CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 525 **Date: APRIL 15, 2005**

CHANGE REQUEST 3733

NOTE: Transmittal 519, Dated April 8, 2005, is being rescinded and replaced by Transmittal 525, Dated April 15, 2005. This transmittal is being rescinded and replaced with Transmittal 525 to correct Part II. Section 10.2.2 is not being deleted from chapter 18. All other changes in the manual instruction remain the same.

SUBJECT: Flu/PPV Revisions

I. SUMMARY OF CHANGES: This instruction revises chapter 18, removing outdated information and clarifying HCPCS codes.

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES: Not Applicable.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/10.2/Billing Requirements
R	18/10.2.1/Healthcare Common Procedural Coding System (HCPCS) and Diagnosis Codes
R	18/10.2.5.2/Carrier Payment Requirements
R	18/10.3.1/Roster Claims Submitted to Carriers for Mass Immunization
R	18/10.3.1.1/Centralized Billing for Flu and Pneumococcal (PPV) Vaccines to Medicare Carriers
R	18/10.4/CWF Edits
R	18/10.4.2/CWF Edits on Carrier Claims

III. FUNDING: No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

10.2 - Billing Requirements

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

A - Edits Not Applicable to PPV or Influenza Virus Vaccine Bills and Their Administration

The CWF and shared systems bypass all Medicare Secondary Payer (MSP) utilization edits in Common Working File (CWF) on all claims when the only service provided is PPV or influenza virus vaccine and/or their administration. This waiver does not apply when other services (e.g., office visits) are billed on the same claim as PPV or influenza vaccinations. If the provider knows or has reason to believe that a particular group health plan covers PPV or influenza virus vaccine and their administration, 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 PPV or influenza virus vaccines. However, first claim development is performed if other services are submitted along with PPV or development is performed if other services are submitted along with PPV or influenza virus vaccines.

See the Medicare Secondary Payer Manual, Chapters 4 and 5, for responsibilities for MSP development where applicable.

B – Intermediary (FI) Bills

Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to FIs.

The following “providers of services” may administer and bill the FI for these vaccines:

- Hospitals;
- Critical Access Hospitals (CAHs);
- Skilled Nursing Facilities (SNFs);
- Home Health Agencies (HHAs); and
- Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Other billing entities that may bill the FI are:

- Independent Renal Dialysis Facilities (RDFs).

All providers bill the FI for hepatitis B on Form CMS-1450. Providers other than independent RHCs and freestanding FQHCs bill the FI for influenza and PPV on Form CMS-1450. (See §10.2.2.2 of this chapter for special instructions for independent RHCs and freestanding FQHCs and §10.2.4 of this chapter for hospice instruction.)

FIs instruct providers, other than independent RHCs and freestanding FQHCs, to bill for the vaccines and their administration on the same bill. Separate bills for vaccines and their administration are not required. The only exceptions to this rule occur when the vaccine is administered during the course of an otherwise covered home health visit since the vaccine or its administration is not included in the visit charge. (See §10.2.3 of this chapter).

C - Carrier Claims

1 - Billing for Additional Services

When a physician/supplier administers PPV, influenza virus, or hepatitis B vaccines without providing any other additional services during the visit, the provider may only bill for the vaccine and its administration. These services are always separately payable, whether or not other services are also provided during the same encounter. The physician/supplier may bill for additional reasonable and necessary services in addition to the administration of PPV, influenza virus, and/or hepatitis B vaccines.

2 - Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary *for the administration of the vaccines,* but must submit an unassigned claim on the beneficiary's behalf. *Effective for claims with dates of service on or after February 1, 2001, per §114 of the Benefits Improvement and Protection Act of 2000, all drugs and biologicals must be paid based on mandatory assignment. Therefore, regardless of whether the physician and supplier usually accept assignment, they must accept assignment for the vaccines, may not collect any fee up front, and must submit the claim for the beneficiary.*

Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

3 - Beneficiary Submitted Claims

Carriers process beneficiary-submitted claims under procedures that are applied in other situations in which unassigned claims (e.g., Form CMS-1490s) are received from beneficiaries. The carrier sends an enrollment application to the physician or supplier shown on the beneficiary's receipt. Carriers must assign a provider number upon receipt of the application. (See the Program Integrity Manual, Chapter 10 for detailed instructions).

4 - Separate Claims for Vaccine and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the

Healthcare Common Procedural Coding System (HCPCS) code for the vaccine, and the physician or supplier (e.g., a drugstore) who actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration. This procedure results in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the Form CMS-1500. When billing for the influenza vaccine only, billers should list only HCPCS code *90658* in block 24D of the Form CMS -1500. The same applies for PPV and hepatitis B billing using PPV and hepatitis B HCPCS codes.

10.2.1 - Healthcare Common Procedural Coding System (HCPCS) and Diagnosis Codes

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

Vaccines and their administration are reported using separate codes. The following codes are for reporting the vaccines only.

HCPCS	Definition
90655	*Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use;*
90656	*Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;*
90657	Influenza virus vaccine, split virus, *for children* 6-35 *months of age*, for intramuscular use;
90658	Influenza virus vaccine, split virus, *for use in individuals 3 years of age and above*, for intramuscular use;
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use *(Discontinued December 31, 2003)*;
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use;
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;

HCPCS	Definition
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use; and
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.

The following codes are for reporting administration of the vaccines only. The administration of the vaccines is billed using:

HCPCS	Definition
G0008	Administration of influenza virus vaccine;
G0009	Administration of pneumococcal vaccine; and
G0010	Administration of hepatitis B vaccine.

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim the applicable following diagnosis code may be used.

Diagnosis Code	Description
V03.82	PPV
V04.8*	Influenza
*V04.81***	*Influenza*
V05.3	Hepatitis B.

**Effective for influenza virus claims with dates of service prior to October 1, 2003.*

***Effective for influenza virus claims with dates of service October 1, 2003 and later.*

If a diagnosis code for PPV, hepatitis B, or influenza virus vaccination is not reported on a claim and the carrier can determine that the claim is a PPV, hepatitis B, or influenza claim, the carrier may enter the proper diagnosis code and continue processing the claim. These claims should not be returned, rejected, or denied for lack of a diagnosis code by the carrier. Effective for dates of service on or after October 1, 2003, carriers may no longer enter the diagnosis on the claim. Carriers must follow current resolution processes for claims with missing diagnosis codes.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the carrier or intermediary may correct the HCPCS code and pay the claim.

For example, if the reported diagnosis code is V04.8 (V04.81 if claim is October 1, 2003, and later) and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine.

Claims for hepatitis B vaccinations must report the I.D. Number of referring physician. In addition, if a doctor of medicine or osteopathy does not order the influenza virus vaccine, the intermediary claims require UPIN code SLF000 to be reported.

10.2.5.2 - Carrier Payment Requirements

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. (See Chapter 17 for procedures for determining *the payment rates* for PPV and Influenza virus 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 flu and PPV vaccines must accept assignment for the vaccine.

The administration of PPV, influenza virus, and hepatitis B vaccines, (HCPCS codes G0009, G0008, and G0010), though not reimbursed directly through the MPFS, is reimbursed at the same rate as HCPCS code 90782 on the MPFS for the year that corresponds to the date of service of the claim.

Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 should be reimbursed at the same rate as HCPCS code *90471*. Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunizer," submits roster bills, or participates in the centralized billing program.

Carriers may not apply the limiting charge provision for PPV, influenza virus vaccine, or hepatitis B vaccine and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Social Security Act (the Act.) 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.

A - No Legal Obligation to Pay

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. (See the Medicare Benefit Policy Manual, Chapter 16.) Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128 (b)(6)(A) of the Act.)

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as public health clinics (PHCs)) may bill Medicare for PPV, hepatitis B, and influenza virus vaccine administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

10.3.1 - Roster Claims Submitted to Carriers for Mass Immunization

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

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. Key information from the beneficiary roster list and the abbreviated Form CMS-1500 is used to process PPV and influenza virus vaccination claims.

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

If other services are furnished to a beneficiary along with PPV or influenza virus vaccine, individuals and entities must submit claims using normal billing procedures, e.g., submission of a Form CMS-1500 or electronic billing for each beneficiary.

Providers submitting electronic roster bills must submit their claims in a National Standard Format (NSF) or the American National Standards Institute Accredited Standards Committee X12 837 Health Care Claim American National Standards Institute (ANSI) ASC X12N 837.

Carriers 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 modified Form CMS-1500. The carrier must replicate the claim for each beneficiary listed on the roster.

Carriers must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for PPV and influenza vaccine and their administration. They must replicate the roster and the Form CMS-1500, highlighting the RRB beneficiary on the roster, and forward the material to the appropriate Palmetto-RRB processing center.

If PHCs or other individuals or entities inappropriately bill PPV or influenza vaccination using the roster billing method, carriers return the claim to the provider with a cover letter explaining why it is being returned and the criteria for the roster billing process. Carriers 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 carriers 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 carriers to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility where services are furnished.

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 1: PPV = "V03.82", Influenza Virus: = "V04.8"

Effective for claims with dates of service on or after October 1, 2003, use V04.81.

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:

PPV: "90732"

Influenza Virus: *"90658"*

Line 2:

PPV: "G0009"

Influenza Virus: "G0008"

Item 24E: (Diagnosis Code):

Lines 1 and 2: "1"

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 PPV 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 33: (Physician's, Supplier's Billing Name): If the provider number is not shown on the roster billing form, the entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or Group Number, as appropriate.

B - Format of Roster Claims

Qualifying individuals and entities must attach to the Form CMS-1500 claims 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, carriers 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. Carriers must key information from the beneficiary roster list and abbreviated Form CMS-1500 to process PPV 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 PPV 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 contractor;
- Patient's health insurance claim number;
- 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 PPV roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering PPV.

WARNING: Beneficiaries must be asked if they have been vaccinated with a PPV.

- Rely on 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.**

10.3.1.1 - Centralized Billing for Flu and Pneumococcal (PPV) Vaccines to Medicare Carriers

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

The CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type “Mass Immunizer,” 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 carriers 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 carrier must verify this through the enrollment process.

Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier 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 flu and PPV 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 flu and PPV 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 carrier per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to the designated processing carrier. However, all carriers must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All Carriers."

A - Processing Carrier

TrailBlazer Health Enterprises is designated as the sole carrier for the payment of flu and PPV claims for centralized billers from October 1, 2000 through the length of the contract. The CMS central office (CO) will notify centralized billers of the appropriate carrier to bill when they receive their notification of acceptance into the centralized billing program.

B - Request for Approval

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 by June 1. Carriers may not process claims for any centralized biller without prior permission from CMS CO. If claims are submitted by a provider that is not currently approved as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

C - Notification of Provider Participation to the Processing Carrier

Before October 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 October 1 and ending September 30 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 carrier for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application).

Whether an entity enrolls as a provider type "Mass Immunizer" or some other type of provider, all normal enrollment processes and procedures must be followed. Authorization from CO 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 carrier must verify that the entity is fully qualified and certified per State requirements in each State in which they plan to operate.

The carrier 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 carrier will extend the activation of the provider number for another year. The entity need not re-enroll with the carrier every year. However, should the States in which the entity plans to operate change, the carrier 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 standard format using either the National Standard Format (NSF) or American National Standards Institute ANSI X12N 837 format (or the HIPAA ANSI X12N 837(version 4010) when required). The processing carrier 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 complete on the electronic format the area that corresponds to Item 32, (Name and Address of Facility, including ZIP code) on Form CMS-1500. The carrier must use the ZIP code in this field to determine the payment locality for the claim.

For electronic claims, the name and address of the facility is reported in:

- The National Standard Format, record EA0, field 39 (facility/lab name) and record EA1, fields 6 through 10 (facility/lab address, city, state and ZIP code);

- The ANSI X12N 837 (version (3051): Claim level loop 2310, 2-250-NM1, with a value of "61" (Performed at the Facility where work was performed) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the Provider Number in NM109. Report the address in N3 and N4; or

- The HIPAA ANSI X12N 837(version 4010): Claim level loop 2310D, 2-250-NM1, with a qualifier value of "FA" (Facility) in NM101, a value of "XX" (NPI) - when implemented) in NM108, and the Provider Number ID in NM109. Prior to NPI, enter the Provider Number in loop 2310D position 2-271-REF using "1C" (Medicare Provider Number) in REF01 and the facility ID in REF02. Report the address in N3 and N4.

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, they must be paid at the same rate as HCPCS code 90782,

which is on the MPFS. The designated carrier 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 carrier must have the correct name and address, including ZIP code, of the entity where the service was provided. If a claim is received with a ZIP code that is not included on the ZIP code file maintained by designated carrier, they should refer to the United State Postal Service (USPS) Web site at http://www.usps.com/ncsc/ziplookup/lookupmenu.htm to determine if the ZIP code presented is valid. If the ZIP code is valid, they should add it to the designated carrier maintained ZIP code file and pay the claim using the appropriate payment locality.

If a claim is received with a ZIP code that is not valid for the street address given and the designated carrier can determine the correct ZIP code from the USPS Web site, the designated carrier must correct the ZIP code on the claim and pay the claim using the appropriate payment locality.

If the ZIP code presented is not a valid ZIP code, or is not a valid ZIP code with the given street address and the correct ZIP code cannot be determined from the USPS Web site, the designated carrier must deny the claim.

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. *Additional information is supplied using remittance advice remarks codes whenever appropriate.*" in addition to 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 flu and PPV 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 flu and PPV 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 Carrier

The processing carrier must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on flu and PPV coverage and billing instructions is available on the CMS Web site for providers.

J - Provider Education Instructions for All Carriers

By April 1 of every year, all carriers 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. Carriers must enter the name of the assigned processing carrier where noted before sending.

NOTIFICATION TO PROVIDERS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and Pneumococcal (PPV) immunizations, can send all claims to a single carrier 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 flu and PPV 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 (CO), 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 and Education Group
7500 Security Boulevard
Mail Stop C4-12-18
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 flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers 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 flu and PPV 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 vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.

- The carrier 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 carrier for this year is [Fill in name of carrier.]

- 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 Media Claims standard 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 carrier] 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 Health

Insurance Claim Number) as the carrier 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 carrier. Beneficiaries are sometimes confused when they receive an MSN from a carrier other than the carrier that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. 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 carrier] 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 carrier]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [Fill in name of carrier].

- 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. [Fill in name of carrier] will not process claims for any centralized biller without permission from CMS CO.

- Each year the centralized biller must contact [Fill in name of carrier] to verify understanding of the coverage policy for the administration of the PPV 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 PPV vaccination.

  The information in items 1 through 6 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 PPV vaccinations;

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

4 - A list of the States in which flu and PPV clinics will be held;

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

6 - Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

10.4 - CWF Edits

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

In order to prevent duplicate payments for flu and pneumonia claims by the same FI or carrier and by local carriers and the centralized billing flu and pneumonia carrier, effective for claims received on or after July 1, 2002, CWF has implemented *a number of edits*.

NOTE: *90659 was discontinued December 31, 2003.*

CWF returns information in Trailer 13 information from the history claim. The following fields are returned to the contractor:

- Trailer Code;
- Contractor Number;
- Document Control Number;
- First Service Date;
- Last Service Date;
- Provider, Physician, Supplier Number;
- Claim Type;
- Procedure code;
- Alert Code (where applicable); and,
- More history (where applicable.

10.4.2 - CWF Edits on Carrier Claims

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

In order to prevent duplicate payment by the same carrier, CWF will edit by line item on the carrier number, the HIC number, the date of service, the flu procedure codes 90657, 90658, or 90659, the pneumonia procedure code 90732, and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658 or 90659, and it already has on record a claim with the same HIC number, same carrier 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 code 90732 and it already has on record a claim with the same HIC number, same carrier 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 HIC number, same carrier number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the carriers a specific reject code for this edit that will be named in the CWF documentation. Carriers 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 carrier and local carrier, CWF will edit by line item for carrier number, same HIC number, same date of service, the flu procedure codes 90657, 90658, 90659, the pneumonia procedure code 90732, and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658 or 90659, and it already has on record a claim with a **different** carrier number, but same HIC number, 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 code 90732 and it already has on record a claim with the same HIC number, different carrier 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 carrier number, but the same HIC number, 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 that will be named in the CWF documentation. Carriers 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."

- RA: At the service level, report adjustment reason code *23 – Payment adjusted because charges have been paid by another payer.*