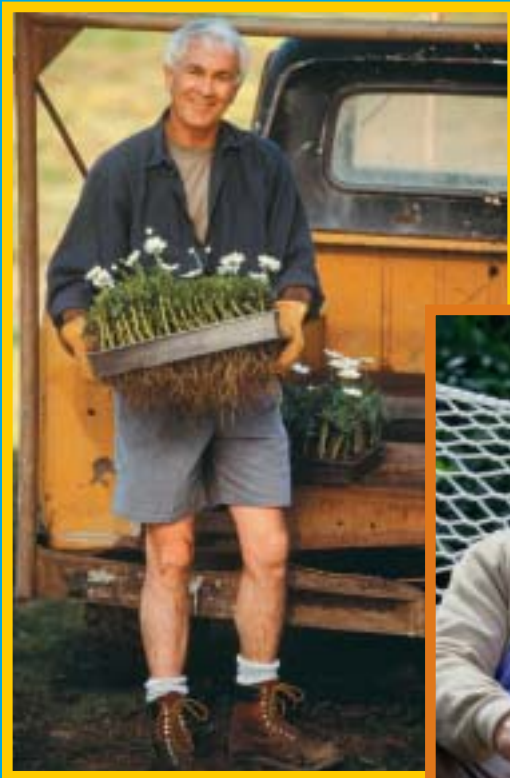


Oregon Adult Immunization Resource Manual

for

*Nursing, Residential Care
and Assisted Living Facilities*



*Revised August 2002. The previous edition
was substantially based on the
100% Immunization Campaign Resource
Manual and used with their permission.*

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SECTION 1:
HOW TO USE
THIS MANUAL



SECTION 1:

HOW TO USE THIS MANUAL

The purpose of the ***Oregon Long Term Care Immunization Resource Manual*** is to promote immunizations of residents and employees of nursing, assisted living, and residential care facilities. The primary immunizations needed by long term care residents are designed to prevent influenza and pneumococcal disease. This Immunization Resource Manual is intended to be a tool to assist facilities in implementing immunization programs for their residents. Studies have shown that when a facility has a formal influenza and pneumococcal immunization program, the residents of the facility are much more likely to be immunized against these diseases. This manual describes different implementation procedures for nursing facilities and for assisted living and residential care facilities. For this manual “***long-term care***” refers to nursing, assisted living and residential care facilities.

Sections 2 through 5 provide information on implementing immunization policies and procedures for long term care facilities and employees of those facilities. These sections also provide sample forms and policies.

Section 6 provides information on how to bill for immunizations, specifically how to bill Medicare.

Section 7 contains a variety of immunization resource materials, some of which are useful in educating facility staff about immunization issues.

Section 8 contains order forms for additional resources, as well as acknowledgments to the American Society of Consultant Pharmacists and Merck Vaccine Division for allowing Oregon to modify their campaign resource manual.



SECTION 2:
NURSING FACILITY
IMMUNIZATION
PROCEDURES



SECTION 2:
NURSING FACILITY
IMMUNIZATION PROCEDURES

The primary body responsible for establishing policies and programs in the nursing facility is the Quality Assessment and Assurance (QA) Committee. Any member of this committee can serve as the immunization “champion” and begin the discussion about the importance of having a formal immunization program within the facility that includes influenza and pneumococcal vaccinations. In addition, the facility should have an employee immunization program. In some larger facilities, the immunization initiative may begin with the Infection Control Committee, which is often a subcommittee of the QA Committee.

Step 1: Educate key facility staff.

All health professionals and facility staff need to be knowledgeable about immunization issues.

With adequate training and resources, any health professional or staff member can take the lead in promoting immunization in the facility and educating the other key players about this issue. This Immunization Resource Manual is intended to assist in these efforts.

Step 2: Develop and approve an immunization program for the facility.

After the members of the QA Committee have been educated about the importance of having an immunization program in the facility, the committee should develop and formalize an immunization program that meets the needs of the facility. To assist in this process, procedures that the facility may use as a starting point for discussion are included in this manual. At the discretion of the committee, a facility may make any needed changes in these procedures to meet the needs of the facility residents.

As a starting point, the QA Committee could adopt a policy on immunization of all health care and facility staff. The committee should consider a policy that includes pre-printed orders or standing orders for pneumococcal and influenza vaccines. Standing orders may offer an advantage over pre-printed orders. Once standing orders are in place, vaccines may be administered without any action on the part of the physician.

The key points of the resident immunization program are:

- ❖ Educate residents and/or responsible parties about immunizations upon admission to the facility. This should include provision of a vaccine information statement for influenza and pneumococcal vaccines.
- ❖ Upon admission to the facility, (or any time thereafter) add a pre-print order or standing order to client records. The pre-print admit order should include a mechanism for consent that can be used at admission and any time in the future. This will preclude the need to get a separate consent each time an annual influenza vaccine is given.
- ❖ For current residents, a similar process of education should be followed when the program is initiated, or when admit orders are updated.
- ❖ Complete an immunization record form on each facility resident. This form should remain in the active medical record at all times. This provides a permanent record of the resident's immunization history and all immunizations administered while residing in the facility. It (or a copy) can be used to communicate immunization status to off-site providers and can be used as a transfer discharge document.
- ❖ The facility should have an organized program for annual administration of influenza vaccine in the fall of each year.
- ❖ For other vaccines, there should be a system for ensuring that each resident gets the needed vaccines according to the recommended schedule. The Infection Control Nurse or Immunization Coordinator should oversee this system.

Step 3: Immunize current residents and new arrivals.

Complete an Immunization Record Form (*see page 26*) for each current resident. Educate residents and/or responsible parties. Obtain consent forms as needed. Administer vaccinations to residents who need them. As each new resident arrives, create an immunization record and follow the same procedure as for current residents. Ideally, new residents will receive any needed immunizations as soon as is feasible after admission.

Before administration of a vaccine, physician authorization must be obtained. This can be done on the pre-admit order, or preferably by each physician's approval of the facility standing orders for immunization.

Step 4: Develop a system to identify residents who are not immunized against influenza and pneumococcal disease.

It is important to be able to quickly identify residents who are not immunized, and are therefore more vulnerable during an outbreak of disease. They may need special consideration like antiviral prophylaxis.

Step 5: Bill Medicare or other insurance.

The facility should have a protocol to ensure that billing for the vaccines, and the administration of the vaccines, is completed accurately and in a timely manner. See Section 6 of this manual for information about the administration of vaccines to Medicare beneficiaries and billing Medicare for vaccines.

Check with private insurance carriers for residents who are paying privately. The Medicaid program may also cover vaccinations. If a resident is enrolled in a Medicare HMO, contact membership services.

Step 6: Evaluate the immunization program.

It is important to periodically evaluate the effectiveness of the immunization program. The percent of residents immunized with the two key vaccines (influenza and pneumococcal) should be continually monitored. Healthy People 2010 objectives include immunization rates of 90% for flu and pneumococcal disease in people aged 65 and older. If a significant number of residents are not immunized, what are the barriers? Are the facility procedures being followed? Are residents frequently refusing the vaccines? If so, why are they refusing?

If the staff determines that the immunization program is less than fully effective, the procedures should be reviewed. Also, review the process for educating residents and responsible parties about immunization issues. What improvements can be made to increase immunizations?

Computer software that tracks immunization status of residents and employees has been developed by OMPRO.

For information, call (503) 279-0100.

Immunization of staff is an important part of protecting long-term care residents from infectious diseases, especially influenza. Facilities should strongly encourage staff to receive annual influenza immunizations.

Sample Immunization Policy and Procedures for Nursing Facilities

IMMUNIZATION POLICY:

All residents will be immunized against vaccine-preventable diseases that may be encountered in this facility. These vaccines will be provided to all persons upon admission, unless medically contraindicated or unless the resident or his or her responsible party refuses.

Upon admission:

1. Obtain an immunization history and complete an immunization record.
2. Advise residents on the benefits and adverse effects of each vaccine prior to administration of the vaccines.
3. If resident or responsible party consents to immunizations:
 - ❖ obtain/verify physician's order unless standing orders are being used;
 - ❖ administer immunizing agents per manufacturer guidelines, as soon as is feasible after admission;
 - ❖ monitor for any adverse reactions for 15-20 minutes after giving the vaccine;
 - ❖ document the immunization in the resident's immunization record;
 - ❖ document any adverse reactions in the medical record and on the resident immunization record and notify the attending physician.
4. If resident or responsible party refuses an immunizing agent included in these orders:
 - ❖ document refusal and the reason(s) in the immunization record.
5. Track the immunization status of individuals who are not immunized for any reason using the "Immunization Status Tracking Form" on pages 27 and 28. Immunize all residents who consent to immunization when vaccines are available.

Document immunization refusal in the immunization record.

SECTION 3:
RESIDENTIAL CARE AND
ASSISTED LIVING FACILITY
IMMUNIZATION
PROCEDURES



SECTION 3:

RESIDENTIAL CARE AND ASSISTED LIVING

FACILITY IMMUNIZATION PROCEDURES

In the assisted living and residential care environment, the structure and committees that are a part of nursing facilities often do not exist. In addition, many facilities do not have staff nurses to administer the vaccines to the residents. These differences create a need for a modified approach to immunization in this setting.

Step 1: Develop a mechanism for on-site administration of immunizations.

Because assisted living and residential care facilities may not have staff members who are qualified to administer immunizations, it may be necessary to make arrangements for an outside provider to come to the facility periodically to administer vaccines. The outside provider may be a home health agency or a contract nurse. In Oregon, pharmacists are also permitted to administer vaccines and may be available to assist with this task. Some residents may have their own physician administer immunizations at the physician's office.

For newly admitted residents, arrangements should be made for vaccinations as soon as is feasible after admission per pre-print or standing orders. In the fall of each year, influenza vaccine should be offered to all residents and administered on-site to those who accept. The immunization provider should be responsible for billing Medicare for the cost of the vaccines and vaccine administration.

Immunization of staff is increasingly being recognized as an important part of protecting long-term care residents from infectious diseases, especially influenza. Facilities should strongly encourage staff to receive annual influenza immunizations.

Step 2: Educate residents about vaccine-preventable diseases and the benefits and risks of immunization.

Educate current residents and newly admitted residents about the benefits and risks of immunization against influenza and pneumococcal disease.

Posters and other consumer-oriented educational materials are available for use. See Section 8 for a list of resource materials that are available for order.

After the resident or responsible party has received information about immunizations, he or she should provide consent for any needed immunizations either upon admission or at any time in the future. This will preclude the need to get a separate consent form each time an annual influenza vaccine, or other needed immunization, is given. If pre-printed orders are used, the prescribing health care provider should update and sign them annually.

Step 3: Immunize current residents and new arrivals.

Establish a date and make arrangements for immunizations for residents. Put up posters and distribute reminders to the residents prior to the day of the immunization service. Resource materials to support these activities are listed in Section 8 of the manual.

Establish a regular immunization day in the facility (perhaps once or twice per month) to immunize new arrivals for pneumococcal disease as needed. During the influenza season, influenza vaccine should also be made available.

Step 4: Evaluate the Immunization Program.

It is important to periodically evaluate the effectiveness of the immunization program. The percent of residents immunized with the two key vaccines (influenza and pneumococcal) should be continually monitored. The Healthy People 2010 goal for both pneumonia and influenza immunization rates for nursing home residents is 90%. If a significant number of residents are not immunized, what are the barriers? Are the facility procedures being followed? Are residents frequently refusing the vaccines? If so, why are they refusing?

If the staff determines that the immunization program is less than fully effective, the procedures should be reviewed. Also, review the process for educating residents and responsible parties about immunization issues. What improvements can be made to increase immunizations?

Computer software that tracks the immunization status of residents and employees has been developed by OMPRO. For information, call (503) 279-0100.



Sample Immunization Policy and Procedures for Assisted Living and Residential Care Facilities

IMMUNIZATION POLICY:

All residents will be immunized against vaccine-preventable diseases that may be encountered in this facility. These vaccines will be provided to all persons upon admission, unless medically contraindicated or unless the resident or his or her responsible party refuses.

Upon admission:

1. Obtain residents' vaccination status.
2. Advise residents on the benefits and adverse effects of each vaccine prior to administration of the vaccines.
3. If resident or responsible party consents to immunizations:
 - ❖ obtain/verify physician's order unless standing orders are being used;
 - ❖ administer immunizing agents per manufacturer guidelines, ideally within 72 hours of admission;
 - ❖ monitor for any adverse reactions for 15-20 minutes after giving the vaccine;
 - ❖ document the immunization in the resident's Immunization Record;
 - ❖ document any adverse reactions in the medical record and in the resident's Immunization Record and notify the attending physician.
4. If resident or responsible party refuses an immunizing agent included in these orders:
 - ❖ document refusal and the reason(s) on the immunization record.
5. Track the immunization status of individuals who are not immunized for any reason using the "Immunization Status Tracking Form" on pages 27 and 28. Immunize all residents who consent to immunization when vaccines are available.

Document immunization refusal in the immunization record.

SECTION 4: **FORMS**

*The following forms are samples
provided for your use in your
facility.*



Written Consent Form*

Influenza

INFLUENZA VACCINE:

The influenza vaccine has been shown to protect older adults from hospitalization and deaths resulting from an influenza infection. The Advisory Committee on Immunization Practices (ACIP) recommends that influenza vaccine be provided to all residents of long term care facilities annually, prior to the influenza season. Reactions at the site of injection may occur. Mild fever or aches may also occur. This facility usually conducts an organized vaccine campaign every fall, before the beginning of the influenza season. However, influenza vaccine will be offered to residents and to new arrivals through the end of January.

INFLUENZA VACCINE:

YES I wish to receive the influenza vaccine while I am residing in this facility.

NO I do not wish to receive the influenza vaccine this year, because

Resident's Name: _____

Resident or Responsible Party's Signature _____

Date: _____

* Facilities differ in their approaches regarding written versus verbal consent. This written consent is included for facilities that require written consent.

Written Consent Form*

Pneumococcal Disease

PNEUMOCOCCAL VACCINE:

The Pneumococcal Polysaccharide Vaccine is effective against 23 pneumococcal types which cause 90 percent of all pneumococcal pneumonia. Current ACIP recommendations include a single dose of the vaccine for persons 65 years and older if they have not been previously vaccinated or whose vaccination status is unknown. A one-time re-vaccination is recommended for persons 65 years and older who have been vaccinated for the first time when they were 60 years of age or younger. Local site reactions are expected in 5 to 10 percent of vaccine recipients. Less than 1 percent of vaccinations have reported slight elevations of body temperature but severe allergic reactions have been documented rarely. Getting the disease is much more likely to cause serious problems than getting the vaccine.

PNEUMOCOCCAL VACCINE:

YES I wish to receive pneumococcal vaccine according to the recommended schedule.

NO I do not wish to receive the pneumococcal vaccine at this time, because

Resident's Name: _____

Resident or Responsible Party's Signature: _____

Date: _____

*Facilities differ in their approaches regarding written versus verbal consent. This written consent is included for facilities that require written consent.

EMPLOYEE IMMUNIZATION RECORD

FACILITY NAME: _____

Employee Name	Social Security Number
Date of Birth	Employment Start Date

Vaccine	Date	Consent Obtained O=Oral W=Written	Vaccine Manufacturer	Vaccine Lot #	Site Given	If Not Administered, Reason 1=employee declined 2=contraindicated 3=vaccine shortage 4=other (explain)	Signature/ Title
Influenza							
Influenza							
Influenza							
Influenza							
Influenza							
Hepatitis B (1)							
Hepatitis B (2)							
Hepatitis B (3)							
Varicella (Chickenpox)							
MMR (Measles, Mumps, Rubella)							
T/d							
Pneumococcal							
TB Clearance - Mantoux/PPD					Notes:		
		Test 1		Test 2			
Test Contraindicated (Date)							
Date Given							
Date Read							
Induration (mm)							

Please keep the original record in the personnel file and give a copy to the employee.

ADULT RESIDENT IMMUNIZATION RECORD

FACILITY NAME: _____

Resident Name	Date of Birth
Date of Admission	Date of Discharge

Vaccine	Date	Consent Obtained O=Oral W=Written	Vaccine Manufacturer	Vaccine Lot #	Site Given	If Not Administered, Reason <small>1=resident declined 2=no MD order 3=vaccine shortage 4=contraindicated 5=other (explain)</small>	Signature/ Title
Pneumococcal							
Pnemococcal Revaccination							
Influenza							
Influenza							
Influenza							
Influenza							
Influenza							
Influenza							
Influenza							
Influenza							
T/d							
TB Clearance - Mantoux/PPD					Notes:		
		Test 1	Test 2				
Date Given							
Date Read							
Induration (mm)							
Test Contraindicated (Date)							

Please keep the original at the facility and give a copy to the resident at discharge or transfer of care.

IMMUNIZATION STATUS TRACKING FORM - INFLUENZA

This form may be used to identify all residents who are not immunized against flu or pneumococcal disease for any reason. They may need special consideration during a disease outbreak.

Not Immunized Against Influenza

Date	Resident Name	Identification #	Reason for No Vaccination	Plan	Initials	Received Flu Shot	Initials
Ex. 10/12/02	Any Name	Chart #	Vaccine shortage	Vaccinate when vaccine becomes available	msd	11/03/02	msd

IMMUNIZATION STATUS TRACKING FORM - PNEUMOCOCCAL

Not Immunized Against Pneumococcal Disease

Date	Resident Name	Identification #	Reason for No Vaccination	Plan	Initials	Received PPV	Initials
Ex. 10/12/02	Any Body	Chart #	Afraid of side effects	Patient/resident/family education	msd	11/03/02	msd

SECTION 5:
EMPLOYEE
IMMUNIZATIONS





SECTION 5:

EMPLOYEE IMMUNIZATIONS

Employees working in a long-term care facility will be potentially exposed to vaccine-preventable diseases. The exposure of the causative organisms may come from resident's secretions, contaminated medical devices used for the care of a resident, or from a colleague. Education relative to vaccine-preventable diseases and availability of vaccines should be a part of a facility's occupational risk management program to maintain a healthy workforce. By following national guidelines (1-4), you provide and enhance an important component of your employee health program. This mandatory program should include all newly hired and currently hired employees.

An effective immunization program for employees includes identifying employees at higher risk of acquiring a vaccine-preventable disease. These employees may have:

- immune-suppressive disorders such as being HIV +;
- immunosuppression as a result of drug therapy or organ transplant;
- pregnancy;
- functional or anatomical disorders of their spleen;
- diabetes;

Often, employees want a rational reason for participating in your immunization program. Informing the employee of the risks taken when a decision is made to not get vaccinated and remain susceptible to vaccine-preventable diseases is essential. Inform susceptible employee of their increased risk of:

- acquiring the vaccine-preventable disease;
- having the disease become chronic or progressive to disability;
- transmitting the disease causing agent to other employees or residents;

POLICY

At the time of hire, the employee shall be provided educational material relative to vaccine-preventable diseases and the facility's policy regarding payment for any vaccine. The current Centers for Disease Control and Prevention (CDC) Guideline and Occupational Safety and Health Administration (OSHA) rule relative to post-exposure management should be followed relative to providing the hepatitis B vaccine (5, 6).

HEPATITIS A VACCINE

Hepatitis A is the most common type of hepatitis in the United States. Hepatitis A is acquired by mouth (fecal-oral). Three vaccines are available: HAVRIX, VAQTA, and TWINRIX (combination hepatitis A and hepatitis B). All vaccines are highly immunogenic, generally resulting in more than 95% of adults developing protective antibodies within two weeks of receiving the series. In nursing homes, the risk of acquiring hepatitis A virus from performing routine duties is very low. The risk of transmitting the virus in the dietary department is very low. Therefore, there is no recommendation at this time to vaccinate employees in nursing homes for the purpose of protecting other employees or residents. Persons at increased risk for acquiring hepatitis A disease should consult their personal provider for information and availability of vaccinations.

HEPATITIS B VACCINE

During the period of 1982-1998, CDC has noted a dramatic decrease in the incidence of hepatitis B disease (7). Risk of acquiring the hepatitis B virus (HBV) while performing routine duties in a nursing home is low. When the virus is acquired, chronic active hepatitis develops in over 25% of carriers, and often results in cirrhosis. Persons with chronic HBV infection are at 12 to 300 times higher risk of liver cancer than non-carriers (4). In 1982, a safe and effective vaccine was Food and Drug Administration (FDA)-approved for usage and, in 1991, a comprehensive vaccination program was adopted. OSHA requires the free offering of a vaccine series with either ENGERIX B or RECOMBIVAX, to employees who are at potential risk for exposure while performing routine duties (6). You should consult your facility's management personnel regarding your eligibility for free vaccine. If you are eligible, arrangements should be made to receive the vaccine within ten (10) days of acceptance of the offer. When the three-vaccine series is completed, you should ascertain whether you have seroconverted (positive antibody test). If you did not seroconvert, your employer should repeat the entire series at no cost to you.

INFLUENZA VACCINE

Each year millions of U.S. citizens are infected with the influenza virus. Hundreds of thousands are hospitalized. Approximately 20,000-40,000 die each year from influenza or influenza-related pneumonia. Institutionalized elderly are particularly susceptible to influenza and, therefore, present an increased risk of exposure to health-care workers caring for these elderly. It is estimated that 30%-40% of those institutionalized may not respond to the influenza vaccine. Therefore, vaccinating the employee reduces the risk of spread of influenza to residents.

- A. Annual flu shots should be offered to employees. The most effective offering includes the employer paying for the cost of vaccine and administration. The vaccine is particularly recommended for employees with histories of diabetes, chronic cardio-pulmonary, or renal diseases. Employees who will be pregnant beyond the 14th week of gestation during flu season, or 50 years of age or older should be advised to be vaccinated.
- B. In the event of an outbreak, the facility should follow the current CDC Guideline for the Prevention of Influenza. This guideline is published by CDC in April of each year. It is available through your county health department.

MEASLES VACCINE

Health-care workers are at increased risk of exposure to the measles virus. Current guidelines recommend that the employee who was born after 1957, has not had measles, and who did not receive the primary series, should receive two measles vaccines. Current guidelines recommend that the employee who was born after 1957 and has had measles, no longer needs to be vaccinated. An employee who was born before 1957 is probably immune to measles, but health care facilities should recommend a single dose of MMR if immune status is uncertain.

PNEUMOCOCCAL VACCINE

Employees should be alerted that certain strains of the bacterium *Streptococcus pneumoniae* (pneumococcus) are becoming very resistant to commonly used antibiotics. Antibiotic treatment failure of life-threatening pneumococcal infections, i.e., sepsis and meningitis, results in increased absenteeism and decreased work productivity. The current pneumococcal vaccine contains most of the strains which cause these diseases. Employees who are at increased risk of complications of pneumococcal disease may have cardio-pulmonary-renal-splenic dysfunction or diabetes.

TETANUS-DIPHTHERIA TOXOID VACCINE (Td)

Current guidelines recommend that the employee who has never received the primary Td series should do so. The guidelines recommend boosting the employee every ten (10) years. Intermittent or prophylactic vaccination after certain injuries shall be at the discretion of the employee's health-care provider.

VARICELLA VACCINE

Institutionalized elderly often develop shingles. Shingles (or, zoster) is the common term for varicella-zoster. The virus usually first infects us as a child with the disease called varicella (or, chickenpox). Decreased immune response as a function of aging, allows the varicella-zoster virus to activate out of its "carrier" condition to form lesions called shingles/zoster. Employees who have never had chickenpox are susceptible to acquiring the varicella-zoster virus upon exposure to the resident with shingles. All susceptible employees should be informed of the availability and issues of the varicella vaccine.

References:

1. Bolyard, E. et al. Guideline for infection control in health care personnel, 1998. AJIC, 1998; 26:289-354.
2. CDC, Immunization of Health-Care Workers. MMWR, Dec. 26, 1997; 46(RR-18); 1-37.
3. CDC, Prevention of Pneumococcal Disease. Recommendations of the Advisory Committee on Immunization Practices. MMWR, April 7, 1997;46(RR-8); 1-24.5
4. CDC, Epidemiology and Prevention of Vaccine-Preventable Diseases. Jan, 2000; 6th Edition.
5. OSHA, Occupational Exposure to Bloodborne Pathogens, needlesticks and other sharps injuries; final rule (OSHA 29 CFR Part 1910) Federal Registry, January, 2001; 66:5318-5325.
6. CDC, Updated U.S. Public Health Services guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for post-exposure prophylaxis. MMWR, June 29, 2001; 50(RR-11):1-42



SECTION 6:
BILLING



SECTION 7

BILLING

Quick Fact Sheet

Billing for Influenza and Pneumococcal (PPV) Vaccinations in Nursing Facilities Under Medicare Part B

When a Skilled Nursing Facility (SNF) resident receives a flu shot in the course of a covered Part A stay, the Consolidated Billing Requirement makes the SNF itself responsible for doing the Medicare billing for the flu shot; however, since this is a preventive service that is outside the scope of the Part A SNF benefit (and, thus, is not included in the PPS payment that Part A makes for the resident's covered stay in the SNF), the SNF would submit a separate bill for the flu shot to Part B.

Coverage of influenza and pneumococcal vaccines and their administration is available only under Medicare Part B regardless of the setting in which they are furnished. Any individual or entity meeting state licensure requirements may qualify to have payment made for furnishing and administering the flu and PPV vaccines to Medicare beneficiaries enrolled under Part B.

Influenza vaccines are typically administered once a year in the fall or winter. PPV vaccines are typically administered once in a lifetime to persons at high risk of pneumonia infection. Considered at high risk are persons 65 years of age and older and immunocompetent adults who are at increased risk of pneumonia infection or its complications because of chronic illness.

Claims are paid for beneficiaries who are at high risk of pneumonia infection and have not received PPV within the last five years **or are revaccinated because they are unsure of their vaccination status.**

Reimbursement rates for influenza and PPV vaccinations change annually. For references, the 2001-2002 influenza vaccine reimbursement amount in Oregon was \$7.13, while the pneumococcal vaccine reimbursement amount was \$15.24. After adding \$4.54 for administration reimbursement, the full amount for flu vaccine reimbursement was \$11.67, while PPV reimbursement was \$19.78.

If your residents belong to any Medicare contracted health maintenance organizations (Medicare + Choice health plans, or M+COs), you will want to determine if vaccinations are included in their capitation rate. Beneficiaries enrolled in M+COs generally must obtain the shot through plan providers, or they will have to pay for it out of pocket. HMO enrollees should check with their plan to determine if they are "locked-in" to plan providers for their flu shot. If not locked in, the flu shot may be obtained from any qualified provider.

Nursing facilities bill for the vaccines and their administration on Form HCFA-1450 using revenue code 636 for the vaccine and 771 for the administration of the vaccine in conjunction with the diagnosis and HCPCS codes. For more information on roster billing, see the section on Centers for Medicare and Medicaid Services (CMS) SNF Billing Procedures.

Roster billing is a simplified process for billing flu and PPV immunizations to Medicare when immunizations occur in mass. It provides a less costly billing alternative than generating a HCFA-1450 for each patient who receives an immunization. Note: roster bills cannot be submitted electronically. For more information on roster billing, see the following section on CMS SNF Billing Procedures.

CMS Skilled Nursing Facility Manual

Chapter V - Billing Procedures

Section 536.2 (abridged)

Last updated February 1, 2002

Find the latest version of this document at:
http://www.hcfa.gov/pubforms/12_SNF/sn500.htm

Special Billing Instructions for Pneumococcal Pneumonia and Influenza Virus Vaccines

Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is made on a cost basis. Deductible and coinsurance do not apply.

A. Coverage Requirements

1. Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that the PPV vaccine and administration be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.
2. Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration are covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

B. General Billing Requirements

You must file your claim on a HCFA-1450, using bill types 22x and 23x. For these bills, you must complete Item 44 (HCPCS) on the HCFA-1450. Bill for the vaccines and their administration on the same claim. There is no requirement for a separate bill for the vaccines and their administration.

C. HCPCS Coding

Bill for the **vaccines** using the following HCPCS codes listed below:

90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658	Influenza virus, split virus, 3 years and above dosage, for intramuscular or jet injection use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use

Bill for the **administration** of the vaccines using the following HCPCS codes:

G0008	Influenza virus vaccine administration code
G0009	Pneumococcal vaccine administration code

D. Applicable Revenue Codes

Bill for the vaccines using revenue code 636. Bill for the administration of vaccines using the revenue code 771.

The following key information is needed to bill for influenza or pneumococcal vaccinations on individual or roster bills:

	HCPCS Vaccine Code and Description	Administration Code	Diagnosis Code
Influenza	90657 - Split virus, 6-35 months dosage	G0008	V04.8
	90658 - Split virus, 3 years and above dosage	G0008	V04.8
	90659 - Whole virus	G0008	V04.8
Pneumococcal	90732 - Pneumococcal Polysaccharide Vaccine (PPV), 23-valent, adult dosage	G0009	V03.82

E. Other Coding Requirements

You must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim.

V04.8 Influenza virus vaccine diagnosis code

V03.82 PPV diagnosis code

In addition, for the influenza vaccine, report UPIN code SLF000 if the vaccine is not ordered by a doctor of medicine or osteopathy.

F. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers (Roster Billing)

Some potential “mass immunizers” have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. A mass immunizer is defined as any entity that gives the influenza virus vaccine to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same day is required.

The simplified process involves use of the HCFA-1450 with preprinted standardized information relative to you and the benefit. When conducting mass immunizations, attach a standard roster to a single preprinted HCFA-1450 that contains the variable claims information regarding the service provider and individual beneficiaries. The roster must contain, at a minimum, the following information:

- Provider name and number
- Date of service
- Patient name and address
- Patient date of birth
- Patient sex
- Patient health insurance claim number
- Beneficiary signature or stamped “signature on file”

NOTE: A stamped “signature on file” can be used in place of the beneficiary’s actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting “signature on file” in lieu of obtaining the patient’s actual signature.

The modified HCFA-1450 shows the following preprinted information in specific form locators (FLs):

- The words “See Attached Roster” in FL 12, (Patient Name)
- Patient Status code 01 in FL 22 (Patient Status)
- Condition code M1 in FLs 24-30 (Condition Code) (See NOTE: next pg.)
- Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code)
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code)
- “Medicare” on line A of FL 50 (Payer)
- The words “See Attached Roster” on line A of FL 51 (Provider Number)
- Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code)

When conducting mass immunizations, you are required to complete the following FLs on the preprinted HCFA-1450:

- FL 4 (Type of Bill)
- FL 47 (Total Charges)
- FL 85 (Provider Representative)
- FL 86 (Date)

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in the Common Working File (CWF) for all mass immunizer roster bills. However, if you know that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for PPV using the normal billing method, i.e., submission of a HCFA-1450 or electronic billing for each beneficiary.

G. Simplified Billing of Pneumococcal Pneumonia Vaccine (PPV) by Mass Immunizers (Roster Billing)

The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the PPV to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required. The simplified process involves use of the HCFA-1450 with pre-printed standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed HCFA-1450 which will contain the variable claims information regarding the service provider and individual beneficiaries.

The roster must contain, at a minimum, the following information:

- Provider name and number
- Date of service
- Patient name and address
- Patient date of birth
- Patient sex
- Patient health insurance claim number
- Beneficiary signature or stamped “signature on file”

NOTE: A stamped “signature on file” can be used in place of the beneficiary’s actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting “signature on file” in lieu of obtaining the patient’s actual signature.

The roster should contain the following language to be used by you as a precaution to alert beneficiaries prior to administering the PPV:

“WARNING: The beneficiary’s vaccination status must be verified before administering the PPV. It is acceptable to rely on the patient’s memory to determine prior vaccination status. If patients are uncertain whether they have been vaccinated within the past five years, administer the vaccine. If patients are certain that they have been vaccinated within the past five years, do not revaccinate.”

The modified HCFA-1450 shows the following preprinted information in specific form locators (FLs):

- The words “See Attached Roster” in FL 12, (Patient Name)
- Patient Status code 01 in FL 22 (Patient Status)
- Condition code M1 in FLs 24-30 (Condition Code)
(Condition Code)
- Condition Code A6 in FLs 24-30 (Condition Code)
- Revenue code 636 in FL 42 (Revenue Code), along with HCPCS code 90732 in FL 44 (HCPCS Code)
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code)
- “Medicare” on line A of FL 50 (Payer)
- The words “See Attached Roster” on line A of FL 51 (Provider Number)
- Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code)

When conducting mass immunizations, you are required to complete the following FLs on the preprinted HCFA-1450:

- FL 4 (Type of Bill)
- FL 47 (Total Charges)
- FL 85 (Provider Representative)
- FL 86 (Date)

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in the Common Working File (CWF) for all mass immunizer roster bills. However, if you know that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for PPV using the normal billing method i.e., submission of a HCFA-1450 or electronic billing for each beneficiary.

SECTION 7:
ADULT IMMUNIZATION
RESOURCES



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ADULT IMMUNIZATION RESOURCES

1. Oregon Department of Human Services (DHS)

Immunization Program
800 NE Oregon St., Ste. 370
Portland, Oregon 97232
Phone: 503-731-4020
Fax: 503-731-3095

www.ohd.hr.state.or.us/imm/welcome.htm

2. Contact your local health department

3. Latest Immunization News

To keep up with the latest information on immunization, the Immunization Newsbrief is published Mondays, Wednesdays, and Fridays (except holidays) by Information, Inc. and the Infectious Diseases Society.

www.infoinc.com/imnews2/regform/html

4. American Society of Consultant Pharmacists (ASCP)

The *ASCP Statement on the Role of the Consultant Pharmacist in Immunization Programs in the Long-Term Care Environment* and *Guidelines on the Role of the Consultant Pharmacist in Immunization Programs for Long-Term Care Environments* are available on the ASCP web site. These documents serve as a useful starting point for the consultant pharmacist who wishes to assist in implementing these programs.

www.immunizeseniors.org

5. Centers for Disease Control and Prevention

A. The National Immunization Program (NIP) home page has a variety of useful information.

www.cdc.gov/nip/

The NIP page includes links to a number of useful publications, including:

- Immunization schedule for adults
- Recommendations of the Advisory Committee of
- Strategies for increasing adult vaccination rates
- Prevention and Control of VPDs in Long-Term Care Facilities (PDF File)
- Patient Education Materials (dated and nondated) (PDF files)

www.cdc.gov/nip/publications/

Flu Home Page

B. This page contains information on latest recommendations, media reports, surveillance, information on the current vaccine supply, and historical information on past flu seasons.

www.cdc.gov/nip/Flu/default.htm

National Vaccine Program Office

C. The National Vaccine Program Office (NVPO) is a division of the U.S. Department of Health and Human Services. The role of the NVPO is to implement the objectives of the National Vaccine Plan. The NVPO has information on immunization policies, concepts, and laws. You'll also find information on vaccine safety, vaccine publications, the future of vaccines, and more.

www.cdc.gov/od/nvpo

6. National Coalition for Adult Immunization

The National Coalition for Adult Immunization has a variety of resource information relating to adult immunization, including downloadable print materials such as posters, brochures, pamphlets, newsletters, reports, and other promotional materials.

www.nfid.org/ncai

National Adult Immunization Week is the third week of October. The National Coalition on Adult Immunization (NCAI) has developed a campaign kit to support this immunization awareness event. To download a copy of the kit with posters, flyers, and other promotional materials, go to:

www.nfid.org/ncai/publications/naiaw-kit

7. Health Care Financing Administration (HCFA)

HCFA pays for influenza and pneumococcal vaccines for Medicare beneficiaries.

www.hcfa.gov

Links for health care providers on the Medicare Learning Network:

www.hcfa.gov/medlearn/cdcflu.htm

Immunization quick reference guide:

www.hcfa.gov/medlearn/refimmu.htm

Flu and Pneumonia Campaign:

www.hcfa.gov/quality/3g.htm

How to bill Medicare for Flu and Pneumococcal Vaccines:

www.hcfa.gov/quality/3g8.htm

8. Immunization Action Coalition/Hepatitis B Coalition

The Hepatitis B Coalition is a program of the Immunization Action Coalition, a nonprofit organization devoted to boosting immunization issues. The coalition has a variety of resources at this site (see address below).

The Immunization Action Coalition also has a free e-mail newsletter designed to inform health professionals about news and resources related to immunization issues. Interested persons can sign at the Coalition web site (see address below).

www.immunize.org

9. The Immunization Gateway: Your Vaccine Fact Finder

This site is a comprehensive collection of direct links to the most authoritative information about vaccines on the Internet, organized so you will not have to deal with cumbersome indices. This site includes links to Canadian WHO, international, and other pertinent resources. This site is a free service from Facts and Comparisons, Inc.

www.immunofacts.com/

Vaccine Information Statement (VIS) Basics

What is a Vaccine Information Statement?

A Vaccine Information Statement (VIS) is a one-page (two-sided) information sheet, produced by the CDC, informing vaccine recipients—or their parents or legal representatives—of the benefits and risks of a vaccine. The law requires them to be given out whenever certain vaccinations are given.

Who must receive a VIS?

All children and adults who receive vaccines covered under the National Childhood Vaccine Safety Act. As of September 2001, VIS's that must be used are DTaP, Td, MMR, Polio, Hepatitis B, Hib, Varicella, and Pneumococcal Conjugate.

Do providers need to use a VIS for Influenza and Pneumococcal Polysaccharide vaccines?

Maybe. These vaccines are not covered by the National Childhood Vaccine Safety Act, but a VIS must be used if the vaccines were purchased through a CDC contract, such as VFC or 317 funds. A VIS is not required for vaccines purchased through other sources.

For optimum patient understanding of risks and benefits of vaccines, the use of VIS's for Influenza and Pneumococcal Polysaccharide vaccines is highly recommended for all vaccines and all providers.

When must a VIS be given out?

They must be given out at the time of each vaccination—prior to administration of the vaccine.



How To Get Vaccine Information Statements VIS's:

❖ National Immunization Program

www.cdc.gov/nip

You can download all VIS's as PDF documents. These can, ideally, then be printed out to look exactly like their print counterparts—and therefore be used as camera-ready copy. In reality, they don't always print out perfectly. Sometimes the graphics don't come through clearly, and sometimes parts of the forms don't print out at all. Here are some tips that might help if you have problems:

- Make sure you have Adobe Acrobat Reader 3.01 or later.
- Download the file directly to disk by holding down the shift key when you click on the link to the PDF file. Save the file to disk and then open Acrobat Reader and print the file.
- Print one page at a time. If your printer is limited in memory, this can help.

❖ Oregon Department of Human Services

A camera-ready version can be downloaded from the DHS Immunization Program website

www.ohd.hr.state.or.us/imm/welcome.htm

Translations

VIS's are translated into a number of languages by the California and Minnesota immunization programs. Availability of VIS's in languages other than English is evolving, but they should be available in these languages:

Arabic, Croatian (Serbian), Haitian Creole, Laotian, Samoan, Tagalog, Armenian, Farsi, Hmong, Portugese, Serbo-Croatian, Vietnamese Cambodian, French, Japanese, Romanian, Somali, Chinese, German, Korean, Russian, Spanish

Translations can currently be found on two websites:

- Minnesota Health Department
www.health.state.mn.us/divs/dpc/adps/translte.htm
- Immunization Action Coalition
www.immunize.org

For more information, call California at (510) 540-2065 or Minnesota at (612) 676-5237.

A set of six videotapes of VIS's (MMR, DTP, Polio, Hepatitis B, Hib, and Varicella) is available in Spanish from the University of Michigan. Tapes run approximately 5-9 minutes each, and a set costs \$25.

For information, call (517) 353-2596.

SECTION 8:
ACKNOWLEDGMENTS



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Oregon DHS Seniors and People with Disabilities (SPD) received permission from the American Society of Consultant Pharmacists to modify their *100% Immunization Campaign Resource Manual*. We thank them for this generous offer. We hope this manual will be useful to Oregon's long term care facilities.

To receive a copy of the original *100% Immunization Campaign Resource Manual*, contact the American Society of Consultant Pharmacists, 1321 Duke Street, Alexandria, VA 22314-3563, (703) 739-1300, e-mail at info@ascp.com, or visit their web site at <http://www.ascp.com/>

Please contact Grace Hague at Oregon DHS Seniors and People with Disabilities to tell us how this manual can be improved.

Sincerely,
The Oregon Adult Immunization Workgroup

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**DHS Seniors and People with Disabilities
Program & Resource Development**

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