CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1278	**Date: JUNE 29, 2007**
	Change Request 5511

Subject: Update to Pub. 100-04, Chapter 18, Section 10 for Part B influenza Billing

I. SUMMARY OF CHANGES: This change request (CR) deletes out dated information and clarifies existing instructions for Part B influenza billing. This CR also accommodates the new reporting requirements for the Form CMS-1500(08-05) and restructures the approval process for centralized billing.

New / Revised Material
Effective Date: July 1, 2007
Implementation Date: July 30, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Code
R	18/10.2.5/Claims Submitted to Carriers
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	18/10.4.2/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 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1278	Date: June 29, 2007	Change Request: 5511

SUBJECT: Update to Pub. 100-04, Chapter 18, Section 10 for Part B Influenza Billing

Effective Date: **July 1, 2007**

Implementation Date: July 30, 2007

I. GENERAL INFORMATION

A. Background: Chapter 18, section 10 is being revised to delete out dated material and clarify existing instructions for Part B influenza billing. This CR also accommodates the new reporting requirements for the Form CMS-1500 (08-05) and restructures the approval process for the centralized billing.

B. Policy: Effective for services furnished on or after May 1, 1993, the Medicare Part B program covers influenza virus vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5511.1	Carriers shall note the revisions made to Pub. 100-04, chapter 18, section 10.	X			X							
5511.2	The designated carrier shall require centralized billing applicants to include with their yearly participation request a list of names and addresses of all entities operating under the corporation's application and information for a contact person.											Designated Carrier
5511.3	The designated carrier shall notify centralized billing applicants and copy CMS central office in writing of the centralized billing applicant's completion and approval of Part 2 of the approval process.											Designated Carrier

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5511.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Bridgitté Davis, (410) 786-4573

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

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

(Rev. 1278; Issued: 06-29-07; Effective Date: 07-01-07; Implementation Date: 07-30-07)

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);
90660	Influenza virus vaccine, live, for intranasal use;
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;
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.
*90471	Immunization administration. (For OPPS hospitals billing for the Hepatitis B vaccine administration)
*90472	Each additional vaccine. (For OPPS hospitals billing for the Hepatitis B vaccine administration)

*** Note:** For claims with dates of service prior to January 1, 2006, OPPS and non-OPPS hospitals report G0010 for Hepatitis B vaccine administration. For claims with dates of service January 1, 2006 and later, OPPS hospitals report 90471 or 90472 for Hepatitis B vaccine administration as appropriate in place of G0010.

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
V04.81**	Influenza
V06.6***	PPV and Influenza
V05.3	Hepatitis B

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

***Effective October 1, 2006, providers may report diagnosis code V06.6 on claims for PPV and/or Influenza Virus vaccines when the purpose of the visit was to receive both vaccines.

If a diagnosis code for PPV, Hepatitis B, or influenza virus vaccination is not reported on a claim, Carriers may not 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*1* 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. Effective October 1, 2006, carriers should follow the instructions in Pub. 100-04, Section 80.3.2.1.1 (Carrier Data Element Requirements) for claims submitted without a HCPCS code.

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 on claims submitted *prior to the date when Medicare will no longer accept identifiers other than NPIs*, or

- The provider's own NPI to be reported in the NPI field for the attending physician on claims submitted *when NPI requirements are implemented*.

10.2.5 - Claims Submitted to Carriers

(Rev. 1278; Issued: 06-29-07; Effective Date: 07-01-07; Implementation Date: 07-30-07)

Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, PPV claims also no longer require that the vaccine be administered under a physician's order or supervision. *Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision.*

A. Reporting Specialty Code/Place of Service (POS) to CWF
Specialty

Carriers use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)) for Public Health Service Clinics.

Carriers use specialty code 73 (Mass Immunization Roster Billers) for centralized billers.
Carriers use specialty code 87 for pharmacists (all other suppliers (drug stores, department stores)).

Entities and individuals other than PHCs and pharmacists use the CMS specialty code that best defines their provider type. A list of specialty codes can be found in Chapter 26. The CMS specialty code 99 (Unknown Physician Specialty) is acceptable where no other code fits.

Place of Service (POS)

State or local PHCs use POS code 71 (State or Local Public Health Clinic). POS 71 is not used for individual offices/entities other than PHCs (e.g., a mobile unit that is non-PHC affiliated should use POS 99). Preprinted Form CMS-1500s *(08-05)* used for simplified roster billing should show POS 60 (Mass Immunization Center) regardless of the site where vaccines are given (e.g., a PHC or physician's office that roster claims should use POS 60). Individuals/entities administering influenza and PPV vaccinations in a mass immunization setting (*including centralized flu billers)*, regardless of the site

where vaccines are given, should use POS 60 for roster claims, paper claims, and electronically filed claims.

Normal POS codes should be used in other situations.

Providers use POS 99 (Other Unlisted Facility) if no other POS code applies.

10.2.5.2 - Carrier Payment Requirements

(Rev. 1278; Issued: 06-29-07; Effective Date: 07-01-07; Implementation Date: 07-30-07)

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 *or the 5 percent Physician Scarcity Area (PSA) 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. 1278; Issued: 06-29-07; Effective Date: 07-01-07; Implementation Date: 07-30-07)

If the PHC or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 *(08-05)* that contains standardized information about the entity and the benefit. Key information from the beneficiary roster list and the abbreviated Form CMS-1500 *(08-05)* is used to process PPV and influenza virus vaccination claims.

Separate Form CMS-1500 *(08-05)* 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 *(08-05)* or electronic billing for each beneficiary.

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 claim. 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.
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 *(08-05)* for Cover Document

Entities submitting roster claims to carriers must complete the following blocks on a single modified Form CMS-1500 *(08-05)*, 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 *(08-05)* 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: Choose appropriate diagnosis code from §10.2.1

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 *vaccine*: "90732"
or
Influenza Virus *vaccine*: *"Select appropriate influenza vaccine code"*
Line 2:
PPV *Administration*: "G0009"
or
Influenza Virus *Administration*: "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 *(08-05)*.

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 (e.g., Hospitals) if it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007.

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: Enter the NPI of the billing provider or group when NPI requirements are implemented. (The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007.)

B. Format of Roster Claims

Qualifying individuals and entities must attach to the Form CMS-1500 *(08-05)* 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 *(08-05)* 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 *(08-05)* 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. 1278; Issued: 06-29-07; Effective Date: 07-01-07; Implementation Date: 07-30-07)

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 *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 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

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

process to participate as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

C. Notification of Provider Participation to the Processing Carrier

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

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). *Providers/suppliers are encouraged to apply to enroll as a centralized biller early as the enrollment process takes 8 -12 weeks to complete. Applicants who have not completed the entire enrollment process and received approval from CO and the designated carrier 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 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 *the appropriate version of* American National Standards Institute (ANSI) format. *Carriers should refer to the appropriate ANSI Implementation Guide to determine the correct location for this information on electronic claims.* 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 *and 33 on Form CMS 1500 (08-05).* The carrier must use the Zip Code in *Item 32* to determine the payment locality for the claim. *Item 33 must be completed to report the provider of service/supplier's billing name, address, Zip Code, and telephone number. When implemented, the NPI of the billing provider or group must be reported. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007.*

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

- *The HIPAA compliant* ANSI X12N 837: Claim level loop 2310D *NM101=FA. When implemented, the facility (e.g., hospitals) NPI will be captured in the loop 2310D NM109 (NM108=XX) if one is available.* Prior to NPI, enter the *tax information* in loop 2310D *NM109 (NM108=24 or 34) and enter the Medicare legacy facility identifier in loop 2310D REF02 (REF01=1C).* Report the address*, city, state, and Zip Code in loop 2310D N301 and N401, N402, and N403. Facility data is not required to be reported at the line level for centralized billing.*

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 the designated carrier, *carriers shall return the claims as unprocessable.*

If a claim is received with a Zip Code that is not valid for the street address given, *carriers shall return the claim as unprocessable.*

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 *C4-10-07*
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 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.

  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 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 *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 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);

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*;*

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

8. *Contact information for designated contact person for centralized billing program.*

10.4.2 - CWF Edits on Carrier Claims

(Rev. 1278; Issued: 06-29-07; Effective Date: 07-01-07; Implementation Date: 07-30-07)

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, 90659, or *90660* the pneumonia procedure code 90732, and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658, 90659, *or 90660* 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, *or 90660* the pneumonia procedure code 90732, and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658, 90659, *or 90660* 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.