



**News Flash - News Flash** – The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that reporting for the 2007 PQRI on claims for dates of service as of July 1, 2007, has begun. Eligible professionals can now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor. Remember, all your informational needs can be met by visiting the PQRI website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website.. Here you will find educational resources, including the PQRI Tool Kit, and links to our most Frequently Asked Questions (FAQs).

MLN Matters Number: MM5511

Related Change Request (CR) #: 5511

Related CR Release Date: June 29, 2007

Effective Date: July 1, 2007

Related CR Transmittal #: R1278CP

Implementation Date: July 30, 2007

**Note:** This article was updated on August 27, 2012, to reflect current Web addresses. All other information is the same.

## Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 for Part B Influenza Billing

### Provider Types Affected

Physicians, non-physician practitioners, and providers who bill Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MAC)), and use CMS-Form 1500 (08-05) for submitting vaccine and roster claims, especially those who wish to participate in the centralized billing program offered by the Centers for Medicare & Medicaid Services (CMS).

### Key Points of CR5511

It is important that providers who want to participate in centralized billing programs understand and follow the rules governing the program. Specifically, approval to participate in the CMS centralized billing program is a two part approval process. Individuals and corporations who wish to enroll as a CMS Mass Immunizer

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Centralized Biller must send their request to participate as a centralized biller in writing by June 1 of the year they wish to begin centralized billing.

These written requests should be sent to the following address:

**Center for Medicare & Medicaid Services  
Division of Practitioner Claims Processing  
Provider Billing and Education Group  
7500 Security Boulevard  
Mail Stop C4-10-07  
Baltimore, Maryland 21244**

CO will complete Part 1 of the approval process by reviewing preliminary demographic information included in the request for participation letter. **Completion of Part 1 is not approval to set up flu clinics, vaccinate beneficiaries, and bill Medicare for reimbursement.**

All new participants must complete Part 2 of the approval process (Form CMS-855 Application) before they may set up flu clinics, vaccinate Medicare beneficiaries, and bill Medicare for reimbursement. **If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year.** The designated Medicare carrier for centralized billing will provide in writing to CMS CO and to approved centralized billers notification of completion and approval of Part 2 of the approval process. The designated carrier may not process claims for any centralized biller who has not completed Parts 1 and 2 of the approval process. If claims are submitted by a provider who has not received approval of Parts 1 and 2 of the approval process to participate as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

Before September 1 of every year, CMS CO provides the designated carrier with the names of the entities that are authorized to participate in centralized billing for the 12 month period beginning September 1 and ending August 31 of the next year.

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application). ***Providers/suppliers are encouraged to apply to enroll as a centralized biller early as the enrollment process takes 8 -12 weeks to complete. Applicants who have not completed the entire enrollment process and received approval from CMS CO and the designated***

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*carrier to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.*

In addition to the centralized billing processes, the following are revised portions of Chapter 18, Section 10, of the *Medicare Claims Processing Manual*, which is attached to CR5511 (the web address for CR5511 is provided in the *Additional Information* section of this article):

#### ***Chapter 18/Section 10.2.5 - Claims Submitted to Carriers***

- The administration of the influenza virus vaccine is covered in the flu vaccine benefit under §1861(s)(10)(A) of the Act, rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent Health Professional Shortage Area (HPSA) incentive payment *or the 5 percent Physician Scarcity Area (PSA) incentive payment.*
- Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision.

#### ***Chapter 18/Section 10.3.1 - Roster Claims Submitted to Carriers for Mass Immunization***

- If a Public Health Center (PHC) or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 (08-05)

#### ***Chapter 18/Section 10.3.1.1 - Centralized Billing for Flu and Pneumococcal (PPV) Vaccines to Medicare Carriers***

##### **Format Clarifications for Roster Cover Document**

Providers submitting roster claims must complete a cover form CMS-1500 (08-05) and are reminded that:

- Item 32 must be completed to report the name, address, and ZIP code of the location where the service was provided (including centralized billers).
- Item 32a must be completed to report the NPI of the service facility (e.g., hospitals) if it is available. The carrier will use the ZIP code in Item 32 to determine the payment locality for the claim. (The NPI can be reported on the form CMS-1500 (08-05) as of January 1, 2007.)
- Once Medicare requires NPI reporting, the NPI of the billing provider or group must be reported in item 33a. (The NPI can be reported on the form CMS-1500 (08-05) as of January 1, 2007.)

##### **Format Clarifications for Roster Claims**

- Item 33 must be completed to report the provider of service/supplier's billing name, address, ZIP code, and telephone number. Once Medicare requires NPI submissions, the NPI of the billing provider or group must be reported.

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- For electronic claims, the name, address, *and ZIP code* of the facility is reported in:
  - The HIPAA compliant ANSI X12N 837: Claim level loop 2310D NM101=FA. When implemented, the facility (e.g., hospital's) NPI will be reported in the loop 2310D NM109 (NM108=XX) if one is available. Prior to NPI, enter the tax information in loop 2310D NM109 (NM108=24 or 34) and enter the Medicare legacy facility identifier in loop 2310D REF02 (REF01=1C). Report the address, city, state, and ZIP code in loop 2310d N301 and N401, N402, and N403. Facility data is not required to be reported at the line level for centralized billing.
  - Providers note that if a claim is received with an invalid ZIP code, carriers will return the claims as unprocessable.
  - If a claim is received with a ZIP code that is not valid for the street address given, carriers will return the claim as unprocessable.

#### **Chapter 18/Section 10.4.2**

- In your annual request to participate in centralized billing you must also:
  - Include the names and addresses of all entities operating under the corporation's application; and
  - Include contact information for a designated contact person for your centralized billing program.

**Providers should note that the practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment upfront.**

### **Additional Information**

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If you have questions, please contact your Medicare carrier or A/B MAC, at their toll-free number, which may be found at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5511) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1278CP.pdf> on the CMS website.

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