CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4247	**Date: March 1, 2019**
	Change Request 11155

SUBJECT: Update to Publication 100-04 Chapters 2, 6, and 18 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This Change Request contains language-only changes for updating the New Medicare Card Project-related language in Publication 100-04, Chapters 2, 6, and 18. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	2/Table of Contents
R	2/10.1/Medicare beneficiary identifiers
R	2/10.1.1/Changes to Medicare beneficiary identifiers
R	2/10.1.2/Contractor Procedures for Obtaining Missing or Incorrect Medicare beneficiary identifiers
R	2/10.1.3/Importance of Medicare beneficiary identifiers
R	2/10.9/A/B MAC (A), (B), or (HHH), or DME MAC Requests to Verify Patient's Medicare beneficiary identifier
R	2/30/Provider/Supplier Obtaining/Verifying the Medicare beneficiary identifier and Entitlement Status
R	2/30.1/Cross-Reference of Medicare beneficiary identifier
R	2/30.2/Health Insurance (HI) Card
R	2/30.3/Temporary Eligibility Notice
R	2/30.4/Certificate of Social Insurance Award
R	2/30.5/Medicare Summary Notice (MSN)
R	2/30.6/Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data
R	2/70/SSO Assistance in Resolving Entitlement Status Problems
R	2/90.1/Patient Identification
R	6/70.2/Billing for Covered Services
R	6/110.2.1/Reject and Unsolicited Response Edits
R	18/10.3.1/Roster Claims Submitted to A/B MACs (B) for Mass Immunization
R	18/10.3.1.1/Centralized Billing for Influenza Virus and Pneumococcal Vaccines to A/B MACs (B)
R	18/10.3.2/Claims Submitted to A/B MACs (A) for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations
R	18/10.4.1/CWF Edits on A/B MAC (A) Claims
R	18/10.4.2/CWF Edits on A/B MAC (B) Claims
R	18/10.4.3/CWF Crossover Edits for A/B MAC (B) Claims
R	18/150.4/Common Working File (CWF)

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4247	Date: March 1, 2019	Change Request: 11155

SUBJECT: Update to Publication 100-04 Chapters 2, 6, and 18 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: April 1, 2019
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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This Change Request contains language-only changes for updating the New Medicare Card Project language related to the MBI in Publication 100-04, Chapters 2, 6, and 18.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11155.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100-04, Chapters 2, 6, and 18.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 2 - Admission and Registration Requirements

Table of Contents

(Rev.4247, Issued: 03-01-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

10.1 - *Medicare beneficiary identifiers*

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The CMS maintains the electronic records for individuals enrolled in the health insurance program. The CMS issues health insurance cards where entitlement is established through the Social Security Administration (SSA), and the Railroad Retirement Board (RRB) issues health insurance cards where entitlement is established through RRB.

See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01) for an extended discussion of HI cards and *Medicare beneficiary identifiers*.

10.1.1 - Changes to *Medicare beneficiary identifier*

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Changes in an individual's entitlement to Medicare benefits may result in an individual being assigned a completely different HICN. For example, an individual not entitled to monthly benefits (000-00-0000T) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B). If a claim is submitted under the old HICN, the Common Working File (CWF) disposition code 51 will notify the *A*/B MAC (A), (B), (HHH), or DME MAC (whom we will refer to as the MAC when all are meant) of the new HICN. The MAC will annotate its records and use the new HICN when submitting future bills or claims.

10.1.2 - Contractor Procedures for Obtaining Missing or Incorrect *Medicare beneficiary identifiers*

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Upon receipt of a claim or other paper on which the *Medicare beneficiary identifier* is omitted, incomplete, inconsistent, or obviously incorrect, the MAC submits the claim to CWF with the best information it has available. Depending on the CWF reply, the MAC follows the instructions in Chapter 27 for handling various disposition codes, trailers, and error codes.

10.1.3 - Importance of *Medicare beneficiary identifiers*

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new

Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The *Medicare beneficiary identifier* is used in Medicare records to identify the beneficiary. The provider or supplier obtains this number before billing. See §30 below for a description of appropriate processes for obtaining the *Medicare beneficiary identifier*.

10.9 - A/B MAC (A), (B), or (HHH), or DME MAC Requests to Verify Patient's *Medicare beneficiary identifier*

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Where the name and *Medicare beneficiary identifier* information on a claim does not match the CMS central record, the A/B MAC (A), (B), or (HHH), or DME MAC will return the claim to the provider and request the provider to verify the information.

The provider will compare the name and number on the claim with that on provider records. If the information submitted was incorrect, the provider will return the claim to the MAC with the corrected information.

If, however, the information in the provider's records identifying the patient is the same as the information submitted on the claim, the provider will contact the SSO for assistance.

30 - Provider/Supplier Obtaining/Verifying the *Medicare beneficiary identifier* and Entitlement Status

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

It is important that the patient's *Medicare beneficiary identifier* be obtained and accurately recorded because the claim cannot be processed if the *Medicare beneficiary identifier* is missing or incorrect. A social security number is not sufficient.

When a patient 65 years of age or over, or a younger patient who possibly has entitlement to Medicare as a disability beneficiary or under the provisions for coverage of persons needing a kidney transplantation or dialysis, is admitted or registered for services, the provider asks for the health insurance card, Temporary Notice of Medicare Eligibility, or other notice the patient has received from CMS or an A/B MAC (A), (B), (HHH), or DME MAC which shows the *Medicare beneficiary identifier*. If a patient or prospective patient is within three months of age 65, or is disabled or has ESRD, and has not applied for HI entitlement, the provider advises the patient to contact the SSO, or to have someone do so on the patient's behalf. The provider may arrange with the SSO to routinely bring such cases to the SSO's attention.

This requirement also applies to inpatient services for which no payment is due because providers are required to submit inpatient claims even when benefits are exhausted or are not payable for some reason. The CMS requires this data to record necessary benefit information on CMS records. Where the patient refuses to request payment and refuses to furnish information about his/her *Medicare beneficiary identifier*,

the provider documents the records accordingly and attempts to get the *Medicare beneficiary identifier* from the SSO.

30.1 - Cross-Reference of *Medicare Beneficiary Identifier*

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

If a beneficiary's entitlement to Medicare has been transferred from one *Medicare beneficiary identifier* to another, the CWF will cross-reference the old number to the new number. If there has been utilization of benefits under each number, all data will be combined under the new number.

A. Disposition Code 51

1. If, after submitting the admission notice or Part B claim to CMS, the MAC receives a disposition code of 51 with trailer code 01 containing a possible *Medicare beneficiary identifier*, the MAC investigates the new *Medicare beneficiary identifier*, and if it believes the new *Medicare beneficiary identifier* is correct, the MAC resubmits the claim under the new *Medicare beneficiary identifier*. CWF responds with an appropriate disposition code and any associated trailers for processing the claim.

2. If the MAC receives a disposition code of 51 without trailer code 01, or after investigation determines the *Medicare beneficiary identifier* in the 01 trailer is incorrect, it denies the claim using the following message:

> Payment cannot be made for the services you received from (name of provider) because we have no record of your Medicare *beneficiary identifier*. Please write your correct number on the claim and resubmit the claim to (name of provider). If you think the number is right, check with your local Social Security Office.

B. Disposition Code 55

If CWF returns disposition code 55 and trailer code 08 containing an error code of 5052, indicating a mismatch in the beneficiary's personal characteristics, CWF will also return to the MAC what it believes to be the proper information on trailer code 10. The header portion of the response also contains the corrected sex and birth date, if applicable, of the beneficiary.

The MAC investigates the information provided, corrects the information on the claim, and resubmits it to CWF. If the MAC continues to receive a code 55, it contacts the Host through locally established procedures. See Chapter 27.

30.2 - Health Insurance (HI) Card

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

As part of health insurance electronic data processing, HI cards are issued by CMS (or by the RRB where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. (See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual.) The health insurance card is used to identify the individual as being entitled and serves as a source of information required to process Medicare claims or bills. The health insurance card displays the beneficiary's name, sex, *Medicare beneficiary identifier*, and effective date of entitlement to hospital insurance and/or medical insurance.

If any MAC receives an inquiry about replacing a lost or destroyed HI card, it informs the inquirer to get in touch with the SSO nearest the inquirer's address for assistance. SSO addresses are generally listed in local telephone directories under "Social Security Administration."

A health insurance card is acceptable without a signature, but the provider will ask the patient to sign it.

30.3 - Temporary Eligibility Notice

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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The SSO may issue a temporary health insurance eligibility notice, pending the issuance of a health insurance card, when the beneficiary is in need of immediate medical services. The provider may obtain the patient's name and *Medicare beneficiary identifier* from the temporary eligibility notice. See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual for an example of the temporary notice.

For claims processed by the A/B MAC (B) or DME MAC, the individual, the individual's physician, or other supplier must show the *Medicare beneficiary identifier* on the request for Medicare payment and on other related bills and documents. Because Health Insurance records are maintained by the individual's *Medicare beneficiary identifier*, the *Medicare beneficiary identifier* must be used on all communications.

30.4 - Certificate of Social Insurance Award

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Health insurance beneficiaries receive a Certificate of Social Insurance Award, SSA-30, showing the *Medicare beneficiary identifier*, dates of entitlement to Part A and/or Part B benefits, and the following statement:

> This notice may be used if Medicare services are needed before you receive your health insurance card.

30.5 - Medicare Summary Notice (MSN)

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

If patients cannot furnish their health insurance cards when admitted, they may have a MSN form showing the *Medicare beneficiary identifier*. A notice is mailed to a beneficiary shortly after Part A or Part B benefits have been paid on the beneficiary's behalf. Deductible status is also shown on these forms.

30.6 - Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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The A/B MAC (A) or (HHH) will allow only Medicare certified providers as defined in §§1861 and 1866(e) of the Social Security Act (the Act) and their billing agents automated access to beneficiary eligibility data. Disclosure of CWF eligibility data is restricted under provisions of the Privacy Act of 1974, 5 U.S.C §552a. Under limited circumstances, the Privacy Act permits CMS to disclose information without consent of the individual. One circumstance is for "routine uses," that is, disclosure for purposes that are compatible with the purpose for which CMS collects the information. In the case of this provider access, a routine use exists which permits release of data to providers or their authorized billing agents for the purpose of verifying a patient's eligibility for benefits under the Medicare program. The use of the data by a provider in preparing claims for hospital-based physicians would be an example of unauthorized use because the physicians are not Medicare providers as defined in the Act.

A/B MACs (A) or (HHH) will adjust their systems to accept the revised standard HIQA/HUQA records from the CMS CWF. The standard data elements to be made available to providers are listed below:

- *Medicare beneficiary identifier*;
- Beneficiary:
  - Last name (first six positions)/first initial;
  - Date of birth;
  - Sex;
  - Date of death;
  - Lifetime reserve days remaining;
  - Lifetime psychiatric days remaining (requesting hospital must use a psychiatric provider number to obtain this data);
  - Cross reference *Medicare beneficiary identifier*;

- Current and prior A and B entitlements, with start and stop dates for Part A, Part B, ESRD, HMO, and hospice; and

- Spell of illness (applicable spell based on the date entered by the provider and the next most recent spell):

    - Hospital full days remaining;

    - Hospital coinsurance days remaining;

    - SNF full days remaining;

    - SNF coinsurance days remaining;

    - Part A cash deductible remaining to be met;

    - Date of earliest billing action for indicated spell-of-illness;

    - Date of latest billing action for indicated spell-of-illness;

    - Blood deductible (combined annual Part A and B remaining to be met for applicable year entered by provider);

    - Part B trailer year (applicable year based on date entered by provider);

    - Part B cash deductible;

    - Physical therapy/speech-language pathology limit (physical therapy and speech-language pathology are applicable to physical therapy limit);

    - Occupational therapy limit;

    - Hospice data (applicable periods based on the date entered by the provider and the next most recent period);

    - ESRD indicator (shows beneficiary is currently entitled);

    - REP payee indicator;

    - MSP indicator;

    - Home Health Benefit Period:

        - Part A visits remaining;

        - Part B visits applied;

- Date of earliest billing action for home health benefit period;
- Date of latest billing action for home health benefit period.

- HMO information (applicable periods based on date entered by the provider):
  - Name;
  - Identification number;
  - ZIP Code;
  - Option code;
  - Start date;
  - Termination date;
  - Pap smear screening risk indicator, professional date, and technical date;
  - Mammography screening risk indicator (applicable to screening services prior to January 1, 1998), professional date, and technical date;
  - Colorectal screening (no risk indicator); procedure code, professional date, and technical date;
  - Pelvic screening risk indicator and professional date;
  - Pneumococcal pneumonia vaccine (PPV) date;
  - Influenza virus vaccine date; and
  - Hepatitis B vaccine date.

See Chapter 10 of this manual for a complete discussion of the HIQH (Health Insurance Query for Home Health Agencies).

The A/B MAC (A) will make sure that psychiatric information is not being made available to all hospitals. This information is to be made available **only** to psychiatric hospitals or hospitals that furnish inpatient psychiatric hospital services.

Providers may use direct entry terminals or dial-up terminals to inquire about beneficiary eligibility utilization and deductible status. The A/B MAC (A) must use either the HIQA screen display (see §30.6.1.1) or create its own Customer Information Control System (CICS) screens from the HUQA data records (see §§30.6.1.2 and 30.6.1.3). Providers may not have access to any other CWF records, e.g., the health insurance master record (HIMR). The data must be from CWF. The A/B MAC (A) will not substitute local history.

70 - SSO Assistance in Resolving Entitlement Status Problems

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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A. Social Security Office (SSO) Assistance

The A/B MAC (A), (B), or (HHH), or DME MAC directs initial requests for assistance to the SSO if the problem is caused by difficulties in determining the beneficiary's correct entitlement status. Examples of situations that may require SSO assistance are:

- Problems involving Railroad Retirement Board (RRB) jurisdiction;
- Evidence that a beneficiary has utilization under more than one *Medicare beneficiary identifier* but there is no awareness of any cross-reference action taken by CMS; or
- The beneficiary's name, address, sex code, date of birth, or date of death is incorrect on the HI master record.

In the event the SSO is unable to resolve the entitlement problem (e.g., cross referencing of HI records), the MAC requests assistance from the RO.

90.1 - Patient Identification

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Upon registration of a Medicare beneficiary, or as soon thereafter as practical, the hospital will ask the patient for his/her health insurance card to obtain the *Medicare beneficiary identifier*. If the patient is unable to provide it, the hospital will contact the SSO for assistance.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

70.2 - Billing for Covered Services

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Upon cessation of a SNF's participation in the program, or when a SNF is not receiving payments for new admissions, the RO is supplied with the names and *Medicare beneficiary identifiers* of Medicare beneficiaries entitled to have payment made on their behalf for services in accordance with §80.1.

SNFs no longer participating in the program, or those under a denial of payment for new admissions, continue to bill for covered services per §80.l. They continue to submit "no-payment" death, discharge and reduction from SNF level of care bills for Medicare beneficiaries admitted prior to the termination of their agreement, or prior to the denial of payments for new admissions.

110.2.1 - Reject and Unsolicited Response Edits

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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A. Reject Edits

When CWF receives a bill from the SNF that shows that a beneficiary became a resident of a SNF, that SNF stay is posted to history. Effective April 2002, for claims processed and adjusted with dates of service on or after April 1, 2001, CWF will apply the reject edits to any claims received after the SNF stay is posted that have dates of service during the periods the beneficiary is shown to have been a resident of the SNF based on that first SNF bill. These claims can be correctly rejected since it will be clear that the beneficiary was in the SNF during those spans that were shown on the SNF claim. This process will repeat when the next SNF bill is received. The process will continue until CWF posts a discharge date, date of death, or the covered number of SNF days has been used.

Based on the CWF line item rejects, A/B MACs (B)/DME MACs must deny assigned and unassigned services they have been billed that should have been consolidated and paid by the SNF and/or billed to the A/B MAC (A). Appeals rights must be offered on all denials. Shared systems must develop, and along with A/B MACs (B)/DME MACs must implement, an automated resolution process whereby when they receive a reject from CWF, they must pay those services correctly billed and only deny those services on the claim incorrectly billed to them.

B. Unsolicited Response Edits

Effective July 1, 2002, CWF implemented the unsolicited response edit based on the same coding files made available for the reject edits. Upon receipt of a Part A SNF claim at CWF, CWF searches paid claims history and compares the period between the SNF from and through dates to the line item service dates of the claims in history. It then identifies any services within the dates of the SNF stay that should have been subject to consolidated billing and should not have been separately paid by the A/B MAC (B)/DME MAC.

The CWF generates an unsolicited response, with a trailer that contains the identifying information regarding the claim subject to consolidated billing and a new trailer containing line item specific information that identifies all the individual services on that claim that fall within the SNF period. The unsolicited response provides all necessary information to identify the claim, including Document Control Number, *Medicare beneficiary identifier*, beneficiary name, date of birth, and beneficiary sex. CWF electronically transmits this unsolicited response to the A/B MAC (B)/DME MAC that originally processed the claim with consolidated services. These unsolicited responses are included in the CWF response file. The unsolicited responses in that file for claims to be adjusted for consolidated billing are identified with a unique transaction identifier. The previously paid claim is not canceled and remains on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response, the shared system software reads the line item information in the new trailer for each claim and performs an automated adjustment to each claim. Services subject to consolidated billing must be denied at the line level. The adjusted claims must then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. A/B MACs (B)/DME MACs must return the claims with entry code 5. Both the covered and the non-covered services must be returned to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible is updated on the beneficiary's file and the corrected deductible information is returned to the A/B MAC (B)/DME MAC in trailer 11. To recover any monies due back to Medicare resulting from these denials, A/B MACs (B)/DME MACs must follow the criteria in current overpayment recovery for the policy guidelines for furnishing demand letters and granting appeals rights.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim is adjusted by the standard system to line item deny all the services on the claim. These fully non-covered claims must be returned to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS's national claims history file. A/B MAC (B)/DME MAC systems must employ existing processes for the submission of fully non-covered claims.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

10.3.1 - Roster Claims Submitted to A/B MACs (B) for Mass Immunization
(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

If the PHC or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 that contains standardized information about the entity and the benefit. See chapter 26, §10 for more information about the CMS-1500 claim form. Key information from the beneficiary roster list and the abbreviated claim form is used to process pneumococcal and influenza virus vaccination claims.

Separate CMS-1500 claim forms, along with separate roster bills, must be submitted for pneumococcal and influenza roster billing.

If other services are furnished to a beneficiary along with pneumococcal or influenza virus vaccine, individuals and entities must submit claims using normal billing procedures, e.g., submission of a separate claim for each beneficiary.

A/B MACs (B) must create and count one claim per beneficiary from roster bills. They must split claims for each beneficiary if there are multiple beneficiaries included in a roster bill. Providers must show the unit cost for one service on the claim. The A/B MACs (B) must replicate the claim for each beneficiary listed on the roster.

A/B MACs (B) must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for pneumococcal and influenza virus vaccine and their administration. If PHCs or other individuals or entities inappropriately bill pneumococcal or influenza virus vaccinations using the roster billing method, A/B MACs (B) return the claim to the provider with a cover letter explaining why it is being returned and the criteria for the roster billing process. A/B MACs (B) may not deny these claims.

Providers must retain roster bills with beneficiaries' signatures at their permanent location for a time period consistent with Medicare regulations.

A. Modified Form CMS-1500 for Cover Document

Entities submitting roster claims to A/B MACs (B) must complete the following blocks on a single modified Form CMS-1500, which serves as the cover document for the roster for each facility where services are furnished. In order for A/B MACs (B) to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility or physical location where services are furnished.

Item #	Instruction
Item 1:	An X in the Medicare block
Item 2:	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11:	(Insured's Policy Group or FECA Number): "NONE"
Item 20:	(Outside Lab?): An "X" in the NO block
Item 21:	(Diagnosis or Nature of Illness): Line A: Choose appropriate diagnosis code from §10.2.1 ICD Ind. Block: Enter 9 if ICD-9-CM or 0 if ICD-10-CM is applicable. Enter the indicator as a single digit between the vertical dotted lines.

Item #	Instruction
Item 24B:	(Place of Service (POS)): Line 1: "60" Line 2: "60" NOTE: POS Code “60" must be used for roster billing.
Item 24D:	(Procedures, Services or Supplies): Line 1: Pneumococcal vaccine: "90732" or Influenza Virus vaccine: “Select appropriate influenza virus vaccine code” Line 2: Pneumococcal vaccine Administration: "G0009" or Influenza Virus Vaccine Administration: "G0008"
Item 24E:	(Diagnosis Pointer): Lines 1 and 2: "A"
Item 24F:	($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC pneumococcal or influenza virus vaccine claims only if your system is able to accept them.
Item 27:	(Accept Assignment): An "X" in the YES block.
Item 29:	(Amount Paid): "$0.00"
Item 31:	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.
Item 32:	Enter the name, address, and ZIP code of the location where the service was provided (including centralized billers).
Item32a:	Enter the NPI of the service facility.
Item 33:	(Physician's, Supplier's Billing Name): The entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or NPI when required.
Item 33a:	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.

B. Format of Roster Claims

Qualifying individuals and entities must attach to the CMS-1500 claim form, a roster which contains the variable claims information regarding the supplier of the service and individual beneficiaries. While qualifying entities must use the modified Form CMS-1500 without deviation, A/B MACs (B) must work with these entities to develop a mutually suitable roster that contains the minimum data necessary to satisfy claims processing requirements for these claims. A/B MACs (B) must key information from the beneficiary roster list and abbreviated Form CMS-1500 to process pneumococcal and influenza virus vaccination claims.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;

NOTE: Although physicians who provide pneumococcal or influenza virus vaccinations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.

- Control number for A/B MAC (B);
- Patient's *Medicare beneficiary identifier*;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file".

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster claim form if the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, the provider is not required to obtain the patient signature on the roster, but instead has the option of reporting signature on file in lieu of obtaining the patient's actual signature.

The pneumococcal roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the pneumococcal vaccination.

WARNING: Beneficiaries must be asked if they have received a pneumococcal vaccination.

- Rely on patients' memory to determine prior vaccination status.

10.3.1.1 - Centralized Billing for Influenza Virus and Pneumococcal Vaccines to A/B MACs (B)

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The CMS currently authorizes a limited number of providers to centrally bill for influenza virus and pneumococcal immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different contractors processing claims. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given and the contractor must verify this through the enrollment process.

Centralized billers must send all claims for influenza virus and pneumococcal immunizations to a single contractor for payment, regardless of the jurisdiction in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) Payment is made based on the payment locality where the service was provided. This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The general coverage and coding rules still apply to these claims.

This section applies only to those individuals and entities that provide mass immunization services for influenza virus and pneumococcal vaccinations and that have been authorized by CMS to centrally bill. All other providers, including those individuals and entities that provide mass immunization services that are not authorized to centrally bill, must continue to bill for these claims to their regular A/B MAC (B) per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to the designated processing contractor. However, all A/B MACs (B) must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All A/B MACs (B)."

A. Processing Contractor

The CMS central office will notify centralized billers of the appropriate contractor to bill when they receive their notification of acceptance into the centralized billing program.

B. Request for Approval

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 centralized biller must send their request in writing. CMS 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 vaccination 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 vaccination 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 for approval each year. The designated contractor shall provide in writing to CMS and approved centralized billers notification of completion and approval of Part 2 of the approval process. The designated contractor 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 contractor must return the claims to the provider to submit to the A/B MAC (B) for payment.

C. Notification of Provider Participation to the Processing Contractor

Before September 1 of every year, CMS will provide the designated contractor 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.

D. Enrollment

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 contractor 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 possible. Applicants who have not completed the entire enrollment process and received approval from CMS and the designated contractor to participate

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

Whether an entity enrolls as a provider type "Mass Immunization Roster Biller" or some other type of provider, all normal enrollment processes and procedures must be followed. Authorization from CMS to participate in centralized billing is dependent upon the entity's ability to qualify as some type of Medicare provider. In addition, as under normal enrollment procedures, the contractor must verify that the entity is fully qualified and certified per state requirements in each state in which they plan to operate.

The contractor will activate the provider number for the 12-month period from September 1 through August 31 of the following year. If the provider is authorized to participate in the centralized billing program the next year, the contractor will extend the activation of the provider number for another year. The entity need not re-enroll with the contractor every year. However, should there be changes in the states in which the entity plans to operate, the contractor will need to verify that the entity meets all state certification and licensure requirements in those new states.

E. Electronic Submission of Claims on Roster Bills

Centralized billers must agree to submit their claims on roster bills in an electronic media claims format. The processing contractor must provide instructions on acceptable roster billing formats to the approved centralized billers. Paper claims will not be accepted.

F. Required Information on Roster Bills for Centralized Billing

In addition to the roster billing instructions found in §10.3.1 of this chapter, centralized billers must provide on the claim the ZIP code (to determine the payment locality for the claim), and the provider of service/supplier's billing name, address, ZIP code, and telephone number. In addition, the NPI of the billing provider or group must be appropriately reported.

G. Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments vary based on the geographic locality where the service was performed.

The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, prior to March 1, 2003, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated contractor must pay per the correct MPFS file for each calendar year based on the date of service of the claim. Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471.

In order to pay claims correctly for centralized billers, the designated contractor must have the correct name and address, including ZIP code, of the entity where the service was provided.

The following remittance advice and Medicare Summary Notice (MSN) messages apply:

> **Claim adjustment reason code 16**, "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code,
>
> **Remittance advice remark code MA114**, "Missing/incomplete/invalid information on where the services were furnished."
>
> **MSN 9.4** - "This item or service was denied because information required to make payment was incorrect."

The payment rates for the vaccines must be determined by the standard method used by Medicare for reimbursement of drugs and biologicals. (See chapter 17 for procedures for determining the payment rates for vaccines.)

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of influenza virus and pneumococcal vaccines must accept assignment for the vaccine. In addition, as a requirement for both centralized billing and roster billing, providers must agree to accept assignment for the administration of the vaccines as well. This means that they must agree to accept the amount that Medicare pays for the vaccine and the administration. Also, since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

H. Common Working File Information

To identify these claims and to enable central office data collection on the project, special processing number 39 has been assigned. The number should be entered on the HUBC claim record to CWF in the field titled Demonstration Number.

I. Provider Education Instructions for the Processing Contractor

The processing contractor must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on influenza virus and pneumococcal coverage and billing instructions is available on the CMS Web site for providers.

J. Provider Education Instructions for All A/B MACs (B)

By April 1 of every year, all A/B MACs (B) must publish in their bulletins and put on their Web sites the following notification to providers. Questions from interested providers should be forwarded to the central office address below. A/B MACs (B) must enter the name of the assigned processing contractor where noted before sending.

NOTIFICATION TO PROVIDERS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and pneumococcal pneumonia virus (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

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

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

CRITERIA FOR CENTRALIZED BILLING

- To qualify for centralized billing, an individual or entity providing mass immunization services for influenza virus and pneumococcal vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.

- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.

- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore.

  NOTE: 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.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is [Fill in name of contractor.]

- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.

- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.

- Centralized billers must submit their claims on roster bills in an approved electronic format. Paper claims will not be accepted.

- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. [Fill in name of contractor] must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare *beneficiary identifier*) as the contractor will not be able to process incomplete or incorrect claims.

- Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary by the contractor. Beneficiaries are sometimes confused when they receive an MSN from a contractor other than the contractor that normally

processes their claims which results in unnecessary beneficiary inquiries to the Medicare contractor. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing contractor. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. [Fill in name of contractor] can provide this information.

- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from [Fill in name of contractor]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [Fill in name of contractor].

- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Claims will not be processed for any centralized biller without permission from CMS.

- Each year the centralized biller must contact [Fill in name of contractor] to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.

- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

- The information in items 1 through 8 below must be included with the individual or entity's annual request to participate in centralized billing:

    1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;

    2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;

    3. The approximate dates for when the vaccinations will be given;

    4. A list of the states in which influenza virus and pneumococcal clinics will be held;

    5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);

    6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations;

    7. Names and addresses of all entities operating under the corporation's application;

8. Contact information for designated contact person for centralized

10.3.2 - Claims Submitted to A/B MACs (A) for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Some potential "mass immunizers," such as hospital outpatient departments and HHAs, 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. The simplified (roster) claims filing procedure has been expanded for the pneumococcal vaccine. A mass immunizer is defined as any entity that gives the influenza virus vaccine or pneumococcal 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 date are required. (See §10.3.2.2 for an exception to this requirement for inpatient hospitals.)

The simplified (roster) claims filing procedure applies to providers other than RHCs and FQHCs that conduct mass immunizations. Since independent and provider based RHCs and FQHCs do not submit individual Form CMS-1450s for the influenza virus vaccine, they do not utilize the simplified billing process. Instead, payment is made for the vaccine at the time of cost settlement.

The simplified process involves use of the provider billing form (Form CMS-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form CMS-1450 that contains the variable claims information regarding the service provider and individual beneficiaries.

Qualifying individuals and entities must attach a roster, which contains the variable claims information regarding the supplier of the service 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 *Medicare beneficiary identifier*; and
- Beneficiary signature or stamped "signature on file."

In addition, for inpatient Part B services (12x and 22X) the following data elements are also needed:

- Admission date;
- Admission type;

- Admission diagnosis;
- Admission source code; and
- Patient status code.

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature for all institutional providers that roster bill from an inpatient or outpatient department provided the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature on the roster. However, the provider has the option of reporting "signature on file" in lieu of obtaining the patient's actual signature on the roster.

The pneumococcal vaccine roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the pneumococcal vaccine.

Warning: Beneficiaries must be asked if they have been vaccinated with the pneumococcal vaccine.

- Rely on the patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate**.

For providers using the simplified billing procedure, the modified Form CMS-1450 shows the following preprinted information in the specific form locators (FLs). Information regarding the form locator numbers that correspond to the data element names below is found in chapter 25:

- The words "See Attached Roster" (Patient Name);
- Patient Status code 01 (Patient Status);
- Condition code M1 (Condition Code) (See NOTE below);
- Condition code A6 (Condition Code);
- Revenue code 636 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 (Revenue Code), along with the appropriate "G" HCPCS code (HCPCS Code);
- "Medicare" (Payer, line A);
- The words "See Attached Roster" (Provider Number, line A); and
- Diagnosis code

- **ICD-9-CM** - V03.82 for the pneumococcal vaccine or V04.8 for Influenza Virus vaccine (Principal Diagnosis Code). For influenza virus vaccine claims with dates of service October 1, 2003 and later, use diagnosis code V04.81.

- **ICD-10-CM** - Use Z23 for an encounter for immunization effective with the implementation of ICD-10.

- Influenza virus vaccines require:

  - the UPIN SLF000 on claims submitted before May 23, 2007, or

  - the provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2007.

Providers conducting mass immunizations are required to complete the following fields on the preprinted Form CMS-1450:

- Type of Bill;

- Total Charges;

- Provider Representative; and

- Date.

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in CWF for all mass immunization roster bills. However, if the provider knows that a particular group health plan covers the pneumococcal vaccine and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed. First claim development alerts from CWF are not generated for the pneumococcal and influenza virus vaccines.

Contractors use the beneficiary roster list to generate claim records to process the pneumococcal vaccine claims by mass immunizers indicating condition code M1 to avoid MSP editing. Standard System Maintainers must develop the necessary software to generate records that will process through their system.

Providers that do not mass immunize must continue to bill for the pneumococcal and influenza virus vaccines using the normal billing method, e.g., submission of a Form CMS-1450 or electronic billing for each beneficiary.

10.4.1 - CWF Edits on A/B MAC (A) Claims

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

In order to prevent duplicate payment by the same A/B MAC (A), CWF edits by line item on the A/B MAC (A) number, the beneficiary *Medicare beneficiary identifier*, and the date of service, the influenza

virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686,
90687, 90688**, or 90756** and the pneumococcal procedure codes 90670 or 90732, and the administration codes G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688**, or 90756** and it already has on record a claim with the same *Medicare beneficiary identifier*, same A/B MAC (A) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.

If CWF receives a claim with HCPCS codes 90670 or 90732 and it already has on record a claim with the same *Medicare beneficiary identifier*, same A/B MAC (A) number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same *Medicare beneficiary identifier*, same A/B MAC (A) number, same date of service, and same procedure code, CWF rejects the second claim submitted when all four items match.

CWF returns to the A/B MAC (A) a reject code “7262” for this edit. A/B MACs (A) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

10.4.2 - CWF Edits on A/B MAC (B) Claims

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

In order to prevent duplicate payment by the same A/B MAC (B), CWF will edit by line item on the A/B MAC (B) number, the *Medicare beneficiary identifier*, the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688**, or 90756**; the pneumococcal procedure codes 90670 or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688**, or 90756** and it already has on record a claim with the same *Medicare beneficiary identifier*, same A/B MAC (B) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS codes 90670 or 90732 and it already has on record a claim with the same *Medicare beneficiary identifier*, same A/B MAC (B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same *Medicare beneficiary identifier*, same A/B MAC (B) number, same date of service, and same procedure code, CWF will reject the second claim submitted.
CWF will return to the A/B MAC (B) a specific reject code for this edit. A/B MACs (B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

In order to prevent duplicate payment by the centralized billing contractor and local A/B MAC (B), CWF will edit by line item for A/B MAC (B) number, same *Medicare beneficiary identifier*, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688**, or 90756**; the pneumococcal procedure codes 90670 or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688**, or 90756** and it already has on record a claim with a different A/B MAC (B) number, but same *Medicare beneficiary identifier*, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS codes 90670 or 90732 and it already has on record a claim with the same *Medicare beneficiary identifier*, different A/B MAC (B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different A/B MAC (B) number, but the same *Medicare beneficiary identifier*, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for this edit. A/B MACs (B) must deny the second claim. For the second edit, the reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

MSN: 7.2 – “This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.”

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

10.4.3 - CWF Crossover Edits for A/B MAC (B) Claims

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

When CWF receives a claim from the A/B MAC (B), it will review Part B outpatient claims history to verify that a duplicate claim has not already been posted.

CWF will edit on the beneficiary *Medicare beneficiary identifier*; the date of service; the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, **90658,** 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688**, or 90756**; the pneumococcal procedure codes 90670 or 90732; and the administration code G0008 or G0009.

CWF will return a specific reject code for this edit. A/B MACs (B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

150.4 - Common Working File (CWF)

(Rev.4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new

Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The Common Working File (CWF) shall edit for the frequency of service limitations of counseling to prevent tobacco use sessions and smoking and tobacco-use cessation counseling services (G0436, G0437, 99406, 99407) rendered to a beneficiary for a combined total of 8 sessions within a 12-month period. The beneficiary may receive another 8 sessions during a second or subsequent year after 11 full months have passed since the first Medicare covered counseling session was performed. To start the count for the second or subsequent 12-month period, begin with the month after the month in which the first Medicare covered counseling session was performed and count until 11 full months have elapsed.

By entering the *Medicare beneficiary identifier*, providers have the capability to view the number of sessions a beneficiary has received for this service via inquiry through CWF.