Medicare
Carriers Manual
Part 3 - Claims Process

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

Transmittal 1801 **Date: MAY 30, 2003**

CHANGE REQUEST 1691

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – Chapter IV	4-4.3 – 4-4.4 (2 pp.)	4-4-.3 4-4.4 (2 pp.)
4480.3 – 4480.6	4-313 4-318.2 (8 pp.)	4-313 – 4-318 (6 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2002*
IMPLEMENTATION DATE: July 1, 2002

Section 4480.2, HCPCS Coding, is being updated to incorporate Program Memorandum (PM) AB-02-014, Change Request 1691, dated January 31, 2002.

Section 4480.4, CWF Edits for Flu and Pneumonia Claims, is being updated to incorporate PM AB-02-014, Change Request 1691, dated January 31, 2002.

Section 4480.5, A/B Crossover Edit, is being updated to incorporate PM AB-02-014, Change Request 1691, dated January 31, 2002.

Section 4480.6, Payment Requirements, is being updated to change the section title only. All other information is that section remains the same.

Section 4480.7, No Legal Obligation to Pay, is being updated to change the section title only. All other information is that section remains the same.

Section 4480.8, Roster Billing, is being updated to change the section title only. All other information is that section remains the same.

Section 4480.9, Health Maintenance Organization (HMO) Processing, is being updated to change the section title only. All other information is that section remains the same.

Section 4480.10, Specialty Cod/Place of Service (POS) Processing, is being updated to change the section title only. All other information is that section remains the same.

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.

Section

Services Provided In Health Manpower Shortage Areas

Healthcare Common Procedure Coding System (HCPCS)

Code	Description
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, 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 (3 dose schedule) for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use;
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule) for intramuscular use;

These codes are for the vaccines only and do not include their administration. The following HCPCS "G" codes are used to bill for administration of vaccines:

Code	Description
G0009	Administration of pneumococcal vaccine
G0008	Administration of influenza virus vaccine
G0010	Administration of hepatitis B vaccine

These three codes should be reimbursed at the same rate as the HCPCS code 90782 as priced on the Medicare Physician Fee Schedule Database. Effective March 1, 2003 HCPCS codes G0008, G0009, And G0010 should be reimbursed at the same rate as HCPCS code 9047.

4480.3 Billing Requirements.--Physicians and suppliers submit claims on Form CMS-1500. The Unique Physician Identification Number (UPIN) must be entered in Item 17A of Form CMS-1500 for PPV and hepatitis B vaccines. No UPIN is required in Item 17A of Form CMS-1500 for influenza virus vaccine claims since Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, no UPIN is required in Item 17A of Form CMS-1500 for PPV claims since Medicare will no longer require that the vaccine be administered under a physician's order or supervision.

Effective with implementation of the National Provider Identifier (NPI), the NPI must be entered in item 17A of Form CMS-1500 for PPV and hepatitis B vaccines. No NPI is required in Item 17A of Form CMS-1500 for influenza virus vaccine claims (or PPV claims with dates of service on or after July 1, 2000) since Medicare does not require that the vaccine (s) be administered under a physician's order or supervision.

A. Diagnosis Codes.--The following diagnosis codes for PPV and influenza virus and hepatitis B vaccines and their administration should appear in Block 21 of Form CMS-1500:

Code	Description
V03.82	PPV
V04.8	Influenza virus vaccine
V05.3	Hepatitis B vaccine

If a diagnosis code for PPV, hepatitis B, or influenza virus vaccination is not reported on a paper or electronic media claim (EMC) and you determine that the claim is a PPV, hepatitis B or influenza claim, you may enter the proper diagnosis code and continue processing the claim. These claims should not be returned, rejected, or denied for lack of a diagnosis code.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is V04.8 and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, change the HCPCS code and pay for the flu shot. However, if the incorrect code is not obviously wrong (e.g., there is no narrative, and the procedure and diagnosis do not agree), follow §4020.5.

B. Reimbursement and Deductible Indicators.--The record submitted to the common working file (CWF) must contain the following indicators:

Reimbursement Ind.	Deductible Ind.	Description
"1"	"1"	PPV
"1"	"1"	Influenza
"0"	"0"	Hepatitis B

A reimbursement indicator of "1" represents 100 percent reimbursement. A deductible indicator of "1" represents a zero deductible. A reimbursement indicator of "0" represents 80 percent reimbursement. 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 PPV or influenza virus vaccine. Use a “1" in the type of service field which indicates medical care for a hepatitis B vaccine.

C. Medicare Secondary Payer (MSP) Edits and First Claim Development.--Bypass all MSP utilization edits in CWF on all claims when the only service provided is PPV or influenza virus vaccine and/or their administration. This waiver does not apply when other services (e.g., office visits) are billed on the same claim as PPV or influenza vaccinations. If the provider knows or has reason to believe that a particular group health plan covers PPV or influenza virus vaccine and their administration, and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed. First claim development alerts from CWF are not generated for PPV or influenza virus vaccine. However, first claim development is performed if other services are submitted along with PPV or influenza virus vaccine.

4480.4 CWF Edits for Flu and Pneumonia Claims.--In order to prevent duplicate payment by the same carrier, CWF will edit by line item on the carrier number, the HIC number, the date of service, the flu procedure codes 90657, 90658, or 90659, the pneumonia procedure code 90732, and the administration code G0008 or G0009.

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

If CWF receives a claim with HCPCS code 90732 and it already has on record a claim with the same HIC number, same carrier number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same HIC number, same carrier number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the carriers a specific reject code for this edit that will be named in the CWF documentation. Carriers must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

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

If CWF receives a claim with either HCPCS codes 90657, 90658 or 90659, and it already has on record a claim with a **different** carrier number, but same HIC number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS code 90732 and it already has on record a claim with the same HIC number, different carrier number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different carrier number, but the same HIC number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for this edit that will be named in the CWF documentation. Carriers must deny the second claim. For the second edit, the reject code should automatically trigger the following Medicare Summary Notice (MSN), Explanation of Medicare Benefits (EOMB), 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.

- EOMB: 7.14 – Medicare records show that this is a duplicate of a claim previously processed by another carrier. You should receive an Explanation of Your Medicare Part B Benefits notice from the carrier that processed the claim.

- RA: At the service level, report adjustment reason code 18 – Duplicate claim/service, and at the line level report remark code M43 – Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary.

4480.5 A/B Crossover Edit

When CWF receives a claim from the carrier, 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 flu 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 that will be named in the CWF documentation. Carriers and FIs must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

4480.6 Payment Requirements.--Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. 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 must accept assignment for the vaccines even if the provider normally does not accept assignment.

The administration of PPV, influenza virus, and hepatitis B vaccines, (HCPCS codes G0009, G0008, and G0010), though not reimbursed directly through the MPFSDB, is reimbursed at the same rate as HCPCS code 90782 on the MPFSDB for the year that corresponds to the date of service of the claim Beginning March 1, 2003 HCPCS codes G0008, G0009, and G0010 should be reimbursed at the same rate as HCPCS code 90741. Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunizer," submits roster bills, or participates in the centralized billing program.

Do not apply the limiting charge provision for PPV, influenza virus vaccine, or hepatitis B vaccine and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Act. The administration of the influenza virus vaccine is covered in the flu shot 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.

4480.7 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 §§2306 and 2309.4.) Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128 (b)(6)(A) of the Act.)

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

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

4480.8 Roster Billing.--The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by PHCs and other individuals and entities that bill the Medicare carriers. Medicare has not developed roster billing 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 PPV.

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. However, the rosters should not be used for single patient bills and the date of service for each vaccination administered must be entered.

Entities that submit claims on roster bills must accept assignment and may not collect any "donation" or other cost sharing of any kind from Medicare beneficiaries for PPV or influenza 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.--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 Immunizer." These individuals and entities must enroll with the carrier by completing the Provider/Supplier Enrollment Application, Form CMS-855. Individuals and entities enrolled as the provider type "Mass Immunizer" must roster bill and must accept assignment. They may not submit claims for any services or items other than for influenza and PPV vaccines and their administration. Carriers must establish an edit to identify "Mass Immunizers" and limit the services they can bill to flu and PPV vaccines and their administration. In addition, carriers must edit to only allow the provider type "Mass Immunizer" to be reimbursed at the assigned payment rate.

B. Modified Form CMS-1500.--Those individuals or entities that qualifies to roster bill may use a preprinted Form CMS-1500 that contains standardized information about the individual or entity and the benefit.

Individuals or entities submitting roster claims to carriers must complete the following blocks on a single modified Form CMS-1500 which serves as the cover document for the roster for each facility where services are furnished.

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 17A (I.D. Number or Referring Physician): This number is required for PPV and hepatitis B vaccines only. Effective for claims with dates of service on or after July 1, 2000, this number will no longer be required for PPV.

Item 20 (Outside Lab?): An "X" in the NO block

Item 21 (Diagnosis or Nature of Illness):
Line 1:

PPV: "V03.82"
Influenza Virus: "V04.8"

Item 24B (Place of Service (POS)):
Line 1: "60"
Line 2: "60"

NOTE: POS code "60" must be used for roster billing.

Item 24D (Procedures, Services, or Supplies):
Line 1:
PPV: "90732"
Influenza Virus: "90659"

Line 2:

PPV: "G0009"
Influenza Virus: "G0008"

Item 24E (Diagnosis Code):
Lines 1 and 2: "1"

Item 24F ($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC PPV or influenza virus vaccine claims only if your system is able to accept them.

Item 27 (Accept Assignment): An "X" in the YES block

Item 29 (Amount Paid): "$0.00"

Item 31 (Signature of Physician or Supplier): The entity's representative must sign the modified Form HCFA-1500.

Item 32 (Name and Address of Facility): N/A

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

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

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

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

C. Roster Claim Form.--Qualifying individuals and entities must attach to the Form CMS-1500 claims form a roster, which contains the variable claims information regarding the supplier of the service and individual beneficiaries. While qualifying entities must use the modified Form CMS-1500 without deviation, work with these entities to develop a mutually suitable roster that contains the minimum data necessary to satisfy claims processing requirements for these claims. Key information from the beneficiary roster list and the abbreviated Form CMS-1500 to process PPV and influenza virus vaccination claims.

The roster must contain at a minimum the following information:

- o Provider name and number;
- o Date of service;

NOTE: Although physicians who provide PPV or influenza virus vaccinations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.

- o Control number for contractor;
- o Patient's health insurance claim number;
- o Patient's name;
- o Patient's address;
- o Date of birth;
- o Patient's sex; and
- o Beneficiary's signature or stamped "signature on file."

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster claim form if the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, the provider is not required to obtain the patient signature on the roster but instead has the option of reporting signature on file in lieu of obtaining the patient's actual signature.

The PPV roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering PPV.

WARNING: Ask beneficiaries if they have been vaccinated with PPV.

- o Rely on patients' memory to determine prior vaccination status.
- o If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine.
- o If patients are certain that they have been vaccinated within the past 5 years, do not revaccinate.

For payment floor purposes, roster bills are considered paper bills and are not paid as quickly as electronic medical claims (EMC). If available, offer electronic billing software free or at-cost to PHCs and other properly licensed individuals and entities. Ensure that the software is as user friendly as possible for the PPV and influenza virus vaccine benefits.

Create and count one claim per beneficiary from roster bills. Split claims in accordance with §3000.1. Providers must show the unit cost for one service on the modified Form CMS-1500 since they will have to replicate the claim for each beneficiary listed on the roster.

Provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for PPV and influenza vaccine and their administration. According to §§3000.2, 3103, and 3110.B, replicate the roster and the Form CMS-1500, highlighting the RRB beneficiary on the roster, and forward the material to Palmetto-RRB. Effective October 1, 2002, follow the new instructions in §3110 for any misdirected RRB claims you receive.

If PHCs or other individuals or entities inappropriately bill PPV or influenza vaccination using the roster billing method, return the claim to the provider with a cover letter explaining why they are being returned and the criteria for the roster billing process. Do not deny these claims.

Providers must retain roster bills with beneficiaries' signatures at their permanent location for a time period consistent with Medicare regulations.

4480.9 Health Maintenance Organization (HMO) Processing Requirements.--HMOs may use roster billing only if vaccinations are the only Medicare-covered services furnished by the HMO to Medicare patients who are not members of the HMO. HMOs must use Place of Service (POS) code 60 for processing roster bill claims.

4480.10 Specialty Code/Place of Service (POS) Processing Requirements.--Entities and individuals other than PHCs and pharmacists use the CMS specialty code that best defines their provider type. If no appropriate CMS specialty code exists for their provider type, providers should use CMS specialty code 99 (Unknown Physician Specialty). PHCs should use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)). Pharmacists should use specialty code 87 (all other suppliers (drug stores, department stores)).

State or local PHCs use POS code 71 (State or Local Public Health Clinic). Use POS 99 (Other Unlisted Facility) if no other POS code applies. It is not intended that POS 71 be used by individuals/entities other than PHCs (e.g., a mobile unit that is non-PHC affiliated should use POS 99). Preprinted Form CMS-1500s used for 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 bills should use POS 60). Individuals/entities administering influenza and PPV vaccinations in a mass immunization setting, regardless of the site where vaccines are given, should use POS 60 for roster bills, paper claims, and electronically filed claims.