

**CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.**

## Immunizations

This section outlines policy related to billing for immunization services.

**Reimbursement Methodology** Vaccines are reimbursed at the Medicare rate of reimbursement when established and published by the Centers for Medicare & Medicaid Services (CMS) or the pharmacy rate of reimbursement when the Medicare rate is not available. The Medicare rate is currently defined as average sales price (ASP) plus 6 percent. The pharmacy rate is currently defined as the lower of (1) the average wholesale price (AWP) minus 17 percent; (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC). For more information on the pharmacy rate of reimbursement please refer to the Pharmacy provider manual section titled *Reimbursement*.

**Billing Guidelines** Reimbursement is determined by the cost of the immunization, plus the physician's administration fee. Only one administration fee will be reimbursed per immunization regardless of the quantity reflected on the claim line.

Established Patient/  
Level One Services:  
CPT-4 Codes Do not use established patient, Level One, Evaluation and Management codes (99211, 99281, 99334 and 99347) to bill Medi-Cal for immunizations. Use the appropriate immunization code.

Free Vaccines:  
Only Administration Fee  
Reimbursable Medi-Cal does not reimburse for the cost of provider-purchased vaccines that are available free from other sources, including the Vaccines For Children (VFC) program. Reimbursement is allowable for vaccine-administration costs only.

Free Vaccines from Vaccines For Children (VFC) Program

Refer to "Required Documentation" in the *Vaccines For Children (VFC) Program* section in the appropriate Part 2 manual for instructions to bill the administration fee associated with vaccines supplied free through the VFC Program.

Free Vaccines from Source Other than VFC Program

Providers bill CPT-4 code 90471 (immunization administration; one vaccine) to Medi-Cal to be reimbursed for the administration of vaccines that are free to the provider through a source other than the VFC program. When billing code 90471, providers must indicate the vaccine administered and its source in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. Code 90471 may not be billed in conjunction with other vaccine immunization codes (90284 – 90749 and X5300 – X7699) administered by the same provider, for the same recipient and date of service.

Items Not Separately  
Billable

Incidental items (e.g. adhesive bandages, tissues, swabs, cotton balls) are included in the rate for the office visit or other listed services. These incidental items must not be billed separately.

Modifier SK (High Risk)

Modifier SK (member of high risk population) must be used in conjunction with all claims for the following immunizations:

<u>CPT-4 Code</u>	<u>Immunization</u>
<b><u>90620, 90621</u></b>	<b><u>Meningococcal</u></b>
90636	Hepatitis A/B combination
90644	Meningococcal
90675	Rabies
90690 – 90693	Typhoid
90704	Mumps
90717	Yellow fever
90725	Cholera
90727	Plague
90732	Pneumococcal
90733	Meningococcal
90734	Meningococcal (Menactra or Menveo)

**BCG Vaccine**

TICE BCG is approved for intravesical use to treat carcinoma-in-situ of the urinary bladder in addition to its percutaneous use for immunization against tuberculosis. BCG TheraCys is, at present, approved only for intravesical use. When billing Medi-Cal for intravesical use of TICE BCG or BCG TheraCys to treat carcinoma-in-situ of the urinary bladder, providers should use CPT-4 code 90586 (BCG, intravesical – 1 dose). Use CPT-4 code 90585 (BCG vaccine, percutaneous – 1 mg) when TICE BCG is used for immunization against tuberculosis.

**DTP/DTaP Immunization Series**

Immunization CPT-4 billing codes for the series of five diphtheria/tetanus/pertussis (DTP or DTaP) injections are as follows:

<u>CPT-4 Code</u>	<u>Description</u>
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for individuals younger than 7 years of age
90702	Diphtheria, tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years of age, for intramuscular use

Medi-Cal does not reimburse for DTaP (CPT-4 code 90700) vaccines administered to recipients 7 years of age and older. Providers must use modifier SL when billing these codes for recipients who qualify for the Vaccines For Children (VFC) program. Providers must submit justification for using a non-VFC vaccine for recipients younger than 7 years of age. Medi-Cal does reimburse for the DT vaccine (CPT-4 code 90702) when administered to recipients younger than 7 years of age. Providers must not use modifier SL when billing this code for recipients who qualify for the VFC program. For claim preparation information, see “Required Documentation” in the *Vaccines For Children (VFC) Program* section of this manual.

**Hepatitis A Vaccine**

The hepatitis A vaccine is reimbursable when billed with the following CPT-4 codes. CPT-4 code 90632 must be billed with modifier SK (high risk). For additional information about CPT-4 code 90633, see "Hepatitis A Vaccine" in the *Vaccines For Children (VFC) Program* section of this manual.

<u>CPT-4 Code</u>	<u>Description</u>
90632	Hepatitis A vaccine, adult dosage – 1,440 units/ml
90633	Hepatitis A vaccine, pediatric/adolescent dosage

For information about the combination hepatitis A and hepatitis B vaccine, see "Hepatitis A and Hepatitis B Combination Vaccine" in this section.

**Medical Necessity**

When billing code 90632, providers must document medical necessity in the *Remarks* field (Box 80)/*Additional Claim Information* 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)

**Hepatitis B Immunization Schedules**

The Department of Health Care Services (DHCS) recommends the following hepatitis B immunization schedule and vaccine (HBVac), and immune globulin (IG) dosages. For information about the combination hepatitis A and hepatitis B vaccine, see “Hepatitis A and Hepatitis B Combination Vaccine” elsewhere in this section.

The DHCS 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 given intramuscularly (IM), generally in the deltoid muscle for adults, toddlers and other children and in the anterolateral thigh muscle for infants. Providers are instructed not to use the buttocks or the intradermal route.

The second recommendation is the United States Public Health Services Advisory Committee (ACIP) approval of Merck Vaccine Division (new alternative for adolescents only) 11 to 15 years of age 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.

The following is pre-exposure, post-exposure and dosage information recommended at age 0 (birth), 1 month and 4 to 6 months (children), adolescents and young adults. The following routine hepatitis B infant immunization regimen (either option 1 or 2) may be used.

**Pre-Exposure**Option 1

Hepatitis B vaccine dose: First dose at birth, second vaccine dose at age 1 to 2 months and third vaccine dose at age 6 to 18 months of age.

Option 2

Hepatitis B vaccine dose: First dose at age 1 to 2 months, second vaccine dose at age 4 months, and third vaccine dose at age 6 to 18 months of age.

For other individuals for whom Hepatitis B vaccine is indicated, the first pre-exposure dose should be followed by the second dose one month later and the third dose four to six months after the first dose.

**Post-Exposure**

Hepatitis B Immune Globulin (HBIG) and the first hepatitis B vaccine dose should be given as soon as possible, followed by the second dose of hepatitis B vaccine one month after the first dose, and the third dose of hepatitis B vaccine four to six months after the first dose.

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Hepatitis B Immune Globulin (HBIG)

Dosing and billing information for HBIG is as follows:

Dosage

Age

Dose

Children younger than 1 year of age 0.5 ml

Children 1 year of age or older 0.06 ml/kg

Billing

For hepatitis B vaccine billing instructions, refer to "Hepatitis B Vaccine" in the *Vaccines For Children (VFC) Program* section of this manual.

Claims for 1.0 ml IG (CPT-4 code 90371) must include the patient's weight in kilograms in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment.

**Hepatitis B Immune Globulin (Hepagam B™) Intramuscular**

Hepatitis B immune globulin, 0.5 ml intramuscular, (HCPCS code J1571) is reimbursable when billed with ICD-9-CM diagnosis code V07.2 and has a maximum daily dose of 8 ml. For quantities exceeding the daily limitation, appropriate documentation is required.

**Hepatitis B Immune Globulin (Hepagam B™) Intravenous**

Hepatitis B immune globulin, intravenous (HCPCS code J1573) is reimbursable when billed with ICD-9-CM diagnosis code V42.7 and has a maximum daily dosage of 64 ml. For quantities exceeding the daily limitation, appropriate documentation is required.

**Hepatitis A and Hepatitis B  
Combination Vaccine**

The hepatitis A and hepatitis B combination vaccine (CPT-4 code 90636) is reimbursable for any recipient 19 years of age or older who is at risk due to the following:

- Receives blood factor products, either for the treatment of a medical disorder or as an occupational exposure
- Has chronic liver disease
- Had a liver transplant
- Uses illicit injectable or non-injectable “street” drugs
- Is a male having sex with other males
- Individuals in high risk situations, such as day-care centers, hemodialysis units, drug and alcohol treatment centers, correctional facilities and places where emergency medical assistance is rendered
- Has come in contact with blood, body fluids, feces or sewage
- Has come in contact with live hepatitis A and/or B virus

**Medical Necessity**

When billing code 90636, providers must use modifier SK (high risk) and document the medical necessity in the patient’s medical record.

**Human Papilloma Virus  
Bivalent Vaccine (Cervarix®)**

CPT-4 code 90650 (human papilloma virus [HPV vaccine], types 16, 18, bivalent, three-dose schedule, for intramuscular use) is a Medi-Cal benefit for female recipients 10 through 25 years of age and a Vaccines For Children (VFC) program benefit for female recipients 9 through 18 years of age.

**Human Papilloma Virus  
Quadrivalent Vaccine  
(Gardasil®)**

CPT -4 code 90649 (human papilloma virus [HPV] vaccine, types 6, 11, 16, 18 [quadrivalent], three-dose schedule, for intramuscular use) is a Medi-Cal benefit for both sexes ages 9 through 26 of age females, who are not pregnant. CPT-4 code 90649 is a Medi-Cal benefit per CDC recommendations as follows:

Recommendations for the male population:

- Ages 11 through 12, routine vaccination
- Ages 13 through 21, who have not been vaccinated previously or who have not completed the three-dose series
- Ages 22 through 26 may be vaccinated
- Special population through age 26, as referenced by CDC, includes the following population:
  - Persons who are immunocompromised as a result of infection (including HIV), disease, or medications
  - Men who have sex with men (MSM)

Recommendations for the female population who are not pregnant:

- Ages 11 through 12, routine vaccination
- Ages 13 through 26, who have not been vaccinated previously or who have not completed the three-dose series

**Reimbursement**

Code 90649 is limited to reimbursement of three times in 12 months, per recipient. The HPV vaccine Gardasil consists of a three-dose regimen, injected at 0, 2 and 6 month intervals. Providers must maintain a vaccination log and document in the recipient's medical records the dates of vaccinations, the vaccination sites, the dosage given and the lot number of the vaccine given.

For reimbursement of this vaccine under *Vaccines for Children (VFC) Program*, refer to *Vaccines For Children (VFC) Program* in this manual.

Reference

1. CDC Recommendations on the Use of Quadrivalent Human Papillomavirus Vaccine in Males — Advisory Committee on Immunization Practices (ACIP), 2011. MMWR. 2011. 60(50);1705-1708.  
[http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a3.htm?s\\_cid=mm6050a3\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a3.htm?s_cid=mm6050a3_e)
2. CDC. Quadrivalent Human Papillomavirus Vaccine - Recommendations of the Advisory Committee on Immunization Practices (ACIP). 2007. 56; 1-24.  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr56e312a1.htm>

**Influenza Vaccine** See the *Vaccines For Children (VFC) Program* section in this manual.

Influenza Virus Vaccine (intramuscular) CPT-4 code 90662 (influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use) is a Medi-Cal benefit for recipients 65 years of age and older. It is an inactivated influenza virus vaccine indicated against influenza diseases caused by the influenza subtypes A and B contained in the vaccine. The vaccine elicits enhanced immune responses against influenza through higher antigen content.

Influenza Virus Vaccine (intradermal) CPT-4 code 90654 (influenza virus vaccine, split virus, preservative-free, for intradermal use) is reimbursable for recipients 18 through 64 years of age.

**Measles, Mumps and Rubella Vaccine (2<sup>nd</sup> Dose Only)** See the *Vaccines For Children (VFC) Program* section in this manual.

**Monovalent Measles, Mumps and Rubella Vaccinations**

The use of monovalent measles, mumps and rubella vaccines instead of polyvalent vaccines is medically justifiable only for prophylaxis of a 6- to 11-month-old child during an outbreak of one of the diseases or for an adult who is known to be immune to the other two diseases. Polyvalent vaccines must be used for routine immunizations.

Medical Necessity

Claims billed with CPT-4 code 90704 will be denied unless sufficient medical justification is included as an attachment or in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. All claims for code 90704 require modifier SK (high risk).

**Meningitis Vaccines**

See also *Vaccines For Children (VFC) Program* in this manual.

Menactra or Menveo

Menactra or Menveo meningitis vaccine is billed with CPT-4 code 90734 (meningococcal conjugate vaccine serogroups A, C, Y and W135 [tetravalent], for intramuscular use). It must be billed as follows:

- VFC benefit for recipients 9 months – 10 years of age who are considered at high risk for exposure to meningitis, such as those who have complement deficiencies, those with functional or anatomic asplenia, children with HIV infection, travelers to or residents of countries in which meningococcal disease is hyperendemic or epidemic, or children who are part of an outbreak of a vaccine-preventable serogroup. Both modifiers SK and SL are required on the VFC claim.
- Children aged 2 through 10 years who have anatomic or functional asplenia. Use modifiers SK and SL for this group when billing for VFC claim
- Add only the SL modifier for recipients 11 – 18 years of age.
- Add the SK modifier for recipients 19 – 55 years of age who are high risk.
- No modifier is required for recipients 19 – 21 years of age who are not considered high risk and are receiving their primary dose.

**Note:** Giving the vaccines solely for the purpose of employment is not a Medi-Cal benefit.

Some codes may also be billed with modifier SL (used for VFC program recipients through 18 years of age). See the *Vaccines For Children (VFC) Program* section in this manual for more information. This does not negate policy that these codes must be billed with modifier SK. Providers should refer to [www.cdc.gov](http://www.cdc.gov) as an added resource for meningococcal updates.

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For adults age 55 years of age or younger, high-risk groups are considered:

- College freshmen living in dormitories
- Microbiologists who are exposed routinely to isolates of *Neisseria meningitidis*
- Military recruits
- Persons who travel or reside in countries where meningococcal disease is hyperendemic or epidemic
- Persons who have persistent complement component deficiencies
- Persons with anatomic or functional asplenia
- Persons with HIV infection

Medi-Cal claims billing for the meningitis vaccine for recipients older than 19 years of age must be submitted with modifier SK. In addition, providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19), or on an attachment to the claim, the reason why the patient is considered high-risk. For example: "Recipient is young adult living in a college dormitory."

#### Hib-MenCY

The administration fee for Hib-MenCY meningitis vaccine is billed with CPT-4 code 90644. Code 90644 must be billed with modifier SK or modifiers SK and SL. Other considerations are as follows:

- If the modifier SL is used alone, claims will be denied
- Use of the modifiers SL and SK are for age 18 years and younger
- Claims are reimbursable with the SK modifier only
- Providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19), or on an attachment to the claim, the reason why the patient is considered high-risk
- Claims billed with modifier SL and SK are reimbursed for an administration fee only

**Infants at Increased Risk for Meningococcal Disease**

Advisory Committee on Immunization Practices (ACIP) recommends that Infants at increased risk for meningococcal disease should be vaccinated with a four-dose series of Hib-MenCY at 2 through 18 months of age. Additionally, Hib-MenCY can be used in infants aged six weeks through 18 months who are in communities with serogroups C and Y meningococcal disease outbreaks, but Hib-MenCY is not adequate for infants traveling to the Hajj or the “meningitis belt” of sub-Saharan Africa (a quadrivalent meningococcal vaccine that contains serogroups A and W135 is required for those infants and may be given starting at age 9 months).

If an infant at increased risk for meningococcal disease is behind on his or her Hib vaccine doses, Hib-MenCY may be used following the same catch-up schedule used for Hib vaccine. However, if the first dose of Hib-MenCY is given at or after 12 months of life, two doses should be given at least eight weeks apart to ensure protection against serogroups C and Y meningococcal disease. For infants at increased risk for meningococcal disease who have received or are going to receive a different Hib vaccine product, ACIP recommends a two-dose series of MenACWY-D if they are aged 9 through 23 months or either of the two quadrivalent meningococcal vaccine products after age 23 months.

Infants at increased risk include those with one or more of the following risk factors:

- Anatomic or functional asplenia including sickle cell disease
- Complement component deficiencies such as C3, C5-9, properdin, factor H, and factor D deficiencies
- In a defined risk group for a community or institutional outbreak
- HIV, if another indication for vaccination exists
- Needing protection prior to traveling or moving to an area where meningococcal disease is epidemic or highly endemic

Revaccination three years after the primary series is considered medically necessary for children who remain at increased risk.

**Meningococcal Vaccines  
Serogroup B (MenB)**

CPT-4 code 90620 (bexsero), meningococcal recombinant protein and outer membrane vesicle vaccine and CPT-4 code 90621 (trumenba), meningococcal recombinant lipoprotein vaccine, are reimbursable for recipients 10 – 18 years of age at increased risk for meningococcal disease attributable to Serogroup B, including:

- Children who have persistent complement component deficiencies (including inherited or chronic deficiencies in C3, C5-C9, properdin, factor H, or factor D or taking eculizumab [Soliris])
- Children who have anatomic or functional asplenia, including sickle cell disease
- Children identified to be at increased risk because of a meningococcal disease outbreak attributable to Serogroup B

<b>CPT-4 Code</b>	<b>Vaccine</b>	<b>Dosing Schedule</b>
<b><u>90620</u></b>	<b><u>bexsero</u></b>	<b><u>0 and 1 – 6 month schedule</u></b>
<b><u>90621</u></b>	<b><u>trumenba</u></b>	<b><u>three doses</u></b>

**Palivizumab (Synagis®)**

Palivizumab 50 mg, CPT-4 code 90378 is reimbursable for passive immunization of certain infants as described below.

The following coverage policy was updated after the publication of the article titled, "Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection" by American Academy of Pediatrics (AAP) in 2014.

Five monthly doses of palivizumab will provide more than six months (24 weeks) of protective serum antibody concentration. For children meeting the policy described below, up to five doses may be authorized for use between November and the following March. If prophylaxis is initiated in December, the fifth and final dose should be administered in April.

A maximum of five doses of palivizumab may be authorized as follows.

- Infants born before 29 weeks, 0 days gestation who are less than 12 months of age at the start of the RSV season
- During the first year of life for preterm infants who develop chronic lung disease (CLD) of prematurity defined as gestational age less than 32 weeks, 0 days and a requirement for greater than 21 percent oxygen for at least the first 28 days after birth
- During the second year of life for preterm infants who develop chronic lung disease (CLD) of prematurity as defined above and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the six-month period before the start of the second RSV season
- Infants who are 12 months or younger with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures and infants with moderate to severe pulmonary hypertension
- Infants with cyanotic heart defects in the first year of life may receive Palivizumab prophylaxis if deemed warranted by the infant's pediatric cardiologist
- Children younger than two years who undergo cardiac transplantation during the RSV season
- An infant younger than 24 months receiving prophylaxis who undergoes cardiopulmonary bypass or extracorporeal membrane oxygenation and continues to require prophylaxis post-operatively may receive a post-operative dose of palivizumab (15 mg/kg)

- During the first year of life, infants with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough
- Children younger than 24 months of age who are profoundly immunocompromised during the RSV season, as assessed by a qualified pediatric Infectious Disease or Immunologic specialist
- During the first year of life, infant with cystic fibrosis with clinical evidence of CLD and/or nutritional compromise
- During the second year of life, infants with cystic fibrosis and manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length less than the 10<sup>th</sup> percentile

**Note:** Qualifying infants born during the RSV season may require fewer doses. For example, infants born in January would receive their last dose in March.

#### Authorization Required

Palivizumab is given by intramuscular injection on a monthly basis during the RSV season. A TAR is required. Providers may request the amount of palivizumab needed for the entire RSV season on one TAR. The usual dosage is 15 mg/kg per injection. One unit equals 50 mg for Medi-Cal billing purposes. Providers may bill for one unit even if only part of the unit was given to the recipient and the remainder of the drug was discarded. It is reimbursable once in a 25-day period.

#### Pentacel Vaccine

The Pentacel pediatric combination vaccine is reimbursable when billed with CPT-4 code 90698 (diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated [DTaP-Hib-IPV] for intramuscular use) and modifier SL. For additional information about CPT-4 code 90698, see “Pentacel Vaccine” in *Vaccines For Children (VFC) Program* of this manual.

### Pneumococcal Vaccine

CPT-4 codes 90670 (pneumococcal conjugate vaccine, 13 valent, for intramuscular use) (PCV13) and 90732 (pneumococcal polysaccharide vaccine 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use) (PPSV23) are indicated for adults 19 years of age or older with specified immunocompromising conditions, with the following recommendations:

- For pneumococcal vaccine-naïve persons:
  - Adults 19 years of age or older with immunocompromising conditions, functional or anatomic asplenia, Cerebrospinal Fluid (CSF) leaks or cochlear implants who have not previously received PCV13 (CPT-4 code 90670) or PPSV23 (CPT-4 code 90732) should receive a dose of PCV13 first, followed by a dose of PPSV23 at least eight weeks later.
  - A second PPSV23 dose is recommended five years after the first PPSV23 dose for persons 19 through 64 years of age with functional or anatomic asplenia and for persons with immunocompromising conditions.
- For persons previously vaccinated with PPSV23:
  - Adults 19 years of age or older with immunocompromising conditions, functional or anatomic asplenia, CSF leaks or cochlear implants who previously have received one or more doses of PPSV23 (CPT-4 code 90732) should be given a PCV13 dose one year or more after the last PPSV23 dose was received.
  - For those who require additional doses of PPSV23, the first such dose should be given no sooner than eight weeks after PCV13 and at least five years after the most recent dose of PPSV23.

**Note:** Individuals who received PPSV23 prior to 65 years of age, for any indication, should receive another dose of the vaccine at 65 years of age or later, if at least five years have elapsed since their previous PPSV23 dose.

### Rabies Biologics

CPT-4 codes 90375 (rabies immune globulin [Rig], human, for intramuscular use) and 90376 (rabies immune globulin, heat-treated [Rig-HT], human, for intramuscular and/or subcutaneous use) must be billed with diagnosis code V01.5. CPT-4 code 90675 (rabies vaccine, for intramuscular use) must be billed with modifier SK.

**Tdap Vaccine**

CPT-4 code 90715 (tetanus, diphtheria toxoids and acellular pertussis vaccine [Tdap], when administered to individuals 7 years or older, for intramuscular use) is a Medi-Cal benefit for recipients 7 years of age and older, with the following recommendations:

- Health care personnel 19 years of age and older, especially those in direct patient contact, are encouraged to receive a dose of Tdap.
- Adults 19 years of age and older who have contact or anticipate having contact with infants younger than 12 months of age (for example, parents, grandparents, healthcare personnel and childcare providers) should receive a single dose of Tdap if they have not previously received Tdap.
- Providers of prenatal care must implement a Tdap immunization program for all pregnant women. Health care personnel should administer a dose of Tdap during each pregnancy, irrespective of the patient's prior history of receiving Tdap. To maximize the maternal antibody response and passive antibody transfer to the infant, optimal timing for Tdap administration is between 27 and 36 weeks gestation, although Tdap may be given at any time during pregnancy.
- Adults 19 through 64 years of age requiring a tetanus toxoid-containing vaccine as part of wound management should receive a single dose of Tdap rather than tetanus and diphtheria toxoids vaccine (Td) if they have not received Tdap previously.
- Providers for adults 19 through 64 years of age are recommended to replace the recipient's next booster dose of Td with a single dose of Tdap.
- Use of Tdap in under-vaccinated children 7 through 10 years of age.
- Tdap is indicated for a single booster dose at 11 or 12 years of age if the childhood DTP/DTaP vaccination series has been completed. Tdap is preferred over Td as adolescents are susceptible to pertussis due to waning immunity.
- Adolescents who did not receive Tdap at 11 or 12 years of age should receive a single dose of Tdap in place of a single Td booster dose. Tdap can be administered regardless of the interval since the last tetanus or diphtheria containing vaccine.

**Note:** The use of modifier SL with code 90715 is needed only when billing for VFC program reimbursement for the use of the vaccine in children ages 7 through 18 years of age.

**Zoster Vaccine (Zostavax)**

The zoster vaccine (CPT-4 code 90736) is reimbursable when administered to adults 50 years of age or older. Zoster vaccine is restricted to administration once in a lifetime per recipient. It should not be administered to children, pregnant women, people with active tuberculosis, those who are receiving immunosuppressive therapy or who are immunocompromised (for example, AIDS, leukemia, lymphomas).