Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1819 **Date: DECEMBER 19, 2000**

CHANGE REQUEST 1421

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3660.6 - 3660.7 (Cont.)	6-341 – 6-342 (8 pp.)	6-341 – 6-342 (8 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: CY January 1, 2001*
IMPLEMENTATION DATE: CY January 1, 2001

Section 3660.7, Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines, requires provider based Rural health centers (RHCs) and federally qualified health centers (FQHCs) not to include charges on Form HCFA-1450 for the influenza virus and pneumococcal pneumonia vaccines. Payment will be made thru the cost settlement process in the same manner that is currently in place for independent RHCs/FQHCs.

Advise your provider based RHCs/FQHCs not to submit claims containing charges for influenza virus vaccine or PPV. If they have already submitted claims containing vaccine charges for which you did not made payment, have them resubmit the claim if there was another reason for the visit. Otherwise, the RHC/FQHC should keep a log of these vaccines for submission with the cost report and you will made payment through the cost settlement process.

MANUALIZATION--*EFFECTIVE DATE: Not Applicable*

- Updates the vaccine HCPCS codes for 2001;
- Revises the payment method for these vaccines due to implementation of the outpatient prospective payment system; and
- Removes Christian Science Sanatoriums from the list of providers that can bill for these services and replaces rural primary care hospitals with critical access hospitals.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only applies 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. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply. Payment for all of these vaccines is on a reasonable cost basis except for hospitals, home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) which are paid under the outpatient prospective payment system (OPPS) and independent ESRD facilities which are paid based on the actual charge or average wholesale price (AWP) as outlined in subsection J. In addition, see subsection K 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:

- Outpatient Physical Therapy (OPTs) providers; and
- 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;
90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated, for intramuscular use;
90732 Pneumococcal polysaccharide vaccine, 23-valent, adult 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 or pediatric/adolescent dosage, for intramuscular use;
90746 Hepatitis B vaccine, adult dosage, for intramuscular use;
90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use;
90748 Hepatitis B and Hemophilus influenza b (HepB-Hib), for intramuscular use.

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, 42X, 52X, 72X, 74X, 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, 42X, 52X, 71X, 72X, 73X, 74X, 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 ESRD Facilities.--Make payment for PPV and influenza vaccines for independent ESRD facilities based on the lower of the actual charge or 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.

L. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.--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. A mass immunizer is defined as any entity that gives the influenza virus 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 is required. (See subsection O for an exception to this requirement for inpatient hospitals.)

The simplified (roster) claims filing procedure applies to providers other than independent RHCs and free-standing FQHCs that conduct mass immunizations. Since independent RHCs and freestanding FQHCs do not submit individual HCFA-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 (HCFA-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form HCFA-1450 that contains the variable claims information regarding the service provider 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".

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, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

For providers using the simplified billing procedure, the modified Form HCFA-1450 shows the following preprinted information in specific FLs:

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code); (See NOTE below)
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0008 in FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number);
- UPIN SLF000 in FL 82; and
- Diagnosis code V04.8 in FL 67 (Principal Diagnosis Code).

Providers conducting mass immunizations are required to complete the following FLs on the preprinted Form HCFA-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);
- FL 85 (Provider Representative); and
- FL 86 (Date).

NOTE: Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if the provide r knows that a particular group health plan covers the influenza virus 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 influenza virus vaccines.

Use the beneficiary roster list to generate HCFA-1450s to process influenza virus vaccine claims by mass immunizers indicating condition Code M1 in FLs 24-30 to avoid MSP editing. Standard System Maintainers will develop the necessary software to generate Form HCFA-1450 records processed through their system.

Providers that do not mass immunize must continue to bill for the influenza virus vaccine using normal billing procedures; i.e., submission of a HCFA-1450 or electronic billing for each beneficiary.

M. Simplified Billing for Influenza Virus and PPV Vaccine Services by HHAs and SNFs.--The following billing instructions apply to both HHAs and SNFs that roster bill for influenza virus and PPV vaccines under the procedures outlined in subsection J:

- When they provide the influenza virus vaccine or PPV in a mass immunization setting, they do not have the option to pick and choose whom to bill for this service. If they are using employees from the certified portion, and as a result will be reflecting these costs on their cost report, they must bill you on the HCFA-1450.

- If they are using employees from the non-certified portion of the facility (employees of another entity that are not certified as part of the HHA or SNF), and as a result, will not be reflecting these costs on their cost report, they must obtain a provider number and bill their carrier on the HCFA-1500.

- If employees from both certified and non-certified portions of the HHA or SNF furnish the vaccines at a single mass immunization site, they must prepare two separate rosters, i.e., one for employees of the certified portion to be submitted to you, and one roster for employees of the non-certified portion to be submitted to the carrier.

N. Simplified Billing of Pneumococcal Pneumonia Vaccine (PPV) by Mass Immunizers.--The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the PPV 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 is required. (See subsection M for an exception to this requirement for inpatient hospitals.) Part A providers other than independent RHCs and freestanding FQHCs that conduct mass immunizations can roster bill for PPV.

Since RHCs and FQHCs do not submit individual HCFA-1450s for the PPV 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 (HCFA-1450) with preprinted

standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form HCFA-1450, which will contain the variable claims information regarding the service provider 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".

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, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

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

WARNING: The beneficiary's vaccination status must be verified before administering the PPV. It is acceptable to rely on the patient's memory to determine prior vaccination status. If the patient is 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 HCFA-1450 shows the following preprinted information in the specific form locators (FLs):

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code);
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with HCPCS code 90732 in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number); and
- Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code).

Providers conducting mass immunizations are required to complete the following FLs on the preprinted HCFA-1450:

- FL 4 (Type of Bill);

- o FL 47 (Total Charges);
- o FL 85 (Provider Representative); and
- o FL 86 (Date).

NOTE: Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the PPV 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.

Use the beneficiary roster list to generate HCFA-1450s to process PPV claims by mass immunizers indicating condition code M1 in FLs 24-30 to avoid MSP editing. Standard System Maintainers will develop the necessary software to generate HCFA-1450 records that will process through their system.

Providers that do not mass immunize must continue to bill for PPV using the normal billing method, i.e., submission of a HCFA-1450 or electronic billing for each beneficiary.

O. Inpatient Roster Billing.--The following billing instructions apply to hospitals that roster bill for the influenza virus vaccine and PPV provided to inpatients under the procedures outlined in subsection L and N:

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

P. Electronic Roster Claims.--As for all other Medicare-covered services, you 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 §3600.1.) If available, you 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.

3660.8 Immunosuppressive Drugs Furnished to Transplant Patients.--Part B of Medicare covers the reasonable cost of FDA-approved immunosuppressive drugs. Payment is made for those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA, as well as those prescription drugs, such as prednisone, that are used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs. Therefore, antibiotics, hypertensives, and other drugs that are not directly related to rejection are not covered. Deductible and coinsurance apply. This benefit is limited to a 1-year period after the date of the transplant procedure if the patient received a Medicare covered organ (e.g., kidney or heart) transplant. Coverage of immunosuppressive drugs received as a result pays for immunosuppressive drugs which are provided outside the 1-year period if they are covered under some other provision of the law (e.g., when the drugs are covered as inpatient hospital services or are of a transplant is contingent upon the transplant being covered by Medicare. (See §3613.) Medicare e furnished incident to a physician's service).

The "1-year period after the date of the transplant procedure" is defined as 365 days from the day on which an inpatient is discharged from the hospital