Medicare
Outpatient Physical Therapy, Comprehensive Outpatient Rehabilitation Facility and Community Mental Health Center Manual

Department of Health and Human Services (DHHS)

Health Care Financing Administration (HCFA)

Transmittal 10 **Date MAY 2000**

REFER TO CHANGE REQUEST 1103

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
415 - 415 (Cont.)	4-33 - 4-34 (2 pp.)	4-33 - 4-34 (2 pp.)

NEW/REVISED PROCEDURES--EFFECTIVE DATE: ***July 1,2000***

Section 415, Pneumococcal Pneumonia, InfluenzaVirus, and Hepatitis B Vaccines, is being updated to reflect the new Medicare requirement that it is no longer necessary to have a doctor's order for receiving the PPV vaccine and its administration.

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.

415. 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. Payment is on a reasonable cost basis. 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.

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 vaccine must 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.--Bill for the PPV, influenza virus vaccine and hepatitis B vaccines on Form HCFA-1450 using bill type 74X (OPTs), and 75X, (CORFs).

Bill for the vaccines and their administration on the same claim. There is no requirement for a separate bill for the vaccines and their administration. However, you may be required to bill separately if your intermediary requires it.

C. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

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;
90744	Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
90745	Hepatitis B vaccine, adolescent/high risk infant 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 vaccine (HepB-Hib), for intramuscular use.

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

D. Applicable Revenue Codes.--Bill for the vaccines using revenue code 636. Bill for the administration of the vaccines using revenue code 771.

E. Other Coding Requirements.--You must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive the vaccines or if the vaccines are the only service billed on a claim. Report code V04.8 for the influenza virus vaccine code V03.82 for PPV and V05.3 for the hepatitis B vaccine. In addition, for the influenza virus vaccine, report UPIN code SLF000 if the vaccine is not ordered by a doctor of medicine or osteopathy.

F. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.-Some potential "mass immunizers," 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.

The simplified process involves use of the HCFA-1450 with preprinted standardized information relative to you and the benefit. When conducting mass immunizations, attach a standard roster to a single pre-printed HCFA-1450 which will contain the variable claim 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 provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you 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 modified HCFA-1450 shows the following preprinted information in the 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);