CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1586	**Date: September 5, 2008**
	Change Request 6079

SUBJECT: Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

I. SUMMARY OF CHANGES: This Change Request revises chapters 1, 18, and 26 to delete incorrect information, clarify unclear language, and to add references to the AB MACs.

New / Revised Material
Effective Date: October 6, 2008
Implementation Date: October 6, 2008

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	1/80.3.2.1.2/Conditional Data Element Requirements for Carriers and DMERCs
R	18/Table of Contents
R	18/10/Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
R	18/10.1/Coverage Requirements
R	18/10.1.1/Pneumococcal Vaccine
R	18/10.1.2/Influenza Virus Vaccine
R	18/10.2/Billing Requirements
R	18/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
R	18/10.2.2/Bills Submitted to FIs/AB MACs
R	18/10.2.2.1/FI/AB MAC Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration
R	18/10.2.2.2/Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)

R	18/10.2.3/Bills Submitted to Regional Home Health Intermediaries
R	18/10.2.4/Bills Submitted by Hospices and Payment Procedures for Renal Dialysis Facilities (RDF)
R	18/10.2.4.1/Hepatitis B/Vaccine Furnished to ESRD Patients
R	18/10.2.5/Claims Submitted to Carriers/AB MACs
R	18/10.2.5.1/Carrier/AB MAC Indicators for the Common Working File (CWF)
R	18/10.2.5.2/Carrier/AB MAC Payment Requirements
R	18/10.3/Simplified Roster Claims for Mass Immunizers
R	18/10.3.1/Roster Claims Submitted to Carriers/AB MACs for Mass Immunization
R	18/10.3.1.1/Centralized Billing for Influenza Virus and Pneumococcal Vaccines to Medicare Carriers/AB MACs
R	18/10.3.2/Claims Submitted to FIs/AB MACs for Mass Immunizations of Influenza Virus and Pneumococcal Vaccinations
R	18/10.3.2.1/Simplified Billing for Influenza Virus and Pneumococcal Vaccine Services by HHAs
R	18/10.3.2.2/Hospital Inpatient Roster Billing
R	18/10.3.2.3/Electronic Roster Claims
R	18/10.4/CWF Edits
R	18/10.4.1/CWF Edits on FI/AB MACs Claims
R	18/10.4.2/CWF Edits on Carrier/AB MAC Claims
R	18/10.4.3/CWF A/B Crossover Edits for FI/AB MAC and Carrier/AB MAC Claims
R	18/10.5/Medicare Summary Notice (MSN)
R	26/10.4/Items 14-33 - Provider of Service or Supplier Information

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1586	Date: September 5, 2008	Change Request: 6079

SUBJECT: Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

Effective Date: October 6, 2008

Implementation Date: October 6, 2008

I. GENERAL INFORMATION

A. Background: This Change Request (CR) revises chapters 1, 18, and 26 to delete incorrect information, clarify unclear language, and to add references to the AB MACs.

B. Policy: The Centers for Medicare & Medicaid Services revised Form CMS-1500 to accommodate the reporting of the National Provider Identifier (NPI). The current Form CMS 1500 (08-05) does not require reporting the NPI for influenza virus and pneumococcal vaccine claims submitted as roster bills.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6079.1	Medicare contractors shall follow the revised Internet Only Manual instructions as applicable.	X		X	X						
6079.2	Medicare contractors shall not return claims as unprocessable to the supplier/provider of service when the rendering provider does not enter his/her NPI into 24J of Form CMS-1500 for influenza virus and pneumococcal vaccine claims submitted as roster bills.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6079.3	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.	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Bridgitté Davis (410) 786-4573, William Ruiz (410) 786-9283

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to assigned carrier claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims. The CMS has specified which remark code(s) should be used when a claim fails a particular "return as unprocessable" edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), carriers must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

Items from the Form CMS-1500 (hardcopy) have been provided. These items are referred to as fields in the instruction.

Carriers must return a claim as unprocessable to the supplier/provider of service:

a. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name and/or NPI is not present in item 17 or 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N285 or N286 is used)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI is required of the supervising physician is not entered in items 17 or 17a. or if the NPI is not entered in item 17b. of the CMS-1500 (8/05). (Remark code N269 or N270 is used.)

c. For diagnostic tests subject to purchase price limitations:

    1. If a "YES" or "NO" is not indicated in item 20. (Remark code M12 is used.)

    2. If the "YES" box is checked in item 20 and the purchase price is not entered under the word "$CHARGES." (Remark code MA111 is used.)

    3. If the "YES" box is checked in item 20 and the purchase price is entered under "$CHARGES", but the supplier's name, address, ZIP Code, the NPI is not entered into item 32a of the Form CMS-1500 (8/05) when billing for purchased diagnostic tests. (Remark code N256, N257, or N258 are used.)

    Entries 4 – 8 are effective for claims received on or after April 1, 2004:

4. On the Form CMS-1500, if the "YES" box is checked in Item 20, and more than one test is billed on the claim;

5. On the Form CMS-1500, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;

6. On the Form CMS-1500, if the "YES" box is checked in Item 20, both the interpretation and test are submitted and the date of service and place of service codes do not match.

7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test has been purchased, more than one test is billed on the claim, and line level information for each total purchased service amount is not submitted for each test.

8. On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the ANSI X12N 837 electronic format if there is an indication on the claim that a test has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.

d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either an ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 or M76 are used.)

e. If modifiers "QB" and "QU" or, effective on or after *January1, 2006*, the modifier "AQ" are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient's home or the physician's office, the name, address, and ZIP Code of the facility where the services were furnished are not entered in item 32. (Remark code MA115 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP *Code* of the service location for all services other than those furnished in place of service home – 12 must be entered.

f. If a *rendering* physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner *who is a sole practitioner or* is a member of a group practice does not enter his*/her* NPI into item 24J of Form CMS-1500 (08-05).

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI. (Remark code *N290* is used.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code(s) MA64, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data are used.)

h. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use Plan ID when effective) is not entered in field 11C, or the primary payer's program or plan name when a Payer or Plan ID (use PlanID when effective) does not exist. (Remark code MA92 or N245 is used.)

i. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. (Remark code M20 if there is a modifier but no HCPCS.)

j. If a date of service extends more than *1* day and a valid "to" date is not present in item 24A. (Remark code M59 is used.)

k. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. (Remark code M51 is used.)

l. If the name, address, and ZIP Code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32 (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service contractors treat as home, must be entered according to Pub. 100-04, chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. (Remark code MA114 is used.)

m. Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 *(08-05)* in item 32.

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents

(Rev.1586, 09-05-08)

10 – Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

For *Carriers/AB MACs*, Part B of Medicare pays 100 percent of the Medicare allowed amount for pneumococcal vaccines and influenza virus vaccines and their administration.

Part B deductible and coinsurance do not apply for *pneumococcal* and influenza virus vaccine.

Part B of Medicare also covers the hepatitis B vaccine and its administration. Part B deductible and coinsurance **do** apply for hepatitis B vaccine.

State laws governing who may administer *pneumococcal* and influenza virus vaccinations and how the vaccines may be transported vary widely. *Medicare contractors* should instruct physicians, suppliers, and providers to become familiar with State regulations for all vaccines in the areas where they will be immunizing.

10.1 - Coverage Requirements

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Pneumococcal vaccine, influenza virus vaccine, and hepatitis B vaccine and their administration are covered only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A.

See *Pub. 100-02,* Medicare Benefit Policy Manual, chapter 15, for additional coverage requirements for *pneumococcal vaccine*, hepatitis B vaccine, and *i*nfluenza *virus* vaccine.

10.1.1 - *Pneumococcal Vaccine*

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the *pneumococcal* vaccine and its administration. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

See *Pub. 100-02,* Medicare Benefit Policy Manual, chapter 15, *section 50.4.4.2* for additional coverage requirements for *pneumococcal vaccine*.

A. Frequency of *Pneumococcal* Vaccinations

Typically, *the pneumococcal vaccine* is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received *the pneumococcal vaccine* within the last *5* years or are revaccinated because they are unsure of their vaccination status.

An initial *pneumococcal vaccination* may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least *5* years have passed since receipt of a previous dose of pneumococcal vaccine.

B. High Risk of Pneumococcal Disease

Persons at high risk for whom an initial vaccine may be administered include:

- All people age 65 and older;
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and
- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, Human Immunodeficiency Virus (HIV) infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccinations of people age 65 or older that are not at highest risk are not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, if the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past *5* years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last *5* years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than *5* years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

10.1.2 - Influenza Virus Vaccine

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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

Typically, one influenza vaccination is allowable per *influenza virus* season. Contractors edit to identify more than one influenza virus vaccine in a 12-month period, and determine medical necessity of services failing the edit. Since there is no yearly limit, contractors determine whether such services are reasonable and necessary (e.g., a patient receives an influenza injection in January for the current *influenza* season and is vaccinated again in November of the same year for the next *influenza* season) and allow payment if appropriate.

See *Pub. 100-02,* Medicare Benefit Policy Manual, chapter 15, *section 50.4.4.2* for additional coverage requirements for *i*nfluenza *v*irus vaccines.

10.2 - Billing Requirements

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

A Edits Not Applicable to *Pneumococcal* or Influenza Virus Vaccine Bills and Their Administration

The *Common Working File (*CWF*)* and shared systems bypass all Medicare Secondary Payer (MSP) utilization edits in CWF on all claims when the only service provided is *pneumococcal* 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 *pneumococcal* or influenza *virus* vaccinations. If the provider knows or has reason to believe that a particular group health plan covers *pneumococcal* 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 *pneumococcal* or influenza virus vaccines. However, first claim development is performed if other services are submitted along with *pneumococcal* or development is performed if other services are submitted along with *pneumococcal* or influenza virus vaccines.

See *Pub. 100-05,* Medicare Secondary Payer Manual, chapters 4 and 5, for responsibilities for MSP development where applicable.

B *Fiscal* Intermediary (FI)*/AB MAC* Bills

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

The following "providers of services" may administer and bill the FI*/AB MACs* for these vaccines:

- Hospitals;
- Critical Access Hospitals (CAHs);
- Skilled Nursing Facilities (SNFs);
- Home Health Agencies (HHAs);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs); and
- Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities.

Other billing entities that may bill the FI*s/AB MACs* are:

- Independent Renal Dialysis Facilities (RDFs).

All providers bill the FI*s/AB MACs* for hepatitis B on Form CMS-1450. Providers other than independent RHCs and freestanding FQHCs bill the FI*s/AB MACs* for influenza *virus* and *pneumococcal vaccinations* 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*/AB MACs* 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*/AB MAC* Claims

1 Billing for Additional Services

If a physician sees a beneficiary for the sole purpose of administering the influenza virus vaccine, the pneumococcal vaccine, and/or the hepatitis B vaccine, they may not routinely bill for an office visit. However, if the beneficiary actually receives other services constituting an "office visit" level of service, the physician may bill for a visit in

addition to the vaccines and their administration, and Medicare will pay for the visit in addition to the vaccines and their administration if it is reasonable and medically necessary.

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 *National Provider Identifier (NPI)* for Part B billing purposes.

3 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 *contractors* receiving two claims, one for the vaccine and one for its administration.

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

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

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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;

HCPCS	Definition
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;
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular 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	Pneumococcus
V04.81**	Influenza
V06.6***	Pneumococcus 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 pneumococcus and/or influenza virus vaccines when the purpose of the visit was to receive both vaccines.

If a diagnosis code for pneumococcus, hepatitis B, or *i*nfluenza *v*irus vaccination is not reported on a claim, *contractors* may not enter the diagnosis on the claim. *Contractors* 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 V04.81 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*/AB MACs* should follow the instructions in Pub. 100-04, *Chapter 1,* 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.

10.2.2 - Bills Submitted to FIs*/AB MACs*

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The applicable types of bills acceptable when billing for influenza *virus* and *pneumococcal vaccines* are 12X, 13X, 22X, 23X, 34X, 72X, 75X, 83X and 85X.

The following revenue codes are used for reporting vaccines and administration of the vaccines for all providers except RHCs and FQHCs. Independent and provider based RHCs and FQHCs follow §10.2.2.2 below when billing for influenza *virus*, *pneumococcal* and hepatitis B vaccines.

Units and HCPCS codes are required with revenue code 0636:

Revenue Code	Description
0636	Pharmacy, Drugs requiring detailed coding (a)
0771	Preventive Care Services, Vaccine Administration

In addition, for the influenza virus vaccine, providers report condition code M1 in Form Locator (FLs) 24-30 when roster billing. See roster billing instructions in §10.3 of this chapter.

When vaccines are provided to inpatients of a hospital or SNF, they are covered under the vaccine benefit. However, the hospital bills the FI on bill type 12X using the discharge date of the hospital stay or the date benefits are exhausted. A SNF submits type of bill 22X for its Part A inpatients.

10.2.2.1 – FI*/AB MAC* Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Payment for Vaccines

Payment for all of these vaccines is on a reasonable cost basis for hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), critical access hospitals (CAHs), and hospital-based renal dialysis facilities (RDFs). Payment for comprehensive outpatient rehabilitation facilities (CORFs), Indian Health Service hospitals (IHS), IHS CAHs and independent RDFs is based on 95 percent of the average wholesale price (AWP). Section 10.2.4 of this chapter contains information on payment of these vaccines when provided by RDFs or hospices. See §10.2.2.2 for payment to independent and provider- based Rural Health Centers and Federally Qualified Health Clinics.

Payment for these vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs)	12x, 13x	Reasonable cost
IHS Hospitals	12x, 13x, 83x	95% of AWP
IHS CAHs	85x	95% of AWP
CAHs Method I and Method II	85x	Reasonable cost
Skilled Nursing Facilities	22x, 23x	Reasonable cost
Home Health Agencies	34x	Reasonable cost
Comprehensive Outpatient Rehabilitation Facilities	75x	95% of the AWP
Independent Renal Dialysis Facilities	72x	95% of the AWP
Hospital-based Renal Dialysis	72x	Reasonable cost

Facilities

Payment for Vaccine Administration

Payment for the administration of influenza virus and *pneumococcal* vaccines is as follows:

Facility	**Type of Bill**	**Payment**
Hospitals, other than IHS Hospitals and CAHs	12x, 13x	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS
IHS Hospitals	12x, 13x, 83x	MPFS as indicated in guidelines below.
IHS CAHs	85x	MPFS as indicated in guidelines below.
CAHs Method I and II	85x	Reasonable cost
Skilled Nursing Facilities	22x, 23x	MPFS as indicated in the guidelines below
Home Health Agencies	34x	OPPS
Comprehensive Outpatient Rehabilitation Facilities	75x	MPFS as indicated in the guidelines below
Independent RDFs	72x	MPFS as indicated in the guidelines below
Hospital-based RDFs	72x	Reasonable cost

Guidelines for pricing *pneumococcal* and influenza *virus* vaccine administration under the MPFS.

Make reimbursement based on the rate in the MPFS associated with the CPT code 90782 or 90471 as follows:

HCPCS code	Effective prior to March 1, 2003	Effective on and after March 1, 2003
G0008	90782	90471
G0009	90782	90471

See §10.2.2.2 for payment to independent and provider based Rural Health Centers and Federally Qualified Health Clinics.

Payment for the administration of hepatitis B vaccine is as follows:

Facility	Type of Bill	Payment
Hospitals other than IHS hospitals and CAHs	12x, 13x	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS
IHS Hospitals	12x, 13x, 83x	MPFS as indicated in the guidelines below
CAHs Method I and II	85x	Reasonable cost
IHS CAHs	85x	MPFS as indicated in guidelines below.
Skilled Nursing Facilities	22x, 23x	MPFS as indicated in the chart below
Home Health Agencies	34x	OPPS
Comprehensive Outpatient Rehabilitation Facilities	75x	MPFS as indicated in the guidelines below
Independent RDFs	72x	MPFS as indicated in the chart below
Hospital-based RDFs	72x	Reasonable cost

Guidelines for pricing hepatitis B vaccine administration under the MPFS.

Make reimbursement based on the rate in the MPFS associated with the CPT code 90782 or 90471 as follows:

HCPCS code	Effective prior to March 1, 2003	Effective on and after March 1, 2003
G0010	90782	90471

See §10.2.2.2 for payment to independent and provider based Rural Health Centers and Federally Qualified Health Clinics.

10.2.2.2 - Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Independent and provider-based RHCs and FQHCs do not include charges for influenza *virus* and *pneumococcal vaccines* on Form CMS-1450. Administration of these vaccines does not count as a visit when the only service involved is the administration of influenza *virus* and/or *pneumococcal* vaccine(s). If there was another reason for the visit, the RHC/FQHC should bill for the visit without adding the cost of the influenza *virus* and *pneumococcal vaccines* to the charge for the visit on the bill. FIs*/AB MACs* pay at the time of cost settlement and adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

Payment for the hepatitis B vaccine is included in the all-inclusive rate. However, RHCs/FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine. As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service are billed on the RHC/FQHC claims in addition to the encounter.

10.2.3 - Bills Submitted to Regional Home Health Intermediaries (RHHIs)

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The following provides billing instructions for Home Health Agency (HHAs) in various situations:

- Where the sole purpose for an HHA visit is to administer a vaccine (influenza *virus*, *pneumococcal*, or hepatitis B), Medicare will not pay for a skilled nursing visit by an HHA nurse under the HHA benefit. However, the vaccine and its administration are covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. RHHIs do not allow HHAs to charge for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 34X and reports revenue

code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is not allowed for the visit

- If a vaccine (influenza *virus*, *pneumococcal*, or hepatitis B) is administered during the course of an otherwise covered home health visit (e.g., to perform wound care), the visit would be covered as normal but the HHA must not include the vaccine or its administration in their visit charge. In this case, the HHA is entitled to payment for the vaccine and its administration under the vaccine benefit. In this situation, the HHA bills under bill type 34X and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

  NOTE: A separate bill is required for the visit

- Where a beneficiary does **not** meet the eligibility criteria for home health coverage, a home health nurse may be paid for the vaccine (influenza *virus*, *pneumococcal*, or hepatitis B) and its administration. No skilled nursing visit charge is billable. Administration of the services should include charges only for the supplies being used and the cost of the injection. RHHIs do not pay for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 34X and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

If a beneficiary meets the eligibility criteria for coverage, but his or her spouse does not, and the spouse wants an injection the same time as a nursing visit, HHAs bill in accordance with the bullet point above.

10.2.4 - Bills Submitted by Hospices and Payment Procedures for Renal Dialysis Facilities (RDF)

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Hospices can provide the influenza virus, *pneumococcal*, and hepatitis B vaccines to those beneficiaries who request them including those who have elected the hospice benefit. These services may be covered when furnished by the hospice. Services for the vaccines should be billed to the local carrier*/AB MAC* on the Form CMS-1500. Payment is made using the same methodology as if they were a supplier. Hospices that do not have a supplier number should contact their local carrier*/AB MAC* to obtain one in order to bill for these benefits.

FIs*/AB MACs* pay for *pneumococcal*, influenza *virus*, and hepatitis B virus vaccines for freestanding Renal Dialysis facilities (RDFs) based on the lower of the actual charge or 95 percent of the average wholesale price and based on reasonable cost for provider-based RDFs. Deductible and coinsurance do not apply for influenza *virus* and

pneumococcal vaccines. FIs*/AB MACs* must contact their carrier*/AB MAC* to obtain information in order to make payment for the administration of these vaccines.

Deductible and coinsurance apply for hepatitis B vaccine.

10.2.4.1 - Hepatitis B Vaccine Furnished to ESRD Patients

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Hepatitis B vaccine and its administration (including staff time and supplies such as syringes) are paid to ESRD facilities in addition to, and separately from, the dialysis composite rate payment.

Payment for the hepatitis B vaccine for ESRD patients follows the same general principles that are applicable to any injectable drug or biological. Hospital-based facilities are paid for their direct and indirect costs on a reasonable cost basis, and independent facilities are paid the lower of the actual charge or 95 percent of the AWP. The allowance for injectables is based on the cost of the injectable and any supplies used for administration, plus a maximum $2 for the labor involved, if the facility's staff administers the vaccine. In addition, the FI*/AB MAC* makes an appropriate allowance for facility overhead.

Where the vaccine is administered in a hospital outpatient department for home dialysis patients or for patients with chronic renal failure (but not yet on dialysis), payment is on a reasonable cost basis. Outpatient hospital vaccines for nondialysis purposes are paid under hospital outpatient PPS rules.

10.2.5 - Claims Submitted to Carriers*/AB MACs*

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Medicare does not require that the influenza *virus* vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, *Medicare does not require that pneumococcal vaccinations* 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. *As a physician order is still required for claims for hepatitis B vaccinations, information on the ordering and/or referring physician must be entered on the claim.*

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

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

Contractors use specialty code 73 (Mass Immunization Roster Billers) for centralized billers *and* 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 *virus* and *pneumococcal* 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.

10.2.5.1 – *Carrier/AB MAC* Indicators for the Common Working File (CWF)

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The *carrier/AB MAC* record submitted to CWF must contain the following indicators:

Description	Payment Indicator	Payment	Deductible Indicator	Deductible	Type of Service
Pneumococcal	"1"	100 percent	"1"	Zero deductible	"V"
Influenza	"1"	100 percent	"1"	Zero deductible	"V"
Hepatitis B	"0"	80 percent	"0"	Deductible applies	"1"

A payment indicator of "1" represents 100 percent payment. A deductible indicator of "1" represents a zero deductible. A payment indicator of "0" represents 80 percent payment. A deductible indicator of "0" indicates that a deductible applies to the claim.

The record must also contain a "V" in the type of service field, which indicates that this is a *pneumococcal* or influenza virus vaccine. Carriers*/AB MACs* use a "1" in the type of service field which indicates medical care for a hepatitis B vaccine.

10.2.5.2 – *Carrier/AB MAC* Payment Requirements

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Payment for *pneumococcal*, 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 *pneumococcal* 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 *influenza virus* and *pneumococcal* vaccines must accept assignment for the vaccine.

Prior to March 1, 2003, the administration of *pneumococcal*, influenza virus, and hepatitis B vaccines, (HCPCS codes G0008, G0009, and G0010), though not reimbursed directly through the MPFS, *were* reimbursed at the same rate as HCPCS code 90782 on the MPFS for the year that correspond*ed* to the date of service of the claim.

Prior to March 1, 2003, HCPCS codes G0008, G0009, and G0010 *are* 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 Immuniz*ation Roster Biller*," submits roster bills, or participates in the centralized billing program.

Carriers*/AB MACs* may not apply the limiting charge provision for *pneumococcal*, 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 *influenza virus* 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.

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 *Pub. 100-02,* Medicare Benefit Policy Manual, chapter 16.) Thus, for example, Medicare may not pay for *influenza virus* 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.)

When an employer offers free vaccinations to its employees, it must also offer the free vaccination to an employee who is also a Medicare beneficiary. It does not have to offer free vaccinations to its non-Medicare employees.

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 PHCs) may bill Medicare for *pneumococcal*, hepatitis B, and influenza virus vaccine*s* administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

10.3 - Simplified Roster Claims for Mass Immunizers

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass *pneumococcal* and influenza virus vaccination programs offered by PHCs and other individuals and entities that give the vaccine to a group of beneficiaries, e.g. at PHCs, shopping malls, grocery stores, senior citizen homes, and health fairs. Roster billing is not available for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure known as roster billing to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary. Effective November 1, 1996, roster billing is also available to individuals and entities billing for *pneumococcal vaccinations*.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing to carriers. However, the rosters should not be used for single patient claims and the date of service for each vaccination administered must be entered.

Entities that submit claims on roster claims must accept assignment and may not collect any “donation” or other cost sharing of any kind from Medicare beneficiaries for *pneumococcal* or influenza *virus* vaccinations. However, the entity may bill Medicare for the amount, which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

A. Provider Enrollment Criteria for Mass Immunizers

Those entities and individuals that desire to provide mass immunization services, but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type “Mass Immuniz*ation Roster Biller*.”

These individuals and entities must enroll by completing the Provider/Supplier Enrollment Application, Form CMS-855. Individuals and entities *that enroll as this provider type* may not bill Medicare for any services other than *pneumococcal and/or* influenza virus vaccines and their administration. In addition, *claims submitted by the provider type* "Mass *Immunization Roster Biller*" *are always* reimbursed at the assigned payment rate.

B. Payment Floor for Roster Claims

Roster claims are considered paper claims and are not paid as quickly as electronic media claims (EMC). If available, offer electronic billing software free or at-cost to PHCs and other properly licensed individuals and entities. *Contractors* must ensure that the software is as user friendly as possible for the *pneumococcal* and influenza virus vaccine benefits.

C. *Medicare Advantage Plans* Processing Requirements

Medicare Advantage Plans may use roster billing only if vaccinations are the only Medicare-covered services furnished by the *Medicare Advantage Plans* to Medicare patients who are not members of the *Medicare Advantage Plans*. *Medicare Advantage Plans* must use Place of Service (POS) code 60 for processing roster claims.

10.3.1 - Roster Claims Submitted to Carriers*/AB MACs* for Mass Immunization

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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 *pneumococcal* and influenza virus vaccination claims.

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

Contractors 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 *contractor* must replicate the claim for each beneficiary listed on the roster.

Contractors 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* vaccination*s* using the roster billing method, *contractors* return the claim to the provider with a cover letter explaining why it is being returned and the criteria for the roster billing process. *Contractors* 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*/AB MACs* 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*/AB MACs* to reimburse by correct payment locality, a separate Form CMS-1500 (08-05) must be used for each different facility *or physical location* 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:
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 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 *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 (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 *as soon as it is available*. The NPI may be reported on the Form CMS-1500 (08-05) as early as *October 1, 2006*.

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. (The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.)*

B. Format of Roster Claims

Qualifying individuals and entities must attach to the Form CMS-1500 (08-05) 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 (08-05) without deviation, *contractors* 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. *Contractors* must key information from the beneficiary roster list and abbreviated Form CMS-1500 (08-05) 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 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 *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.
- 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 *Influenza Virus* and Pneumococcal Vaccines to Medicare Carriers*/AB MACs*

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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 Immuniz*ation* 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 carrier*/AB MAC* 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 carriers*/AB MACs* must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All Carriers*/AB MACs*."

A. Processing *Contractor*

Trailblazers Health Enterprises is designated as the sole *contractor* for the payment of *influenza virus* and *pneumococcal* claims for centralized billers from October 1, 2000, through the length of the contract. 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 local carrier*/AB MAC* 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 standard format using the appropriate version of American National Standards Institute (ANSI) format. *Contractors* should refer to the appropriate ANSI Implementation Guide to determine the correct location for this information on electronic claims. 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 complete on the electronic format the area that corresponds to Item 32 and 33 on Form CMS 1500 (08-05). The *contractor* must use the ZIP *C*ode 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 *C*ode, and telephone number. *In addition,* the NPI of the billing provider or group must be *appropriately* reported.

For electronic claims, the name, address, and ZIP *C*ode of the facility are 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, *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.)"*

and

Remittance advice remark code MA114, "Missing/incomplete/invalid information on where the services were furnished."

and

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 Carriers*/AB MACs*

By April 1 of every year, all carriers*/AB MACs* 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*/AB MACs* 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 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 *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).

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 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 *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 Health Insurance Claim Number) 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 billing program.

10.3.2 - Claims Submitted to *FIs/AB MACs* for Mass Immunizations of Influenza *Virus* and *Pneumococcal Vaccinations*

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

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 health insurance claim number; 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 and a table to crosswalk the CMS-1450 form locators to the 837 transaction 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 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.

- 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 immuniz*ation* 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 Form CMS-1450s 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 Form CMS-1450 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.

10.3.2.1 - Simplified Billing for Influenza Virus and *Pneumococcal Vaccine* Services by HHAs

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The following billing instructions apply to HHAs that roster bill for influenza virus and *pneumococcal* vaccines.

- When a*n* HHA provides the influenza virus vaccine or *the pneumococcal vaccine* in a mass immunization setting, it does not have the option to pick and choose whom to bill for this service. If it is using employees from the certified portion, and as a result will be reflecting these costs on the cost report, it must bill the FI*/AB MAC* on the Form CMS-1450.
- If the HHA is using employees from the noncertified portion of the agency (employees of another entity that are not certified as part of the HHA), and as a result, will not be reflecting these costs on the cost report, it must obtain a provider number and bill their carrier*/AB MAC* on the Form CMS-1500.
- If employees from both certified and noncertified portions of the HHA furnish the vaccines at a single mass immunization site, they must prepare two separate rosters, e.g., one for employees of the certified portion to be submitted to the *FI/AB MAC* and one roster for employees of the noncertified portion to be submitted to the carrier*/AB MAC.*

10.3.2.2 - Hospital Inpatient Roster Billing

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

The following billing instructions apply to hospitals that roster bill for the influenza virus vaccine and *the pneumococcal vaccine* provided to inpatients:

- Hospitals do not have to wait until patients are discharged to provide the vaccine. They may provide it anytime during the patient's stay;
- The roster should reflect the actual date of service;
- The requirement to provide the vaccine to five or more patients at the same time to meet the requirements for mass immunizers is waived when vaccines are provided to hospital inpatients. Therefore, the roster may contain fewer than five patients or fewer than five patients on the same day; and
- The roster should contain information indicating that the vaccines were provided to inpatients to avoid questions regarding the number of patients or various dates.

10.3.2.3 - Electronic Roster Claims

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

As for all other Medicare-covered services, FIs*/AB MACs* pay electronic claims more quickly than paper claims. For payment floor purposes, roster bills are paper bills and may not be paid as quickly as EMC. (See chapter 1.) If available, FIs*/AB MACs* must offer free, or at-cost, electronic billing software and ensure that the software is as user friendly as possible for the influenza virus vaccine benefit.

10.4 - CWF Edits

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

In order to prevent duplicate payments for *influenza virus* and *pneumococcal vaccination* claims by *the local contractor/AB MAC* and the centralized billing *contractor*, 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.)

10.4.1 - CWF Edits on FI*/AB MAC* Claims

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

In order to prevent duplicate payment by the same FI*/AB MAC*, CWF edits by line item on the FI*/AB MAC* number, the beneficiary Health Insurance Claim (HIC) number, and the date of service, the *influenza virus* procedure codes 90657, 90658, or 90659, the pneumonia procedure code 90732, and the administration codes 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 FI*/AB MAC* 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 code 90732 and it already has on record a claim with the same HIC number, same FI*/AB MAC* 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 HIC number, same FI*/AB MAC* number, same date of service, and same procedure code, CWF rejects the second claim submitted when all four items match.

CWF returns to the FI*/AB MAC* a reject code “7262” for this edit. FIs*/AB MACs* 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 Carrier*/AB MAC* Claims

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

In order to prevent duplicate payment by the same carrier*/AB MAC*, CWF will edit by line item on the carrier*/AB MAC* number, the HIC number, the date of service, the

influenza virus procedure codes 90657, 90658, 90659, or 90660*;* the *pneumococcal* 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*/AB MAC* 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*/AB MAC* 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*/AB MAC* number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the carrier*/AB MAC* a specific reject code for this edit. Carriers*/AB MACs* 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 carrier*/AB MAC*, CWF will edit by line item for carrier number, same HIC number, same date of service, the *influenza virus* procedure codes 90657, 90658, 90659, or 90660; the *pneumococcal* 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*/AB MAC* 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*/AB MAC* 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*/AB MAC* 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. Carriers*/AB MACs* 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 23 – Payment adjusted *due to the impact of prior payer(s) adjudication including payment and/or adjustments. This change to be effective April 1, 2008: The impact of prior payer(s) adjudication including payments and/or adjustments.*

10.4.3 - CWF A/B Crossover Edits for FI*/AB MAC* and Carrier*/AB MAC* Claims

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

When CWF receives a claim from the carrier*/AB MAC*, 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 HIC number; the date of service; the *influenza virus* procedure codes 90657, 90658, or 90659; the pneumonia procedure code 90732; and the administration code G0008 or G0009.

CWF will return a specific reject code for this edit. *Contractors* must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

10.5 - Medicare Summary Notice (MSN)

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Contractors must generate a Medicare Summary Notice (MSN) for *the pneumococcal,* influenza *virus*, hepatitis B vaccines, and their administration.

For vaccines rendered to beneficiaries other than *pneumococcal*, influenza virus or hepatitis B, which are not covered by Medicare, they must send the following MSN message.

MSN: 18.2:

> This immunization and/or preventive care is not covered.

The Spanish version of this MSN message should read:

> Esta inmunización y/o servicios preventivos no están cubiertos.

10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev.1586, Issued: 09-05-08, Effective: 10-06-08, Implementation: 10-06-08)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of

a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;

- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);

- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;

- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

Item 17a – Enter the ID qualifier 1G, followed by the CMS assigned UPIN of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24J of this section.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter the NPI/PIN of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI) of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS

code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H - Leave blank. Not required by Medicare.

Item 24I - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.

Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;

- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;

- Ambulatory surgical center services for covered ASC procedures;

- Home dialysis supplies and equipment paid under Method II;

- Ambulance services;

- Drugs and biologicals; and

- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 - Enter the name and address, and ZIP Code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and ZIP Code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP Code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP Code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP Code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall be entered if other than home.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - If required by Medicare claims processing policy, enter the PIN of the service facility. Be sure to precede the PIN with the ID qualifier of 1C. There should be one blank space between the qualifier and the PIN.

NOTE: Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

NOTE: Effective May 23, 2008, Item 33b is not to be reported.