Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1103

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2049.4 (Cont.) - 2049.4 (Cont.)	2-18.3 - 2-18.4 (2 pp.)	2-18.3 - 2-18.4 (2 pp.)
4480.1 - 4480.6 (Cont.)	4-311 - 4-316 (6 pp.)	4-311 - 4-316 (6 pp.)

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

Section 2049.4, Reasonabless and Necessity, is revised to eliminate the requirement that the pneumococcal pneumonia vaccine be ordered by a physician who is a doctor of medicine or osteopathy. It also eliminates the need to provide the person with a record of their vaccination.

Section 4480, Billing for Pneumococcal, Hepatitis B, and Influenza Virus Vaccines, is revised to delete the requirement for a physician's order or supervision for claims for pneumococcal (PPV) vaccinations with dates of service on or after July 1, 2000.

Section 4480.3, Billing Requirements, deletes the requirement for the UPIN in Item 17A of the form HCFA-1500 for PPV claims with dates of service on or after July 1, 2000.

Section 4480.4, Payment Requirements, updates the manual to include procedures currently in use for pricing the administration rates for PPV, hepatitis and flu claims.

Section 4480.6, Simplified Roster Bills, revises Items 17A and 24D.

Instruct your providers of these changes in your next regularly scheduled bulletin. Also instruct your providers of these changes in any flu season articles published in your bulletins prior to the start of the flu season.

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.

1. Not for Particular Illness.--Medications given for a purpose other than the treatment of a particular condition, illness, or injury are not covered (except for certain immunizations). Exclude the charge for medications, e.g., vitamins, given simply for the general good and welfare of the patient and not as accepted therapy for a particular illness.

2. Injection Method Not Indicated.--Medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration. For example, the accepted standards of medical practice for the treatment of certain diseases is to initiate therapy with parenteral penicillin and to complete therapy with oral penicillin. Exclude the entire charge for penicillin injections given after the initiation of therapy if oral penicillin is indicated unless there are special medical circumstances which justify additional injections.

3. Excessive Medications.--Medications administered for treatment of a disease which exceed the frequency or duration of injections indicated by accepted standards of medical practice are not covered. For example, the accepted standard of medical practice in the maintenance treatment of pernicious anemia is one vitamin B-12 injection per month. Exclude the entire charge for injections given in excess of this frequency unless there are special medical circumstances which justify additional injections.

Supplement the guidelines as necessary with guidelines concerning appropriate use of specific injections in other situations. Use the guidelines to screen out questionable cases for special review, further development or denial when the injection billed for would not be reasonable and necessary. Coordinate any type of drug treatment review with the PRO.

If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, exclude the entire charge (i.e., for both the drug and its administration). Also exclude from payment any charges for other services (such as office visits) which were primarily for the purpose of administering a noncovered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury).

A. Antigens.--Payment may be made for a reasonable supply of antigens that have been prepared for a particular patient if: (1) the antigens are prepared by a physician who is a doctor of medicine or osteopathy, and (2) the physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen. Antigens must be administered in accordance with the plan of treatment and by a doctor of medicine or osteopathy or by a properly instructed person (who could be the patient) under the supervision of the doctor. The associations of allergists that HCFA consulted advised that a reasonable supply of antigens is considered to be not more than a 12-week supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See §§2005.2 and 2050.2.)

B. Immunizations.--Vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered. However, pneumococcal, hepatitis B, and influenza virus vaccines are exceptions to this rule. (See items 1, 2, and 3.) In cases where a vaccination or inoculation is excluded from coverage, deny the entire charge.

1. Pneumococcal Pneumonia Vaccinations.--Effective for services furnished on or after May 1, 1981, the Medicare Part B program covers pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. This includes revaccination of patients at highest risk of pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons at highest risk . Effective July 1, 2000, 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.

An initial vaccine may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of pneumococcal vaccine.

Persons at high risk for whom an initial vaccine may be administered include all people age 65 and older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past 5 years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last 5 years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than 5 years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

2. Hepatitis B Vaccine.--With the enactment of P.L. 98-369, coverage under Part B was extended to hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. This coverage is effective for services furnished on or after September 1, 1984.

High-risk groups currently identified include (see exception below):

- o End stage renal disease (ESRD) patients;
- o Hemophiliacs who receive Factor VIII or IX concentrates;
- o Clients of institutions for the mentally retarded;
- o Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
- o Homosexual men; and
- o Illicit injectable drug abusers.

4480. BILLING FOR PNEUMOCOCCAL, HEPATITIS B, AND INFLUENZA VIRUS VACCINES

Coverage of the pneumococcal vaccine (PPV), influenza virus vaccine, and hepatitis B vaccine and their administration is available only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A. Payment is 100 percent of the Medicare allowed amount for PPV and influenza virus vaccine. Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine. Part B deductible and 80% coinsurance do apply for hepatitis B vaccine. Mandatory assignment does not apply.

State laws governing who may administer PPV and influenza virus vaccinations and how the vaccines may be transported vary widely. Urge physicians and suppliers to become familiar with State regulations for all vaccines in the areas where they will be immunizing.

A. Pneumococcal Vaccine (PPV).--Effective for services furnished on or after July 1, 1981, the Medicare program covers PPV and its administration if ordered by a physician who is a doctor of medicine or osteopathy. Therefore, the beneficiary may not receive the vaccine upon request without a physician's order or supervision. (See §2049.) Effective for claims with dates of service on or after July 1, 2000, a physician's order or supervision will no longer be required for PPV.

B. Hepatitis B Vaccine.--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.

C. Influenza Virus Vaccine.--Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration are covered when furnished in compliance with any applicable State law by any provider of service or any entity or individual with a provider or supplier number. 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.

4480.1 General Claims Processing Requirements.--

A. Frequency of Vaccinations.--Typically, PPV is administered once in a lifetime. Pay claims for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status. (See §2049.4 for payment policy for PPV.)

Typically, one influenza vaccination is allowable per flu season. Establish an edit to identify more than one influenza virus vaccine in a 12-month period, and determine medical necessity of services failing the edit. Since there is no yearly limit, determine whether such services are reasonable and necessary (e.g., a patient receives an influenza injection in January for the current flu season and is vaccinated again in November of the same year for the next flu season.)

B. Billing for Additional Services.--When an individual or entity administers PPV, influenza virus, or hepatitis B vaccines and additional services are provided, the individual or entity may bill for an office visit and Medicare will pay for an office visit if it is reasonable and medically necessary and for other reasonable and medically necessary services associated with the office visit.

C. Nonparticipating Physicians and Suppliers.--Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary but must submit an unassigned claim on the beneficiary's behalf. Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

D. Beneficiary-Submitted Claims.--Process beneficiary-submitted claims under procedures that are applied in other situations in which unassigned claims (e.g., HCFA-1490s) are received from beneficiaries. (See §3042.) Send an explanation of Part B billing requirements and an enrollment application to the physician or supplier shown on the beneficiary's receipt. Assign a provider number upon receipt of the application.

E. Separate Claims for Vaccines and Their Administration.--In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the HCPCS code for the vaccine, and the physician or supplier (e.g., a drugstore) which actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration. This procedure will result in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the HCFA-1500. When billing for the influenza vaccine only, billers should list only HCPCS code 90659 in block 24D of the HCFA-1500. The same applies for PPV and hepatitis B billing using PPV and hepatitis B HCPCS codes.

A preprinted roster bill includes HCPCS codes for both the vaccine and its administration. When billing for influenza vaccine administration only, billers should cross out the HCPCS code for the vaccine. For example, billers should leave HCPCS code G0008 and cross out HCPCS code 90659. Likewise, when billing for the influenza vaccine only, billers should leave HCPCS code 90659 and cross out HCPCS code G0008. The same rule applies for PPV HCPCS codes.

F. Explanation of Medicare Benefits (EOMB) and Medicare Summary Notice (MSN).--An EOMB or MSN must be generated for hepatitis B vaccines and their administration. Effective April 1, 1999, you are required to generate beneficiary EOMBs or MSNs for PPV and influenza virus vaccines and their administration.

4480.2 HCPCS Coding.--The following HCPCS codes are used for billing vaccines:

Code	Description
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

Code	Description
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 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.

4480.3 Billing Requirements.--Physicians and suppliers submit claims on Form HCFA-1500. The Unique Physician Identification Number (UPIN) must be entered in Item 17A of the HCFA-1500 for PPV and hepatitis B vaccines. No UPIN is required in Item 17A of the HCFA-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 the HCFA-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 the HCFA-1500 for PPV and hepatitis B vaccines. No NPI is required in Item 17A of the HCFA-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 the HCFA-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 or influenza claim, you may enter the proper diagnosis code and continue processing the claim. PPV and influenza vaccination 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 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. The allowable charge for the vaccine cannot exceed the lower of the actual charge or 95 percent of the median of all average wholesale prices (AWP).

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. 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.

4480.5 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.

4480.6 Simplified Roster Bills.--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 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 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, this simplified claims filing procedure also applies 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 which submit claims on roster bills (and therefore must accept assignment) 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.--All individuals and entities that will submit PPV and influenza benefit claims to Medicare on roster bills must complete the Provider/Supplier Enrollment Application, Form HCFA-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process. Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV and influenza virus vaccinations. Establish an edit to identify individuals and entities that plan to participate in the Medicare program only for the purpose of mass immunizing beneficiaries.

B. Modified HCFA-1500.--If the PHC or other individual or entity qualifies to use the simplified billing process, it may use a preprinted HCFA-1500 that contains standardized information about the entity and the benefit.

Entities submitting roster claims to carriers complete the following blocks on a single modified HCFA-1500 which serves as the cover document for the roster.

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: "VO3.82"
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 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.