

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2446	Date: April 26, 2012
	Change Request 7794

SUBJECT: New Influenza Virus Vaccine Code

I. SUMMARY OF CHANGES: This CR provides instructions for payment and CWF edits to be updated to include influenza virus vaccine code Q2034 for claims with dates of service on or after July 1, 2012, processed on or after October 1, 2012.

EFFECTIVE DATE: July 1, 2012

IMPLEMENTATION DATE: October 1, 2012

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/1/1.2/Table of Preventive and Screening Services
R	18/10/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
R	18/10/10.4.1/CWF Edits on FI/AB MAC Claims
R	18/10/10.4.2/CWF Edits on Carrier/AB MAC Claims
R	18/10/10.4.3/CWF A/B Crossover Edits for FI/AB MAC and Carrier/AB MAC Claims

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

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

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: 2446	Date: April 26, 2012	Change Request: 7794
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SUBJECT: New Influenza Virus Vaccine Code

Effective Date: July 1, 2012

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: This CR provides instructions for payment and CWF edits to be updated to include influenza virus vaccine code Q2034 (Influenza virus vaccine, split virus, for intramuscular use (Agriflu)) for claims with dates of service on or after July 1, 2012, processed on or after October 1, 2012.

B. Policy: Effective for claims with dates of service on or after July 1, 2012, influenza virus vaccine code Q2034 will be payable by Medicare.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physicians practitioners and supplier who administer the influenza virus vaccination must take assignment on the claim for the vaccine.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M M A C	F I I E R	C A R I E R	R H H I S S	Shared-System Maintainers				OTH ER	
		F	M	V	C	M	S	S	W	F		
7794.1	Contractors shall update their systems to accept code Q2034 for dates of service on or after July 1, 2012.	X		X	X	X	X				X	IOCE
7794.2	Effective for dates of service between July 1, 2012 and September 30, 2012, contractors shall use local pricing guidelines to determine payment rates for influenza virus vaccine code Q2034.	X			X							
7794.2.1	Effective for dates of service on and after October 1, 2012, contractors shall use Medicare Part B payment limit for Q2034 according to the established payment rate in the October 2012 Part B drug pricing file.	X			X							
7794.3	Contractors shall pay for influenza virus vaccine code Q2034 to hospitals (12X and 13X), SNFs (22X and 23X), HHA (34X), hospital-based RDFs (72X), and CAHs (85X) based on reasonable cost.	X		X		X	X					
7794.4	Contractors shall pay for influenza virus vaccine code Q2034 to IHS Hospitals (12X, 13X), and IHS CAHs (85X), based on the lower of the actual charge or 95% of	X		X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H H I S S	Shared-System Maintainers				OTH ER
F I S S	M C S						V M S	C W F			
	the Average Wholesale Price (AWP).										
7794.5	Contractors shall pay for influenza virus vaccine code Q2034 to CORFs (75X), and independent RDFs (72X), based on the lower of the actual charge or 95% of the AWP.	X		X			X				
7794.6	Contractors shall add influenza virus vaccine code Q2034 to existing influenza virus vaccine edits.						X			X	
7794.7	Until systems are implemented, contractors shall hold institutional claims containing code Q2034 with dates of service on or after July 1, 2012, received before October 1, 2012.	X		X		X					
7794.8	Once the system changes described in this instruction are implemented, contractors shall release the held claims, appending condition code 15.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H H I S S	Shared-System Maintainers				OTH ER
F I S S	M C S						V M S	C W F			
7794.9	<p>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.</p> <p>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 one 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.</p>	X		X	X	X					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): William Ruiz (410) 786-9283, william.ruiz@cms.hhs.gov for institutional claims and Bridgitté Davis (410) 786-9283, bridgitte.davis@cms.hhs.gov for practitioner claims.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

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

Section B: *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.

1.2 – Table of Preventive and Screening Services

(Rev. 2446, Issued: 04-26-12, Effective: 07-01-12, Implementation: 10-01-12)

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	*Not Rated	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	WAIVED
Cardiovascular Disease	80061	Lipid panel	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	B	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	*Not Rated	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	*Not Rated	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	B	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	B	WAIVED
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	A	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	A	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	A	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	B	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	77057	Screening mammography, bilateral (2-view film study of each breast)	B	WAIVED
	G0202	Screening mammography, producing direct digital image, bilateral, all views		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	B	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77083	Radiographic absorptiometry (e.g., photo densitometry, radiogrammetry), 1 or more sites		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	*Not Rated	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	A	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90654	<i>Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64</i>	B	WAIVED
	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	Q2034	<i>Influenza virus vaccine, split virus, for intramuscular use (Agriflu)</i>		WAIVED
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)		WAIVED
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)		WAIVED
	Q2037	Influenza virus vaccine, split virus when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)		WAIVED
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)		WAIVED
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G9141	Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)		WAIVED
	G9142	Influenza A (H1N1) Vaccine, any route of administration		WAIVED
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of hepatitis B vaccine	A	WAIVED
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening	A	WAIVED
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening		WAIVED
Smoking Cessation	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Annual Wellness Visit	G0438	Annual wellness visit, including PPS, first visit	*Not Rated	WAIVED
	G0439	Annual wellness visit, including PPS, subsequent visit		WAIVED

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

(Rev. 2446, Issued: 04-26-12, Effective: 07-01-12, Implementation: 10-01-12)

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

HCPCS Definition

- Q2034 Influenza virus vaccine, split virus, for intramuscular use (Agriflu)*
- 90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 – 64;
- 90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use;
- 90656 Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;
- 90657 Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
- 90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use;
- 90660 Influenza virus vaccine, live, for intranasal use;
- 90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- 90669 Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
- 90670 Pneumococcal conjugate vaccine, 13 valent, 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

HCPCS Definition

- 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 until December 31, 2010, OPPS hospitals report 90471 or 90472 for hepatitis B vaccine administration as appropriate in place of G0010. Beginning January 1, 2011, providers should report G0010 for billing under the OPPS rather than 90471 or 90472 to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccine.

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

Diagnosis Code	Description
V03.82	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 influenza virus 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 the 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 May 23, 2008, when Medicare began accepting NPIs, only
- The provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2008, when NPI requirements were implemented.

10.4.1 - CWF Edits on FI/AB MAC Claims

(Rev. 2446, Issued: 04-26-12, Effective: 07-01-12, Implementation: 10-01-12)

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 *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662 and the pneumococcal procedure codes 90669, 90670, or 90732, and the administration codes G0008 or G0009.

If CWF receives a claim with either HCPCS codes *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662 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 codes 90669, 90670, or 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. 2446, Issued: 04-26-12, Effective: 07-01-12, Implementation: 10-01-12)

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 *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662 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 codes 90669, 90670, or 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 *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662 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 codes 90669, 90670, or 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 18 – duplicate claim or service

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

(Rev. 2446, Issued: 04-26-12, Effective: 07-01-12, Implementation: 10-01-12)

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 *Q2034*, 90654, 90655, 90656, 90657, 90658, 90660, or 90662; the pneumococcal procedure codes 90669, 90670, or 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.