **90461** is additionally reported for the counseling associated with

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each additional component of any combination vaccine or toxoid.

The **+** symbol next to code **90461** indicates that it is an add-on code, just like **90466** was an add-on code to **90465** and **90468** was an add-on code to **90467.** An add-on code (ie, **90461)** can only be reported in conjunction with the primary code (in this case, **90460).**

How does *CPT* define a vaccine *component?*

A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined above.

How many components are in the common pediatric vaccines and which pediatric IA codes would I report with each?

Please see the following chart:

Vaccine	No. of Vaccine Components	Immunization Administration Code(s) Reported
HPV	1	**90460**
Influenza	1	**90460**
Meningococcal	1	**90460**
Pneumococcal	1	**90460**
Rotavirus	1	**90460**
IPV	1	**90460**
Hib	1	**90460**
Td	2	**90460, 90461**
DTaP or Tdap	3	**90460, 90461, 90461**
MMR	3	**90460, 90461, 90461**
DTaP-IPV/Hib (Pentacel)	5	**90460, 90461, 90461, 90461, 90461**
DTaP-HepB-IPV (Pediarix)	5	**90460, 90461, 90461, 90461, 90461**
DTaP-IPV (Kinrix)	4	**90460, 90461, 90461, 90461**
MMRV (ProQuad)	4	**90460, 90461, 90461, 90461**

HPV, human papillomavirus; Td, tetanus and diphtheria; DTaP, diphtheria, tetanus, and acellular pertussis; Tdap, tetanus, diphtheria, and acellular pertussis; MMR, measles, mumps, and rubella; Hib, *Haemophilus influenzae* type b; IPV, inactivated poliovirus; HepB, hepatitis B; MMRV, measles, mumps, rubella, and varicella.

How are the pediatric IA codes (90460–90461) different from the non-age specific IA codes (90471-90474)?

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Please see the following chart:

	Pediatric IA Codes	Non-Age Specific IACodes
	90460–90461	**90471-90474**
Reported per	Component	Immunization (single or combination)
Age restriction	18 years and younger	None
Counseling	Required by physician or other qualified health care professional[a]	None
Routes of administration	Use for all routes of administration.	Codes differ based on route of administration (eg, injectable versus intranasal).

[a]Note that *Current Procedural Terminology* now defines the term "other qualified health care professional" refer to the next question.

The IA codes specify that the counseling must be performed by a physician or "other qualified health care professional." What determines who qualifies as an "other qualified health care professional"?

This guideline was revised and clarified in the 2012 *CPT* manual. A "physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.

To report *CPT* codes **90460–90461,** the physician or the qualified health care professional who is reporting the service must perform face-to-face counseling (and so document that the counseling was personally performed).

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Some vaccines are given in a series—an initial dose and then one or more booster doses over a period of time. Is it a correct assumption that counseling codes 90460 and 90461 are only appropriate prior to the initial dose, and that further counseling sessions prior to the booster doses would *not* be required, only a vaccine administration code? *If* additional counseling is reportable for subsequent booster doses, why?

The decision for counseling will depend on patient and parent questions and concerns and not on the initial versus booster dose. For certain vaccines in a series, such as the human papillomavirus vaccine given to adolescents, the adolescent may return for subsequent doses to be administered by clinical staff, in which case counseling is unlikely to be provided and IA code **90471** would be reported instead of **90460.**

However, if the patient or parent has new questions or concerns at the return visit and the physician or other qualified health care professional is asked to address these concerns, it would be appropriate to report IA code **90460.** For infants who are receiving 3 doses of diphtheria, tetanus, and acellular pertussis (DTaP) in the first year of life, it is common for parents to be anxious and have questions and concerns at each visit. Parents hear stories from friends or read new information on the Internet and want to make sure that vaccines are safe even though the child may have already had a dose.

Do codes 90460-90461 require that the physician or the qualified health care professional perform the *actual administration* of the vaccine? In other words, do they have to be the ones to physically inject the patient with the vaccine in order to report the codes?
No, the physician or the qualified health care professional does not have to perform the actual administration of the vaccine in order to report codes 90460-90461. The administration (whether it is an injection or an oral/intranasal administration) can be performed by the clinical staff per the physician's or the qualified health care professional's orders.

Can codes 90460–90461 be reported even when the vaccine counseling occurs on a different date of service from the actual administration?

Vignette A
A physician or other qualified health care professional counsels a patient or parent on all vaccines needed during the annual preventive medicine service visit. Because the parent refuses multiple vaccines on the same day, the patient is on an alternative vaccine schedule and some of the vaccines are given over a series of visits. These subsequent visits are for vaccines only and the physician or other qualified health care professional does not see the patient or parent. Can codes 90460–90461 be reported on each day that vaccine(s) is administered?

Vignette B
A physician or other qualified health care professional counsels a patient or parent on vaccines during an office visit. However, because the patient is ill, vaccine administration is deferred at the parent's request until the patient's illness has resolved. Therefore, the vaccines are administered on a different day than the vaccine counseling. Can codes 90460–90461 be reported?

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No. *CPT 2012* currently states that codes **90460–90461** are reported when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. Because the situations in these vignettes essentially split the actual administration from the vaccine counseling into separate dates of service, codes **90460–90461** cannot be reported. In these situations, continue to report IA using codes **90471–90474** because they do not have explicit counseling requirements as part of their descriptors.

What constitutes sufficient documentation for vaccine counseling with these codes? Do we have to document counseling for each separate vaccine component?
CPT guidelines indicate that you must provide documentation to support the reporting of a given service. As an example, documentation should list all vaccine components along with a notation such as "counseling for all components completed." The documentation format (eg, check box, handwritten, electronic template, etc) for this service should be the same as it is for other services. Physicians and other qualified health care professionals can choose whatever format meets their needs as long as it is reflective of the service provided and is documented by the reporting clinician. Documentation should support the service provided and is not meant to be onerous. At the same time, payers may have their own rules on use of "auto-populated" or "pre-populated" templates that may not reflect actual services provided.

Will there ever be an occasion, given the guidelines for reporting pediatric IA codes (90460–90461), for which we would need to report 90471–90474?
Yes, if you see older patients (ie, those 19 years and older), there is no counseling performed on the patient, or the health care professional counseling does not meet the new CPT definition for an *other qualified health care professional,* such as clinical staff (eg, LPNs, RNs).

How will we report a patient encounter in which 2 injectable, single component vaccines are administered, yet counseling is only provided on 1 of the 2 vaccines? Will we report 90460 for the first (ie, counseled) vaccine and 90472 for the second (ie, non-counseled) vaccine?
Yes. If counseling is performed for one single-component vaccine but not another, code **90472** (or **90474** if the second, non-counseled vaccine is administered orally or intranasally) is reported for the non-counseled additional vaccine.

In a single encounter, can I report code 90460 more than once?
Yes, it is possible and allowable. Keep in mind that each vaccine administered is its own entity. Therefore, for each individual vaccine administered, you will report code **90460** because every vaccine will have at minimum one vaccine component. Because **90460** represents the first vaccine component of each vaccine, if you report **90460** in multiple units, you lose the ability to separately designate each vaccine administered during the course of a single patient encounter.

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Then, depending on the specific vaccine, code **90461** may be additionally reported if the vaccine is a multiple component vaccine.

For example, if you administer a measles, mumps, and rubella (MMR) vaccine and a varicella vaccine at the same encounter, you will report codes **90460, 90461,** and **90461** for the MMR vaccine and **90460** for the varicella vaccine.

What are the medically unlikely edits (MUEs), which are the maximum units per day for each vaccine administration code?

IA Code	MUE
90460	9
90461	8
90471	1
90472	4
90473	1
90474	1

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What National Correct Coding Initiative (NCCI) procedure to procedure edits impact immunization administration and other commonly reported codes in pediatrics?

CPT Code	**Paired With**	**Appropriate Coding**
99381-99395 (E/M)	**90460, 90461, 90471-90474**	Append modifier **25** to the **99381-99395**
99201-99205	**90460, 90461, 90471-90474**	Append modifier **25** to the **99201-99205***
99212-99215	**90460, 90461, 90471-90474**	Append modifier **25** to the **99212-99215***
90460	**90471**	No modifier to override; do not report together
90460	**90473**	No modifier to override; do not report together
90471	**90473**	No modifier to override; do not report together
96372	**90460, 90461, 90471-90474**	Append modifier **59** to **96372**

*Refer to our resource on when it is appropriate to report an E/M service in addition to the immunization administration codes

We have received multiple claim denials stating 90460 and/or 90461 is a "duplicate" service. How should we report the appropriate IA codes when a patient presents for her 2-month-old well-child check and given the DTaP-Hib-IPV (Pentacel®) vaccine, pneumococcal vaccine, and rotavirus vaccine in order to avoid denials?

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The limitations imposed by some claims processing systems may reject the multiple 90460 codes or multiple 90461 codes appearing on the same claim form as "duplicate claims." The following is what some payers have indicated will work with their systems:

A patient presents for her 2-month-old well-child check and given the DTaP-Hib-IPV (Pentacel®) vaccine, pneumococcal vaccine, and rotavirus vaccine:

First Claim Form:

	CPT descriptor	**CPT code**	**Units**
Line 1	DTaP-Hib-IPV (Pentacel®) vaccine	90698	1
Line 2	Pneumococcal vaccine	90670	1
Line 3	Rotavirus vaccine	90680	1
Line 4	First component administration for each vaccine	90460	3
Line 5	Each additional component administration for each vaccine	90461	4

Second Claim Form:

	CPT descriptor	**CPT code**	**Units**
Line 1	Preventive medicine service <1 year	99391	1

Be sure to increase your charges according to the number of units report for the 90460 and 90461.

Can the IA codes (90460–90461) be reported in the neonatal intensive care unit setting where the independent physician is providing face-to-face counseling and dissemination of information about the vaccine components but the hospital-employed nursing staff is providing the supplies and administering the vaccine?
No. Because this situation essentially splits the actual administration (as performed by facility-employed nurses) from the vaccine counseling (as performed by the physician), codes **90460–90461** cannot be reported.

The pediatric IA codes **(90460–90461)** are no different from their predecessor pediatric IA codes **(90465–90468)** in this regard. Because the Medicare Resource-Based Relative Value Scale values for the IA codes include the work (counseling), practice expense (clinical staff time, medical supplies, and medical equipment), and professional liability insurance expense, all 3 of these components must originate from one source for the codes to be able to be reported. In this situation, the facility is incurring practice expense while the physician is doing the work of vaccine counseling. Therefore, the codes cannot be reported. Again, this restriction is no different from the restriction in place with the previous pediatric IA codes **(90465–90468). Can codes 90460–90461 be reported for vaccines administered in the continuity clinic setting even when only the resident-in-training (education-limited license) does the vaccine counseling?**

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The IA service is unique. As such, the Physicians at Teaching Hospitals (PATH) guidelines do not specifically address this issue, and each academic center will need to determine the appropriate approach within its institution.

However, we can encourage each academic center to be compliant by

- Being aware of IA codes **90460–90461**
- Being aware of the lack of defined guidance for IA per se in the PATH guidelines
- Reaching out to local or regional public and private payers for specific guidance, as might be done with other services not addressed by the Centers for Medicare & Medicaid Services

What *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* codes should we report with the pediatric IA codes when vaccines are administered during a routine well-baby/infant/child check and at other encounters such as a follow-up?

Report **Z23** *encounter for immunization* regardless of when a vaccine is given. Note that there are not vaccine specific *ICD-10-CM* codes for different vaccines like there is in *ICD-9-CM*. You will report the **Z23** and link it to both the vaccine product and the vaccine administration code regardless of the type of encounter. There is a parenthetical after the **Z23** that states to report the **Z23** in addition to any well child ICD-10-CM codes. Therefore, when vaccines are given during a well child exam, you will report the well child exam code first (eg, Z00.129) followed by **Z23**.

I was surprised at the Medicare Resource-Based Relative Value Scale (RBRVS) practice expense values for code 90461, which is reported for each additional vaccine component and, therefore, does not represent much incremental practice expense beyond the first vaccine component.

The Centers for Medicare and Medicaid Services (CMS) did not accept the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values for the **90460-90461** codes and instead assigned what it felt to be a crosswalk to the former pediatric IA codes.

How do you charge vaccine administration fees for patients who qualify for the Vaccines for Children (VFC) program?

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The legislation that created the VFC program requires that the Secretary, Department of Health and Human Services, establish a limit on the amount of money that a provider can charge for the administration of vaccines to VFC-eligible children. The Final Rule released in November of 2012 set the current regional maximum fee per state. Therefore you may charge all VFC eligible patients for the administration of the vaccines but not the vaccines themselves. For those who qualify for Medicaid, you must defer to your Medicaid provider to determine how you can submit the *CPT* codes for payment. Some Medicaid plans require that you submit the *CPT* code for the product that you administered in order to be paid for the administration (which is not the most appropriate mode of submission), while most require that you submit the appropriate vaccine administration code (**90460, 90471-90474**) to be paid for the administration fee.

Note that under VFC, you may not be paid "per component" or under *CPT* code **90461**, however, *CPT* code **90460** should be the administration code of choice when most appropriate. While there may be some confusion surrounding this, note that *CPT* code **90461** is the only code excluded from payment under VFC.

Do the IA codes require that we submit vaccine registry data electronically?

No. While the vignette for all IA codes says, "…the immunization tracking number is entered into a computerized statewide registry," vignettes simply describe the typical patient and do not set requirements to report a code. Because the immunization registry reference is not included as part of the *CPT* code descriptor, use of an immunization registry is not required to appropriately report the IA codes.

How do we know what vaccine product is reported with what CPT code?

The AAP has developed a vaccine coding table that guides practices to choose the correct CPT code for the specific vaccine product. Please refer to the vaccine coding table.