DELAWARE HEALTH AND SOCIAL SERVICES

Delaware Division of Medicaid and Medical Assistance

Medicaid Coverage of COVID-19 Vaccine Administration, Monoclonal Antibody Treatment, Oral Antiviral Medications (New), Vaccine Counseling (New) and Over the Counter Testing (New)

Medicaid Provider Information and FAQs

March 16, 2022

The Delaware Division of Medicaid and Medical Assistance (DMMA), in collaboration with the Delaware Division of Public Health (DPH), is working with federal, state and local stakeholders to implement Medicaid and CHIP coverage of the COVID-19 vaccine, new treatments, vaccine counseling and over-the-counter (OTC) testing. At this time, COVID-19 vaccines have been purchased from the drug manufacturers by the federal government and are free of charge to DPH-approved providers and to the pharmacies obtaining the vaccines directly from the federal government. Medicaid Fee-for-Service ("DMAP FFS") and Medicaid Managed Care Organizations (MCOs) will pay a COVID-19 vaccine administration fee for Medicaid and CHIP members.

Providers are not permitted to charge Medicaid members for the COVID-19 vaccine or administration of the vaccine.

DMMA has published the following Medicaid Provider COVID-19 Vaccine Administration and Monoclonal Antibody Treatment FAQs and will continue to update this information. For more information on Delaware's efforts to implement an efficient and equitable distribution of COVID-19 vaccines to all Delaware communities, please refer the DPH COVID-19 Vaccine page on the DHSS website.

Pharmacy providers should pay special attention to the section of these FAQs dedicated to pharmacy providers.

March 2022 Update: Information has been added below on coverage of COVID-19 over the counter testing, vaccine counseling and coverage of oral antiviral medications.

General Provider Vaccine FAQs:

1. ***(Updated)*** **Question: What COVID-19 vaccines are available?**

   Answer: The FDA has approved COVID-19 vaccines for individuals 5 years and

older under the Emergency Use Authorization (EUA). Guidance and information about COVID-19 vaccine eligibility can be found on the CDC website located here.

2. **Question: Will Medicaid and CHIP provide coverage of COVID-19 vaccines approved for use?**

   Answer: Yes. For now, the cost of the vaccine itself is being paid for by the Federal government. Medicaid will cover a vaccine administration fee for Medicaid and CHIP beneficiaries. Members of Medicaid MCOs (AmeriHealth Caritas of Delaware or Highmark Health Options) will receive coverage through their MCO and other Medicaid beneficiaries will receive coverage through Medicaid Fee for Service (FFS).

3. **Question: How is vaccine administration covered for Medicaid beneficiaries dually enrolled in Medicare ("dual eligibles")?**

   Answer: Medicare is the primary payer for COVID-19 vaccine administration.

4. **Question: Does Medicaid provide coverage of the COVID-19 vaccine for the uninsured?**

   Answer: No. Providers can seek reimbursement for vaccine administration for the uninsured through the HRSA COVID-19 Uninsured Program. Providers can find details on participation and billing through this program here.

5. **Question: Where can providers obtain information about private insurance coverage of COVID-19 vaccines?**

   Answer: Information on private insurance coverage of COVID-19 vaccines is available through the Delaware Department of Insurance.

6. **Question: How can Medicaid providers sign up to become a COVID-19 vaccinator?**

   Answer: Any provider interested in becoming a COVID-19 vaccinator and receiving vaccine directly from the Delaware DPH must first become an enrolled COVID-19 vaccinator through DPH. **Providers must enroll with DPH for COVID-19 vaccines, even if they are already enrolled for other vaccines.** Information on DPH provider enrollment can be found here.

   Any provider planning to bill for COVID-19 vaccine administration should ensure that they are enrolled with DMAP FFS and with both MCOs (AmeriHealth Caritas of Delaware and Highmark Health Options). Information on provider enrollment is available at the following websites:

   DMMA
   AmeriHealth Caritas of Delaware
   Highmark Health Options

7. **Question: Which Medicaid participating provider types can be reimbursed for COVID-19 vaccine administration to eligible members?**

   Answer: Any active Medicaid provider type whose scope of practice currently includes vaccine administration may be reimbursed for COVID-19 vaccine administration. Pharmacy providers should see the "Pharmacy" section of this document for guidance specific to pharmacies.

   Any provider planning to bill for COVID-19 vaccine administration should ensure that they are enrolled with DMAP FFS and with both MCOs (AmeriHealth Caritas of Delaware and Highmark Health Options).

8. **Question: What are the Medicaid reimbursement rates for the COVID-19 vaccine administration?**

   Answer: For most providers, Delaware Medicaid Fee-for-Service (FFS) and our partner MCOs (AmeriHealth Caritas of Delaware and Highmark Health Options) will be using the unadjusted Medicare fee schedule rates for COVID-19 vaccine administration. Effective March 15, 2021, and consistent with the updated Medicare rates from CMS, the Medicaid rate for COVID-19 vaccine administration is $40.00 for each dose of COVID-19 vaccine; this includes payment of a third shot for immunocompromised individuals. CMS may update this information and providers should refer to the CMS website for the most updated coverage codes and rates.

   For doses administered prior to March 15, 2021, Medicaid will pay $28.39 to administer single-dose vaccines. For COVID-19 vaccine requiring a series of two or more doses, the initial dose administration payment rate is $16.94 and $28.39 for the administration of the final dose in the series.

   See Questions #11 and #12 for additional guidance for FQHCs and school-based wellness centers.

9. **Question: How are Medicaid providers reimbursed for COVID-19 vaccine administration?**

   Answer: DPH-approved Medicaid providers will be reimbursed for the applicable Current Procedural Terminology (CPT) administration code when a COVID-19 vaccine has been administered to eligible Medicaid members. All non-pharmacy providers submitting claims for the administration fee for COVID-19 vaccines must use the CMS 1500 claim form or the 837P format (see pharmacy-specific billing instructions later in these FAQs). **Please note that for COVID-19 vaccines, the charge will need to be entered as $.01. However, these vaccines are provided at no charge from the federal government and there will be no payment on the vaccine code itself. Medicaid DMAP FFS and Medicaid MCOs will only make payment on the vaccine administration code. Vaccine procedure codes and administration fee codes should be billed together on the same claim.** Delaware providers should use the COVID-19 vaccine administration CPT codes listed on the CMS website.

   2/12/2021 Update: Administration payment is not reimbursed separately when billed with a visit or bundled service including a medical component. However, providers

that participate in a vaccination event or administer the vaccine without other Medicaid services will be reimbursed the vaccine administration fee(s).

10. **Question: For Medicaid beneficiaries in long-term care facilities, how will COVID-19 vaccine administration be provided and reimbursed?**

    Answer: Medicaid-participating long-term care facilities have two options for coordinating access to COVID-19 vaccines: vaccination in the community (including physicians, pharmacies, day programs and senior centers) and vaccination onsite through a pharmacy partner enrolled in the Federal Retail Pharmacy Program.

    For more information on these options and how to set up an onsite vaccination clinic, please refer to the CDC's website for information on "Long-term Care Administrators and Managers: Options for Coordinating Access to COVID-19 Vaccines."

    For Medicaid long-term care facilities that elect to become DPH-approved vaccinators for their Medicaid residents, reimbursement for COVID-19 vaccine administration is through the existing Medicaid per diem rate paid for a resident. No additional reimbursement will be made at this time.

11. **Question: For Medicaid beneficiaries receiving COVID-19 vaccinations through federally-qualified health care centers (FQHCs), how will COVID-19 vaccine administration be reimbursed?**

    Answer: COVID-19 vaccine administration qualifies as an FQHC "visit" and is eligible for the Prospective Payment System (PPS) encounter rate. FQHC providers must provide the vaccine code and vaccine administration code on the claim/encounter.

    An FQHC visit that includes a medical component and a COVID-19 vaccination is reimbursed as a single visit, eligible for a single PPS encounter rate.

    3/16/2021 Update: Medicaid reimbursement for FQHC vaccine administration visits will apply to vaccines administered by FQHC providers at alternative (non-traditional) sites. See Question #15.

    FQHC Billing Instructions: FQHC providers must provide the vaccine code and vaccine administration code on each claim/encounter.

    A. FQHC Vaccination administration only, claims submission process:

- Submit with the appropriate FQHC Encounter Visit "G" Code
    - G0466 FQHC Visit New Patient
    - G0467 FQHC Visit, Established Patient

      Along with a **U4** Informational Modifier at the end

- Submit with the appropriate Vaccine CPT Code 91300, 91301, or 91303 (Depending on the vaccine type provided)

- Submit the appropriate Vaccine Administration CPT Code 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A or 0031A (Depending on the vaccine type provided)

The "**U4**" modifier will indicate that the only service performed on that date was administering the COVID-19 vaccine and nothing further. If there were other services performed on the same date, then the U4 modifier should not be submitted.

B. FQHC Vaccination when other medical/dental/behavioral health services are provided on the same date; claims submission process

- Submit with the appropriate FQHC Encounter Visit "G" Code
  - G0466 FQHC Visit New Patient
  - G0467 FQHC Visit, Established Patient
- Submit with the appropriate Qualifying Visit 90000 series CPT service code (for MCOs only)
- Submit with the appropriate Vaccine CPT Code 91300, 91301, or 91303 (Depending on the vaccine type provided)
- Submit the appropriate Vaccine Administration CPT Code 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A or 0031A (Depending on the vaccine type provided)

Do not include the "**U4**" modifier.

9/20/21 Update: CPT codes 0003A and 0013A were added to the instructions.

12. **Question: For Medicaid beneficiaries receiving COVID-19 vaccinations through school-based wellness centers (SBWCs), how will COVID-19 vaccine administration be reimbursed?**

    Answer: COVID-19 vaccine administration qualifies as a SBWC "visit" and is eligible for the applicable visit rate. SBWC providers must provide the vaccine code and vaccine administration code on the claim/encounter.

    A SBWC visit that includes a medical component and a COVID-19 vaccination is reimbursed as a single visit, eligible for a single visit rate.

13. **Question**: Should a Medicaid provider include the vaccine and vaccine administration code on a claim if the cost of administering the vaccine is included as part of the visit or bundled service?

    Answer: Yes. Providers should include the vaccine and vaccine administration code on the claim to assist DMMA with tracking and reporting purposes.

14. **Question: How will PACE providers be reimbursed for COVID-19 vaccine administration?**

    Answer: Most PACE enrollees have Medicare coverage and Medicare is the primary payer for COVID-19 vaccine administration. For Medicaid-only PACE members,

PACE sites are responsible for COVID-19 vaccine administration under the existing capitation payment.

15. **Question: Can Medicaid providers provide COVID-19 vaccines at alternative (non-traditional) sites?**

    Answer: COVID-19 vaccine administration may be provided at alternative sites (e.g., drive-through sites) when delivered by a qualified Medicaid provider (such as a physician) otherwise authorized to administer COVID-19 vaccines in Delaware.

Pharmacy-Specific Provider Vaccine FAQs:

1. **Question: When pharmacies provide the COVID-19 vaccine, can pharmacists be the prescriber?**

   Answer: Yes. Under the authority of the PREP Act, Delaware pharmacists are permitted to be the prescriber for the COVID-19 vaccine on the pharmacy claim.

2. **Question: What is the Medicaid pharmacy dispensing fee for the COVID-19 vaccine?**

   Answer: Delaware Medicaid (DMAP FFS) and our partner MCOs (AmeriHealth Caritas of Delaware and Highmark Health Options) will be using the unadjusted Medicare fee schedule rates for COVID-19 vaccine administration. Effective March 15, 2021, pharmacy providers will be paid a dispensing fee of $40.00 for each dose.

   CMS may update this information and providers should refer to the CMS Website for the most updated information.

3. **(Updated) Question: What are the billing instructions for pharmacy providers?**

   Answer: Pharmacy providers must bill COVID vaccines as a pharmacy benefit.

   Pharmacy providers must follow DMAP FFS procedures and NCPDP Emergency Preparedness guidance. This includes using the submission clarification codes to identify if the pharmacy is administering the first or second dose for two-dose vaccines. Per NCPDP guidelines, a submission code is not necessary for single-dose vaccines.

   Specific Billing Fields:

   - Submission Clarification Codes-
     - For the initial dose for two-dose vaccines, the pharmacy should submit a Clarification Code of 2 (Other Override) in the Submission Clarification Code (420-DK) field.
     - For the second dose, the pharmacy should submit a Clarification Code of 6 (Starter Dose)

- For the third dose for patients who are approved to receive a third dose, the pharmacy should submit a Clarification Code of 7
-For a booster dose, the pharmacy should submit a Clarification Code of 10 (Booster Dose)
3/16/2021 and 9/17/21 Update: Submission Clarification Code for one-dose vaccines – this field may be left blank. If the pharmacy submits a 2, 6 or 7 in this field for a one-dose vaccine, the claim will not reject for that reason.
Ingredient Cost Submitted – Until further notice, submit the value of $0.01. The pharmacy will be paid $0.00 for the ingredient cost.

- 3/16/2021 Update: Dispensing Fee – Effective March 15, 2021, pharmacy providers will be paid a dispensing fee of $40.00 for each dose. CMS may update this information and providers should refer to the CMS website for the most updated coverage codes and rates.
- 3/16/2021 Update: DUR Edits – the three DUR Edits, 440-E5, 438-E4, 441-E6, do not need to be provided for payment of COVID vaccines.
- Copay – There will be no copay for the vaccine.
- Prescriber – The pharmacy should submit the name and NPI of the prescribing provider if presented with a prescription for the vaccine. Pharmacists are permitted to prescribe the vaccine and therefore be the prescriber for the COVID vaccine on the pharmacy claim. If the pharmacist is the prescriber, enter the pharmacist's NPI in the prescriber field.
- Quantity Dispensed – The Billing Unit is a milliliter (ML).
- Days Supply – The Days Supply is "1" regardless of the vaccine administered.

9/20/21 Update: Instructions were updated to include reference to third doses.
March 2022 Update: Instructions were updated for booster doses.

General Provider Monoclonal Antibody Treatment FAQs:

1. **(Updated) Question: What monoclonal antibodies have been authorized and are available for use?**

   Answer: The FDA had previously authorized REGEN-COV (casirivimab/imdevimad) and bamlanivimab/etesevimab, under the Emergency Use Authorization (EUA) for two indications: 1) the treatment of mild to moderate COVID-19 in adults and pediatric patients 12 years of age and older weighing at least 40 kilograms who are at high risk for progressing to severe COVID-19 and/or hospitalization and 2) post-exposure prophylaxis in individuals at high risk for progressing to severe COVID-19. They are not approved for patients who have been hospitalized or require oxygen therapy. They can be given in an outpatient setting or in the home or residence.

   On January 24, 2022 the FDA revised the authorizations for two monoclonal antibody treatments – bamlanivimab and etesevimab (administered together) and REGEN-COV (casirivimab and imdevimab) – to limit their use to only when the patient is likely to have been infected with or exposed to a variant that is susceptible to these treatments. As these treatments are not active against the omicron variant, these treatments are not authorized in any U.S. states, territories, and jurisdictions at

this time. In the future, if patients in certain geographic regions are likely to be infected or exposed to a variant that is susceptible to these treatments, then use of these treatments may be authorized in these regions.

At this time, Sotrovimab is not covered by Medicaid.

In addition, the FDA has authorized:

- Tocilizumab for hospitalized adults and pediatric patients 2 years of age and older who are receiving systemic corticosteroids and require supplemental oxygen. This is covered as a hospital inpatient benefit for Medicaid patients.

2. **(Updated) Question: Are there monoclonal antibodies that were authorized but are no longer available or were not available for a period of time?** Yes. There are two products by Eli Lilly that were originally authorized Effective 4/16/21 the EAU for bamlanivimab was revoked due to the lack of established effectiveness against the delta variant. On 6/25/21, the Federal Government paused distribution of the combination product, bamlanivimab and etesevima. In September, distribution resumed and the EAU was expanded to include post-exposure prophylaxis for certain individuals who have been exposed to COVID-19 positive persons, in addition to treating people who are at high risk of progressing to severe disease.

3. **Question: Which Medicaid providers can obtain monoclonal antibodies?**

   Answer: As most of these products are administered by intravenous infusion and are for patients with COVID-19, outpatient and inpatient hospitals and other providers authorized to infuse medications that have immediate access to medications to treat a severe infusion reaction and to activate the emergency medical system may obtain these medications. Any provider planning to bill for monoclonal antibody administration should ensure that they are enrolled with DMAP FFS and with the applicable MCO (AmeriHealth Caritas of Delaware and Highmark Health Options).

4. **Question: Will Medicaid and CHIP provide coverage of monoclonal antibodies approved for use under the FDA's Emergency Use Authorization (EUA)?**

   Answer: Yes. For now, the cost of the drug itself is being paid for by the Federal government. Medicaid will cover an infusion administration fee for Medicaid and CHIP beneficiaries. Members of Medicaid MCOs (AmeriHealth Caritas of Delaware or Highmark Health Options) will receive coverage through their MCO and other Medicaid beneficiaries will receive coverage through Medicaid Fee for Service (FFS).

5. **Question: How is monoclonal antibody infusion administration covered for Medicaid beneficiaries dually enrolled in Medicare ("dual eligibles")?**

   Answer: Medicare is the primary payer.

6. **Question: What are the Medicaid reimbursement rates for the COVID-19**

monoclonal antibody administration?

Answer: Delaware Medicaid Fee-for-Service (FFS) and our partner MCOs (AmeriHealth Caritas of Delaware and Highmark Health Options) will be using the Medicare fee schedule rates for monoclonal antibody administration. The Medicaid rate for monoclonal antibody administration in an outpatient setting is $450 and in a home or residence is $750. Tocilizumab may only be administered in an inpatient hospital setting and should be billed in accordance with inpatient hospital billing procedures. CMS may update this information and providers should refer to the CMS website for the most updated coverage codes and rates.

7. **Question: How are Medicaid providers reimbursed for COVID-19 monoclonal antibody administration?**

   Answer: DPH-approved Medicaid providers will be reimbursed for the applicable Current Procedural Terminology (CPT) administration code when a monoclonal antibody has been administered to eligible Medicaid members in an outpatient or home setting. All providers submitting claims for the administration fee for monoclonal antibodies must use the CMS 1500 claim form or the 837P format. **Please note that for drug itself, providers should not bill the drug product code pursuant to NCCI edit requirements. Since these drugs are provided at no charge from the federal government and there will be no payment on the drug code itself, NCCI requirements state that the product should not be billed. Medicaid DMAP FFS and Medicaid MCOs will only make payment on the administration code.** Delaware providers should use the CPT codes listed on the CMS website. The M codes for the administration should be billed under revenue code 771.

   Inpatient use should be billed in accordance with inpatient hospital billing procedures.

COVID-19 Over the Counter (OTC) Testing

1. **Question: Does Medicaid cover over the counter COVID-19 tests?**

   Answer: Yes. Effective January 15, 2022, DMMA enrolled pharmacies may bill for OTC EUA FDA-authorized self-administered COVID-19 antigen and PCR tests. These tests can be dispensed and reimbursed as a pharmacy-billed benefit for use of DMMA members at home with or without a prescription issued by a DMMA enrolled provider. Members of Medicaid MCOs (AmeriHealth Caritas of Delaware or Highmark Health Options) will receive coverage through their MCO and other Medicaid beneficiaries will receive coverage through Medicaid Fee for Service (FFS).

   The following coverage criteria apply:

   - A maximum of eight tests are covered per rolling 30 days per member. If a member requires additional tests, prior authorization may be required.
   - Pharmacists must follow the National Council for Prescription Drug Programs (NCPDP) standard and use the National Drug Code (NDC) found on the package.

- No copayment will apply.
- Pharmacies will be reimbursed at the State Specific Maximum Allowable Cost (DMAC) (price on file) for each item billed or Usual & Customary. DMAC on COVID-19 OTC antigen tests are $12.00; while COVID-19 OTC PCR tests are $80.00.
- Regular Dispensing Fees will apply.
- Covered test kits and reimbursement are listed below:

NDC	Label Name (Test Name)	# of Tests in Kit	Billing Unit	Effective Date	State Specific Maximum Allowable Cost (DMAC)
11877001133	Binaxnow COVID AG Card Home Test	2	2	01/15/2022	$12/test; $24/kit
11877001140	Binaxnow COVID-19 AG Self-test	2	2	01/15/2022	$12/test; $24/kit
14613033972	Quickvue at-home COVID-19 Test	2	2	01/15/2022	$12/test; $24/kit
56964000000	Ellume COVID-19 Home Test	2	2	01/15/2022	$12/test; $24/kit
8337000158	Inteliswab COVID-19 Rapid Test	2	2	01/15/2022	$12/test; $24/kit
56362000589	IHEALTH COVID-19 AG Rapid Test	2	2	01/15/2022	$12/test; $24/kit
82607066027	Flowflex COVID-19 AG Home Test	2	2	01/15/2022	$12/test; $24/kit
82607066026	Flowflex COVID-19 AG Home Test	1	1	01/15/2022	$12.00
50010022431	Carestart COVID-19 AG Home Test	2	2	01/15/2022	$12/test; $24/kit
42022224	Pixel COVID-19 Home Collection Kit	1	1	01/15/2022	$80.00/test
10055097004	Lucira Check-It COVID-19 Test	1	1	01/15/2022	$80.00/test

NOTE:

- Test kits cannot be broken. The entire test kit should be dispensed where the quantity billed equals the number of tests in the package.
- The COVID-19 OTC test coverage benefit is subject to change.

COVID-19 Oral Antiviral Medications

1. **Question: Does Medicaid cover COVID-19 oral antiviral medications:**

   Answer: Yes. Medicaid will cover Oral COVID-19 Antivirals Paxlovid™ and Molnupiravir. DMMA-enrolled pharmacies may bill for U.S. Food and Drug Administration (FDA) authorized Emergency Use Authorization (EUA) approved COVID-19 oral tablets Paxlovid, effective December 22, 2021 and Molnupiravir effective December 23, 2021 dispensed for use to DMMA members in a home setting with a prescription issued by a DMMA Medicaid-enrolled provider. These medications are not authorized for initiation of treatment in patients requiring hospitalization.

   - Both medications must be prescribed under a prescribing provider per EUA guidance.
   - Per EUA guidelines, Paxlovid is only for patients 12 years and up, while Molnupiravir is only for patients 18 years and up.
   - Pharmacies must follow the National Council for Prescription Drug Programs standard and use the NDC found on the package.
   - No prior authorization will be required for these medications.
   - Pharmacies will be NOT be reimbursed for the ingredient cost since the drugs are federally provided at no cost.
   - Current dispensing fees will apply as applicable to DMMA FFS and each MCO.
   - Copayment will not apply.

   References

   1. Paxlovid https://www.fda.gov/media/155049/download
   2. Monupiravir https://www.fda.gov/media/155053/download

COVID-19 Vaccine Counseling

1. Question: Does Medicaid cover COVID-19 Vaccine Counseling?

Answer: Yes. Medicaid will cover COVID-19 vaccine counseling for all ages.

Medicaid will also cover vaccine counseling for all vaccines (COVID and non-COVID) for individuals ages 0-20. The billing guidance below will address the codes to use for providers. **School Based providers should review Question #2 below for updated guidance on codes 99401-99404.**

In general, codes to use for vaccine counseling are:

- 99401 - Preventive medicine counseling and /or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

- 99402 - Preventive medicine counseling and /or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes

COVID-19 Vaccine Counseling for any age:

- 99401 & 99402 medical claims must be billed **with a CR modifier** to identify COVID-19 Vaccine counseling for any age (note: this is not an issue on pharmacy claims so modifier is not needed).

Vaccine Counseling (other than COVID-19 vaccines) only for individuals ages 0-20:

- 99401 & 99402 are to be billed to identify vaccine counseling for any non-COVID vaccine counseling for individuals ages 0-20 (note: this is not an issue on pharmacy claims so modifier is not needed).

2. **Question: How does Medicaid coverage of vaccine counseling impact School Based providers who bill codes 99401-99404 for dental assessments for children ages 0-20?**

   Answer: Up until now, codes 99401 through 99404 have only been used by DMAP for dental assessment services provided through school-based providers for Medicaid members ages 0 through 20. In order to maintain billing codes for dental assessments and accommodate the need for billing codes for COVID and non-COVID vaccine counseling, school based providers should follow these instructions:

   - 99401 through 99404 must be billed **with a DA modifier** (Oral Health Assessment by a licensed health professional other than a Dentist) for EPSDT School Based Services provided for Medicaid members ages 0 through 20 for dental assessments.
   - 99401 & 99402 must be billed **with a CR modifier** to identify COVID-19 Vaccine counseling for any age.
   - 99401 & 99402 are to be billed to identify vaccine counseling for any non-COVID vaccine counseling for individuals ages 0-20.