Medicare
Carriers Manual
Part 3 - Claims Process

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

Transmittal 1731 **Date: DECEMBER 12, 2001**

CHANGE REQUEST 1950

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Secs. 4481- 4481 (Cont.)	4-319 – 4-324 (6 pp.)	4-319 – 4-324 (6 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* September 1, 2001
IMPLEMENTATION DATE: December 12, 2001

Section 4481, Centralized Billing for Flu and Pneumococcal (PPV) Vaccination Claims, is revised to change the yearly enrollment period for centralized billers from October 1 through September 30 to September 1 through August 31. This will allow centralized billers to begin vaccinating in September and billing for those services.

TrailBlazer, the carrier that currently processes claims for centralized billers, may adjust the enrollment period for approved centralized billers as necessary to accommodate the billing and reimbursement for services provided with September 2001 dates of service.

It also adds a statement to be included in the notification to providers that centralized billing does not apply to Railroad Retirement Board, United Mine Workers or Indian Health Services claims.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

4481. CENTRALIZED BILLING FOR FLU AND PNEUMOCOCCAL (PPV) VACCINATION CLAIMS

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

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are 3 different carriers processing claims. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given which the carrier must verify through the enrollment process.

Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) Payment will be made based on the payment locality where the service was provided. This process is only available for claims for the flu and PPV vaccines and their administration. The general coverage and coding rules found in §2049.4 and §4480 are also applicable to centrally billed flu and PPV claims.

This section applies only to those individuals and entities that will provide mass immunization services for flu and PPV vaccinations and that have been authorized by CMS to centrally bill. All other providers, including those individuals and entities that will provide mass immunization services that are not authorized to centrally bill, must continue to bill for these claims to their regular carrier per the instructions in §4480.

The claims processing instructions in this section apply only to the designated processing carrier. However, all carriers must follow the instructions in §4481L, Provider Education Instructions for **All** Carriers.

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

B. Request for Approval.--If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Carriers may not process claims for any centralized biller without prior permission from CMS CO. If claims are submitted by a provider that is not currently approved as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

C. Notification of Provider Participation to the Processing Carrier.--Before October 1 of every year, CMS CO will notify the designated carrier as to the names of the entities that are authorized to participate in centralized billing for the twelve month period beginning October 1 and ending September 30 of the next year.

D. Enrollment.--Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier for centralized billing through completion of the Form HCFA-855 (Provider Enrollment Application).

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

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

E. Electronic Submission of Claims on Roster Bills.—Centralized billers must agree to submit their claims on roster bills in an Electronic Media Claims standard format using either the National Standard Format (NSF) or American National Standards Institute (ANSI) X12.837 format (or the HIPAA ANSI X12N 837(version 4010) when required). The processing carrier must provide instructions on acceptable roster billing formats to the approved centralized billers. Paper claims will not be accepted.

F. Required Information on Roster Bills for Centralized Billing.--In addition to the roster billing instructions found in the Medicare Carriers Manual, §4480.6, Roster Billing, centralized billers must complete on the electronic format the area that corresponds to Item 32, (Name and Address of Facility, including zip code) on Form HCFA-1500. The carrier must use the zip code in this field to determine the payment locality for the claim.

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

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

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

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

G. Payment Rates and Mandatory Assignment.--The payment rates for the administration of the vaccinations will be based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments vary based on the geographic locality where the service was performed.

The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated carrier must pay per the correct MPFS file for each calendar year based on the date of service of the claim.

In order to pay claims correctly for centralized billers, designated carrier must have the correct name and address, including zip code, of the entity where the service was provided. If a claim is received with a zip code that is not included on the zip code file maintained by designated carrier, they should refer to the United State Postal Service (USPS) website to determine if the zip code presented is valid. If the zip code is valid, add it to the designated carrier maintained zip code file and pay the claim using the appropriate payment locality.

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

If the zip code presented is not a valid zip code, or is not a valid zip code with the given street address, and the correct zip code can not be determined from the USPS web site, deny the claim.

Use the following remittance advice and Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) messages:

Claim adjustment reason code 16, "Claim/service lacks information which is needed for adjudication," in addition to remittance advice remark code MA114, "Did not complete or enter accurately the name and address, the carrier assigned PIN, or the Regional Office assigned OSCAR number of the entity where the services were furnished." (Substitute "NPI" for "PIN" when effective.

EOMB 9.33, "Your service was denied because information required to make payment was missing. We have asked your provider to resubmit a claim with the missing information so that it may be processed."

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 which is based on the lower of cost, or 95 percent of the AWP.

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

H. Common Working File Information.--To better identify these claims in their internal systems 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 to CWF in field 49, (Demonstration Number), positions 272 and 273.

I. Provider Education Instructions for the **Processing** Carrier.--The processing carrier must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on flu and PPV coverage and billing instructions is available on the CMS home page for providers.

J. Provider Education Instructions for **All** Carriers.--By April 1 of every year, all carriers must publish in their bulletins and put on their websites the following notification to providers. Questions from interested providers should be forwarded to the central office address below. Carriers must enter the name of the assigned processing carrier where noted before sending.

Notification to Providers

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and Pneumococcal (PPV) immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations will be reimbursed at the assigned rate based on the Medicare Physician Fee Schedule for the appropriate locality. The vaccines will be reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals which is based on the lower of cost or 95 percent of the Average Wholesale Price (AWP).

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

Division of Practitioner Claims Processing
Provider Billing and Education Group
Center for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

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

CRITERIA FOR CENTRALIZED BILLING

- To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least 3 different carriers processing claims.

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

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

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

- The payment rates for the administration of the vaccinations will be 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 will be made at the assigned rate.

- The payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals which is based on the lower of cost, or 95 percent of the AWP. Payment will be made at the assigned rate.

- Centralized billers must submit their claims on roster bills in an Electronic Media Claims standard format using either the National Standard Format (NSF) or American National Standards Institute ANSI X12N 837 (version 3051) format (or the HIPAA ANSI X12N 837(version 4010) when required). Paper claims will not be accepted.

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

- Centralized billers must obtain an address for each beneficiary so that an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an EOMB or MSN from a carrier other than the carrier that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

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

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

- If an individual or entity's request for centralized billing is approved, the approval is limited to the twelve-month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. [Fill in name of carrier] will not process claims for any centralized biller without permission from CMS CO.

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

- The centralized biller will be responsible for providing the beneficiary with a record of the PPV vaccination.

The information in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:

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

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

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

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

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

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