Priority Health	BILLING POLICY No. 181
Immunizations	
Date of origin: 03/01/2026	**Review dates: None yet recorded**

DEFINITION

Immunization services are reimbursed in accordance with the members' specific benefit plan, applicable state and federal regulations and the providers contracted fee schedule. Coverage is subject to plan benefits, age limitations and established clinical guidelines.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Vaccine administration criteria that must be included in your documentation:

- Drug administered
- Dosage administered
- Location of vaccination

When billing for multiple vaccine administrations, you can either report administration add-on codes per line or report as multiple units on one line

Coding specifics

Initial administration coding

Only one initial administration code can be reported per day, regardless of vaccine administration method.

Initial administration of CPT codes 90460 (18 years and younger), 90471 and 90473 cannot be billed together on the same date of service.

When one of these initial administration codes is billed, report all additional vaccine/toxoid components administered with the appropriate add-on code (i.e. 90461, 90472 or 90474). Reference your CPT book for coding guidelines if you have additional questions.

When submitting a National Drug Code (NDC), confirm it's valid and matches the vaccine(s) administered.

Report codes 90460 and 90461 only when the physician or qualified health care professional provides **face-to-face counseling** of the patient/family during the administration of the vaccine.

Immunization administration of vaccine that is not accompanied by face-to-face counseling or patient over the age of 18, assign a code from range: 90471-90474.

A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism.

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

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.)

Immunization and administration codes reported with the following diagnosis codes will not be reimbursed.

- Z28.0- Z28.29 - immunization not carried out because of contraindication
- Z28.8- Z28.9 - immunization not carried out for unspecified reason

Claims will deny immunization administration (90460-90461, 90471-90474, 90480-90481) when billed without a vaccine/toxoid code (90476-90750, 90756, 90758, 90759, 91304, 91318-91322, Q2034-Q2039) by any provider on the same date of service. The AMA, CPT Manual and the HCPCS Level II Manual, immunization administration for vaccines and toxoids (90460-90461, 90471-90474, 90480-90481) must be reported in addition to the vaccine and toxoid codes (90476-90750, 90756, 90758, 90759, 91304, 91318-91322, Q2034-Q2039).

For Priority Health Medicaid, vaccines should be reported with a zero allowed amount for vaccines supplied though the State as part of the Vaccine for Children (VFC) program. See the Michigan VFC Provider Manual for additional detail.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Related policies

https://www.priorityhealth.com/provider/manual/services/preventive-care/vaccines

https://www.priorityhealth.com/provider/manual/services/preventive-care/medicare/medicare-vaccines

https://www.priorityhealth.com/provider/manual/services/preventive-care/flu-vaccines

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
March 2026	Added new code