Medicare
Intermediary 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
3157 - 3157 (Cont.) 3660.6 - 3660.7 (Cont.)	3-63.3A - 3-63.3B (2 pp.) 6-341- 6-341.3 (4 pp.)	3-63.3A - 3-63.3B (2 pp.) 6-341- 6-341.3 (4 pp.)

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

Section 3157, Routine Services and Appliances, eliminates the requirement that the pneumoccal pneumonia vaccine be ordered by a physician who is a doctor of medicine or osteopathy. It also eliminates the need to determine the person's age, health and vaccination status and to provide the person with a record of his or her vaccination.

Section 3660.7, Pneumococcal Pneumonia, Influenza Virus and Hepatitis B Vaccines, is being updated to the new Medicare requirement that it is no longer necessary to have a doctor's order for receiving the PPV vaccine and its administration.

Instruct your providers of these changes in your next regularly scheduled bulletin. Also, instruct your providers of these changes an 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.

and presentability essential to the well-being of the patient and of other patients who must associate with him or her. However, under the personal comfort exclusion, more elaborate services, such as professional manicures, hair styling, etc., are excluded even when furnished routinely and without special charge.

3157. ROUTINE SERVICES AND APPLIANCES

Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, "Black Lung Benefits," the service is not covered under Medicare and the claimant should be advised to contact his/her social security office regarding the filing of a claim for reimbursement under the "Black Lung" program.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ--the lens of the eye. (See §3110.4.)

Expenses for <u>all</u> refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

A. <u>Immunizations</u>.--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 antirabies 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., <u>is not covered.</u> 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. <u>Pneumococcal Pneumonia Vaccinations</u>.--Effective for services furnished on or after May 1, 1981, the Medicare Part B program covers pneumococcal pneumonia vaccines 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 or pneumococcal infection. Typically these vaccines are administered once in a lifetime except for persons at high 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 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.--The hepatitis B vaccine and its administration are covered under Medicare Part B when furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B.

High-risk groups currently identified include:

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

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 the 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 services 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. 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 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);
- Christian Science Sanatoriums (CSSs);
- Rural Primary Care Hospitals (RPCHs);
- Home Health Agencies (HHAs); and
- Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Other billing entities that may bill you are:

- Rural Health Clinics (RHCs);
- Federally Qualified Health Centers (FQHCs);
- Outpatient Physical Therapy (OPTs) providers; and
- Independent Renal Dialysis Facilities (RDFs).

NOTE: See subsection I for billing of these services by hospices.

All providers bill you for hepatitis B on Form HCFA-1450. Providers other than independent RHCs and freestanding FQHCs bill you for influenza and PPV on Form HCFA-1450. Independent RHCs and freestanding FQHCs do not include charges for influenza and PPV on Form HCFA-1450. They count visits under current procedures except they do not count or bill for visits when the only service involved is the administration of influenza and PPV. 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. For independent RHCs and freestanding FQHCs that bill you for hepatitis B, include payment in the all inclusive rate.

Instruct your providers, other than independent RHCs and freestanding FQHCs, to bill for the 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 G below.)

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;
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 (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, 71X, (provider-based RHCs only) 72X, 73X (provider-based FQHCs only), 74X, 75X, 83X, and 85X are the only bill types acceptable when billing for influenza and PPV. When billing for hepatitis B, all the above bill types apply including 71X for independent RHCs and 73X for freestanding FQHCs.

E. Applicable Revenue Codes.--All providers listed in subsection B with the exception of independent RHCs and freestanding FQHCs bill you for the vaccines using revenue code 636 and for the administration of the vaccines using revenue code 771. Independent RHCs and freestanding 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 subsection J for a more detailed explanation of roster billing.)

G. 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.

H. 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.)

I. Special Billing Instructions for Hospices and Payment Procedures for ESRD Facilities.--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.

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.

J. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.--Some potential "mass immunizers," such as hospital outpatient departments and home health agencies (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 M for an exception to this requirement for inpatient hospitals.)