Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2483

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3660.6 - 3660.7 (Cont.)	6-341 - 6-341.3 (4 pp.)	6-341 - 6-341.3 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2003*
IMPLEMENTATION DATE: July 1, 2003

Section 3660.7, Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines, is being updated to change some subsection references and to eliminate outpatient physical therapy providers (bill type 74X) as an entity that may bill for vaccines.

This section is also being updated to reflect a new payment methodology for hospitals, home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs) that are currently being reimbursed for influenza and pneumococcal pneumonia vaccines (PPV) under the outpatient prospective payment system. Payment for all other providers remains the same for these vaccines. In addition, payment for the hepatitis B vaccine remains the same.

NOTE: Although the effective date of the change to payment for influenza and PPV vaccines and their administration is January 1, 2003, due to the need for shared systems changes, this provision will be implemented in July. As a result, if you receive claims with dates of service January 1, 2003 through June 30, 2003 containing any of the HCPCS for the influenza and PPV vaccines and their administration, hold the claims and do not release them for processing until your SSM has implemented the July release. The affected codes are 90657, 90658, 90659, 90732. Advise your hospitals, CORFs and HHAs that claims containing these HCPCS will be held and not processed until the system change is completed.

For vaccines furnished during the period January 1, 2003 through June 30, 2003, if a hospital, CORF or HHA furnishes additional services that would be reported on the same claim as the vaccines, advise them that they may wish to remove the vaccine and administration charges from the claim in order to receive payment for the remaining services. In this instance an adjustment bill would need to be submitted to include the vaccine and administration charges after the SSM implements the July release.

When releasing the held claims for payment apply applicable interest and enter condition code 15 to indicate the claims are clean claims in which payment was delayed due to a CMS processing delay and are therefore, not subject to contractor performance evaluation for claims processing timeliness.

These instructions should be implemented within your current operating budget.

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.

3660.6 Billing for Parenteral and Enteral Nutrition (PEN).--Providers can bill for PEN therapy when it meets the coverage guidelines in the Coverage Issues Manual, §§65-10-65-10.3 as a prosthetic device. HHAs, SNFs, and hospitals that provide PEN supplies, equipment and nutrients as a prosthetic device under Part B must use Form HCFA-1500 to bill the appropriate DME. The DME regional carrier is determined according to the residence of the beneficiary.

Region A

MetraHealth (Travelers)
DME Region A Service Office
Suite 339, 320 South Pennsylvania Blvd.
Wilkes-Barre, PA 18701-2215

Region B

AdminaStar Federal, Inc.
P.O. Box 7078
Indianapolis, IN 46207-7078

Region C

Palmetto Government Benefits Administrators
Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

Region D

CIGNA
Medicare Region D DMERC
P.O. Box 690
Nashville, TN 37202

Return claims containing PEN charges for Part B services where the bill type is 12, 13, 22, 23, 33, or 34. Part B payments cannot be made for PEN items furnished during an admission that is covered by Part A. A separate PEN bill must be sent to the appropriate DME regional carrier when a patient received a combination of Part B or Parts A and B services.

A. SNF Billing for PEN.--A SNF includes the cost of PEN items it supplies beneficiaries on its cost report. The services of SNF personnel who administer the PEN therapy are considered routine and are included in the basic Part A payment for a covered stay. SNF personnel costs to administer PEN therapy are not covered under the Part B prosthetic device benefit.

If PEN supplies, equipment and nutrients qualify as a prosthetic device and the stay is not covered by Part A, they are covered by Part B. Part B coverage applies regardless of whether the PEN items were furnished by the SNF (see §3137) or an outside supplier. (See Carriers Manual, §2130.) The Part B PEN bill must be sent to the DME regional carrier regardless of whether supplied by the SNF or an outside supplier.

Enteral nutrients provided during a stay that is covered by Part A are classified as food and included in the routine Part A payment sent to the SNF. (See Provider Reimbursement Manual, §2203.1E.) Parenteral nutrient solutions provided during a covered Part A SNF stay are classified as intravenous drugs. The SNF must bill you for these service as ancillary costs. (See Provider Reimbursement Manual, §2203.2.)

3660.7 Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines.--Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Deductible and coinsurance do not apply. Payment is on a reasonable cost basis for the providers listed in subsection B except for, comprehensive outpatient rehabilitation facilities (CORFs), and independent ESRD facilities which are paid based on the lower of the actual charge or 95 percent of the average wholesale price (AWP) as outlined in subsection K.

NOTE: For PPV and influenza virus vaccines provided to hospital outpatient departments, HHAs and CORFs payment is made under OPPS effective August 1, 2000. Effective January 1, 2003, payment is made on a reasonable cost basis for hospitals and HHAs and on the lower of charges or 95 percent of the AWP for CORFs.

Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply. For the hepatitis B vaccine payment is on a reasonable cost basis for the providers listed in subsection B except for hospitals, home health agencies and CORFs which are paid under the outpatient prospective payment (OPPS) and independent ESRD facilities which are paid based on the lower of the actual charges or 95 percent average wholesale price (AWP).

See subsection J for payment of these vaccines when provided by a hospice.

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

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

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

B. General Billing Requirements.--Follow the general bill review instructions in §3604.

The following "providers of services" may bill you for these vaccines:

- Hospitals;
- Skilled Nursing Facilities (SNFs);
- Critical Access Hospitals (CAHs);
- Home Health Agencies (HHAs); and
- Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Other billing entities that may bill you are:

- Independent Renal Dialysis Facilities (RDFs).

All providers bill you for hepatitis B on Form HCFA-1450. Providers other than independent and provider-based RHCs/FQHCs bill you for influenza and PPV on Form HCFA-1450. Instruct your providers, other than independent and provider-based RHCs/FQHCs, to bill for vaccines and their administration on the same claim. 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 subsection H below.)

NOTE: See subsection G for billing of these vaccines by rural health clinics (RHCs) and federally qualified health centers (FQHCs) and subsection J for billing by hospices.

C. HCPCS Coding.--The provider bills for the vaccines using the following HCPCS codes:

90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use;
Q3021	Injection, hepatitis B vaccine, pediatric or adolescent, per dose;
Q3022	Injection, hepatitis B vaccine, adult, per dose and,
Q3023	Injection, hepatitis B vaccine, immunosuppressed patients (including renal dialysis patients), per dose.

These codes are for reporting of the vaccines only. The provider bills for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV vaccine, and G0010 for the hepatitis B vaccine.

D. Applicable Bill Types.--Bill types 13X, 22X, 23X, 34X, 72X, 75X, and 85X are the only bill types acceptable when billing for influenza and PPV. When billing for hepatitis B, the applicable bill types are 13X, 22X, 23X, 34X, 71X, 72X, 73X, 75X and 85X.

E. Applicable Revenue Codes.--All providers listed in subsection B with the exception of RHCs and FQHCs bill you for the vaccines using revenue code 636 and for the administration of the vaccines using revenue code 771. RHCs and FQHCs follow subsection B for influenza and PPV and bill hepatitis B just like any other RHC/FQHC service using revenue code 52X (freestanding clinic).

F. Other Coding Requirements.--The provider must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim. Providers report code V04.8 for the influenza virus vaccine, code V03.82 for PPV, and code V05.3 for the hepatitis B vaccine.

In addition, for the influenza virus vaccine providers report UPIN code SLF000 if the vaccine is not ordered by a doctor of medicine or osteopathy and enters condition code M1 in FLs 24-30 when roster billing. (See subsections L and N for a more detailed explanation of roster billing.)

G. Special Instructions for Independent and Provider-based RHCs/FQHCs.--Independent and provider-based RHCs and FQHCs do not include charges for influenza and PPV on Form HCFA-1450. They count visits under current procedures except they do not count as visits when the only service involved is the administration of influenza and PPV. If there was another reason for the visit, the RHC/FQHC should bill for the visit without adding the cost of the influenza and PPV to the charge for the visit on the claim. Make payment at the time of cost settlement and adjust interim rates to account for this additional cost if you 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.

H. Special Billing Instructions for Regional Home Health Intermediaries (RHHIs).--The following provides billing instructions for HHAs in various situations:

o Where the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, 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 is covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection.

Do not allow HHAs to charge for travel time or other expenses (i.e., gasoline). In this situation, the HHA bills under bill type 34X and reports revenue code 636 along with the appropriate HCPCS code for the vaccine and revenue code 771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is not allowed for the visit.

o If a vaccine (influenza, PPV 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 636 along with the appropriate HCPCS code for the vaccine and revenue code 771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is required for the visit.

o Where a beneficiary does not meet the eligibility criteria for home health coverage, a home health nurse may be paid for the vaccine (influenza, PPV 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. 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 636 along with the appropriate HCPCS code for the vaccine and revenue code 771 along with the appropriate HCPCS code for the administration.

If a beneficiary meets the eligibility criteria for coverage, and their spouse does not, and the spouse wants an injection the same time as a nursing visit, instruct your HHAs to bill in accordance with the bullet point above.

I. Special Billing Instructions for Hospital Inpatients.--When vaccines are provided to inpatients of a hospital, they are covered under the vaccine benefit. However, the provider bills you on bill type 13X using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of hospital bundling rules. (See subsection M for an exception.)

J. Special Billing Instructions for Hospices.--Hospices can provide the influenza virus, PPV, and hepatitis B vaccines to those beneficiaries who request them including those who have elected the hospice benefit. These services are coverable when furnished by the hospice. Services for the vaccines should be billed to the local carrier on the HCFA-1500. Payment will be made using the same methodology as if they were a supplier. Hospices that do not have a supplier number should contact their local carrier to obtain one in order to bill for these benefits.

K. Payment Procedures for CORF and ESRD Facilities.--Make payment for PPV and influenza vaccines for CORFs and independent ESRD facilities based on the lower of the actual charge or 95 percent of the average wholesale price (AWP). Deductible and coinsurance do not apply. Contact your carrier to obtain information in order to make payment for the administration of these vaccines.

Part B of Medicare also covers the hepatitis B vaccine. For coverage and payment rules for hepatitis B vaccine and its administration, see §2711.4 of the Provider Reimbursement Manual, Part 1, Chapter 27. Deductible and coinsurance apply.