

Wisconsin | Anthem Blue Cross and Blue Shield | BadgerCare Plus and Medicaid Supplemental Security Income (Medicaid SSI) programs

Reimbursement Policy Vaccines for Children (VFC) Program

Policy Number: **G-05022**

Policy Section: **Prevention**

Last Approval Date: **07/21/2025**

Effective Date: **07/21/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://anthem.com/wi/provider>.

Policy

The health plan allows reimbursement of the administration fee for vaccines provided by the Vaccines for Children (VFC) Program for eligible members 18 years of age and younger, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Medicaid providers who participate in the VFC Program and immunize children shall comply with all the reporting requirements and procedures.

Reimbursement is based on the fee schedule or contracted/negotiated rate of the vaccine administration up to maximum fee limits set by the Centers for Disease Control and Prevention (CDC) and modifier SL. The health plan does not reimburse providers for the vaccine serum, as it is provided free of charge through the VFC Program.

Although providers shall only be reimbursed for the administration of the vaccine, serum code(s) must be included on the claim to meet regulatory and Healthcare Effectiveness Data and Information Set (HEDIS®) reporting requirements that members are receiving the proper immunization(s). Claims submitted without applicable serum and administration codes and modifiers may not be eligible for reimbursement. The health plan does not allow separate reimbursement for the administration code.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Reimbursement of Office Visits

Vaccine administrations are separately reimbursable expenses from well-child exams or office visits. The health plan allows reimbursement of a minimal office visit when the vaccine administration is the only service performed.

Non-VFC Members/Vaccines

For members not eligible for, or for vaccines not eligible under, the VFC Program, the health plan reimburses providers for administration and serum based on the fee schedule or a contracted/negotiated rate.

Reimbursement During State Supply Shortages

During documented supply shortages within applicable state VFC Programs, the health plan will reimburse providers for serum(s) based on the fee schedule or contracted/negotiated rate and applicable modifiers. Health plans shall develop internal processes and procedures to track state VFC Program and CDC information to monitor vaccine shortages.

Related Coding

Standard correct coding applies.

Definitions

- **Minimal Office Visit** - Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified healthcare professional.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Modifier Usage

References and Research Materials

This policy has been developed through consideration of the following:

- CDC § 441.615 Administration fee requirements
- CMS
- Social Security Act, Section 1928: Program for Distribution of Pediatric Vaccines
- State contract
- State Medicaid

- State VFC Programs

Policy History

- **02/23/2026** - Update due to regulatory directive: added modifier SL
- **11/04/2024** - Review approved and effective: no changes
- **11/04/2022** - Review approved: updated language; updated minimal office visit definition
- **04/20/2018** - Review approved and effective:
- **09/15/2016** - Review approved and effective policy language updated
- **07/13/2015** - Review approved and effective: updated Definition section; updated policy template
- **07/01/2014** - Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in

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accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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