



**PUBLIC HEALTH**  
ALWAYS WORKING FOR A SAFER AND  
**HEALTHIER WASHINGTON**

**PPHF Public Health  
Reimbursement Project  
Navigating Medicare**

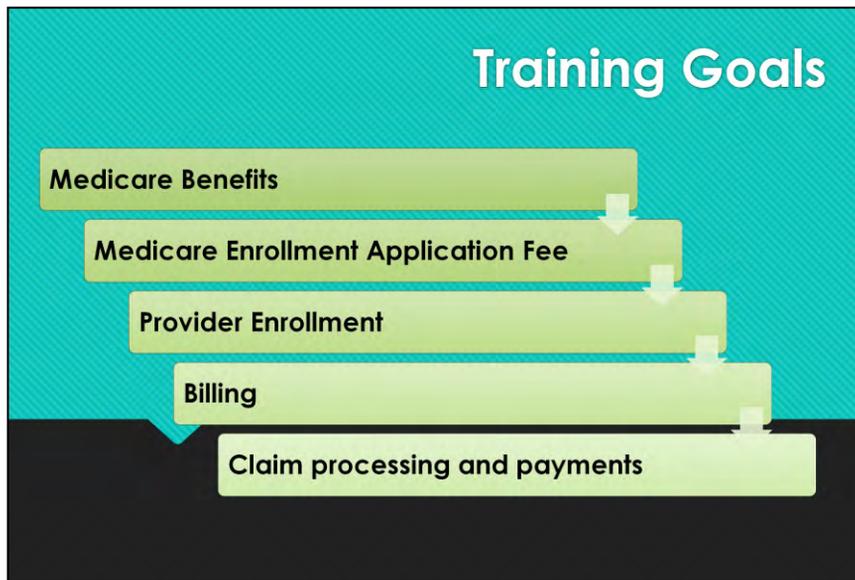
**May 28<sup>th</sup> and 29<sup>th</sup>**

We'd like to thank you for joining us for this training on Medicare for Washington State Local Health Jurisdictions. This training will help you learn more about working with Medicare as an LHJ.

You can find additional information about billing Medicare in the Washington State Local Health Jurisdiction Immunization Billing Resource Guide

[http://www.jeffersoncountypublichealth.org/pdf/LHJ\\_Billing\\_Resource\\_Guide.pdf](http://www.jeffersoncountypublichealth.org/pdf/LHJ_Billing_Resource_Guide.pdf)

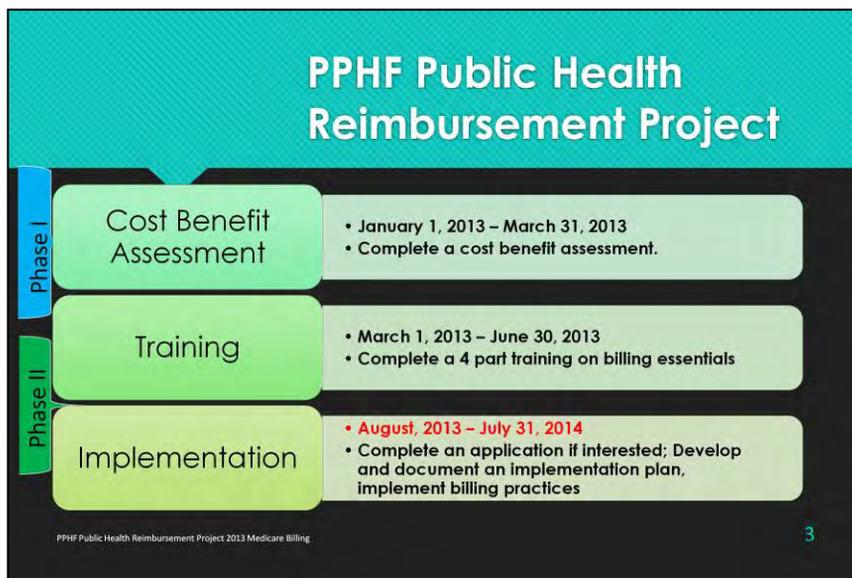
# Training Goals



This training will provide information about Medicare and help you understand

- Medicare Benefits – Brief Medicare 101
- The Enrollment Application Fee (Revalidation/Re-enrollment)
- We'll share information on the types of providers Medicare contracts with and how to enroll
- We'll give information and examples about billing,
- And discuss ways to submit claims and process payments

This training will not offer information about ICD-10 coding or readiness.



The Public Health Reimbursement Project is divided into two phases. These two phases will help you prepare and bill third party payers like private insurance, Medicare and Medicaid.

The first phase is from January 1, 2013 – June 30, 2013. 86% of LHJ have submitted a cost benefit assessment.

This is the third training in the four-part series to help you with billing.

Phase 2 is from **August 1, 2013 – July 31, 2014**, this timeline for this phase has been modified.

- 21- LHJs submitted a letter of intent to participate in this phase and will begin implementing billing practices.
- Application packets were sent on May 22, 2013.
- Participating LHJs will be asked to complete and return the application by June 14<sup>th</sup>. We will notify the LHJs once the applications have been reviewed by a panel and final funding amounts are determined.
- We will provide technical assistance, funding and mentors to help you succeed. We will continue to share billing information and training opportunities to all LHJs.

# LHJs and Medicare

## *Current Landscape*

- Preliminary Data from the Cost Benefit Assessment
  - 86% of LHJs submitted an assessment.
  - 77% of LHJs reported that they bill Medicare.
  - 80% of LHJs with an electronic system (practice management/EMR/EDI) use it to bill Medicare.
  - 47% of LHJs would like help with billing Medicare.

# Why You Need Information About Medicare

Centers for Medicare and Medicaid Services (CMS)

Leading Health Care Reform

Sets the stage and standards for many health plans

Supports health care access and delivery

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Most of you already bill Medicare but some may not know much about Medicare in general so we want to share some Medicare 101 information to help you understand it better.

While some of you have decided not to bill Medicare, it is still worth keeping up with what they do. Even if you do not enroll with or bill Medicare, CMS impacts the way we work with other payers. Many of you may understand or be familiar with their role in Medicaid, here are other examples of CMS roles:

First of all, Medicare is managed by the Centers for Medicare and Medicaid Service or CMS. They are the leading agency for healthcare reform which means they are implementing the foundations of the Affordable Care Act.

They set healthcare delivery standards for many health plans. - Medicare evaluates services, procedures, costs, values and methods of care.

So many health plans use this information to establish and update their guidelines, requirements, rates and expectations of the health services they offer and many make decisions about their coverage and rates based on Medicare's standards. This is important to consider as you begin contracting and billing private insurance companies.

CMS sets the infrastructure of health care access and delivery by ensuring support and services to the

Aged and Disabled through Medicare

And the uninsured, high risk, and low income through their management of Federal Medicaid.

# Medicare Coverage

**Part A – Hospital Coverage**

**Part B – Medical Coverage**

(Additional Cost)

**Part C – Private Medicare approved plans**

(i.e. Medicare advantage plans – Additional Cost)

**Part D – Prescription Drug Coverage**

Additional State Coverage for Medicare Part D

[Extra Help](#)

[Medicare Savings Programs Part D Cost](#)

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Medicare Beneficiaries may receive coverage through 4 different Medicare plans called “parts”.

**Part A is Hospital Coverage** helps cover inpatient care in hospitals, as well as skilled nursing facility, hospice, and home health care.

**Part B is Medical Coverage** which is similar to private health insurance, it helps cover doctor and other health care providers' services, outpatient care, durable medical equipment, home health care, and some preventive services. Medicare beneficiaries are automatically enrolled in part B unless they choose to opt out. Beneficiaries pay more for Part B benefits, the rate for 2013 is \$104.95/month.

**Part C is Private Medicare approved plans** that cover both A and B benefits including Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE). These plans offer more coverage and cost more than part B.

**Part D is Prescription drug coverage** that pays for pharmacy related items and services including some durable medical equipment (DME) and some vaccines. Medicare beneficiaries must enroll in a Part D plan to receive benefits. Some of your clients may qualify for or already receive extra help paying for monthly premiums, annual deductibles and co-payments related to part D covered drugs and services. For example, clients with Medicare and SSI (Supplemental Social Security Income) and Medicare AND clients with Medicare and Medicaid already get extra help. This may require you to bill a secondary payer. However, in most cases Medicare will forward the charges and balances to the next payer.

<https://secure.ssa.gov/i1020/start> – Extra Help

<http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf> - Medicare Savings Programs Fact Sheet

In general, all Medicare beneficiaries automatically receive hospital and medical coverage through their Medicare A and B benefits. Medicare clients cannot have a Medicare B or D plan without an A plan. We will be focusing more on the Part B - medical and Part D – prescription drug benefits.

# Medicare and Your Clients

## Medicare beneficiaries

- May have Medicare Part A, B, D and some will have C
- Some don't know their coverage
- Primarily aged population with Medicaid expansion (blind, disabled)

## Non-Covered Services

- Advanced Beneficiary Notice Form

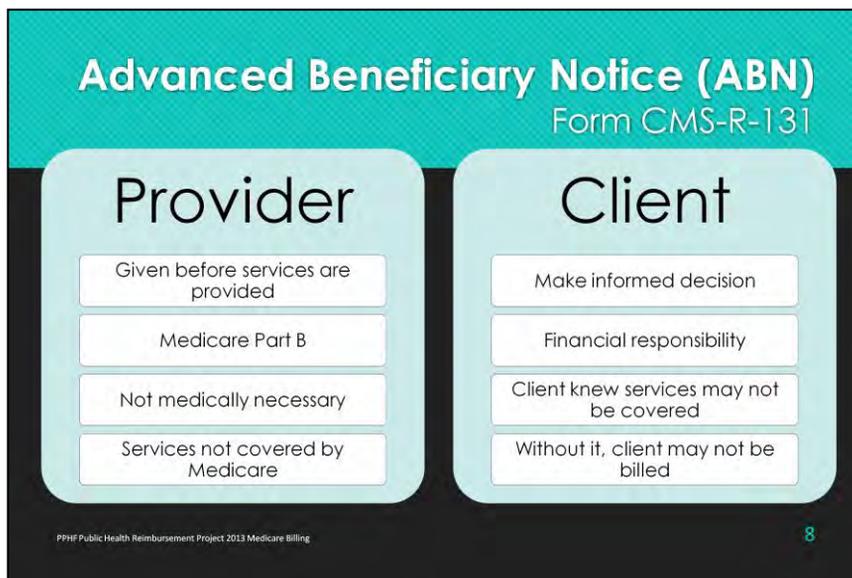
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## Your clients

- May have Medicare A, B, D and some will have C or a Medicare Advantage plan that pays before Medicare will pay.
- You may want to ask clients about the Part C plan. Many clients will assume that you know that their Medicare plan includes additional coverage from a third party like Regence, Humana or Aetna yet only show you their red, white and blue Medicare ID card. If they are asking for a service that typically is not covered by Medicare it may be a sign that they have additional coverage.
- Many don't know their coverage. Since clients can opt in and out of different services and many of them receive assistance enrolling with Medicare so they may not understand the coverage they have.
- The majority of your Medicare clients will be elderly. You may need to allow more time to assist them. Request as much information over the phone or prior to the appointment as possible. If you can't get it all over the phone, ask them to bring the information you need with them, be very specific.

**Non-Covered Services:** Not all services are covered by Medicare. To protect beneficiaries and providers, an Advanced Beneficiary Notice or ABN Form must be completed, signed and kept in the client's file.



The ABN form provides protection for both the provider and the client.

### Provider Protection

- The ABN form must be given before services are provided to ensure that the client understands what services he/she will be expected to pay for.
- The form is specific to Medicare Part B services. This form is often used even if the provider is not enrolled in Medicare or the client does not have Medicare Part B. This gives the provider the opportunity to discuss the financial responsibility for non-covered services to Medicare eligible clients.
- The form should be used if the services may be considered not medically necessary or services may not be covered by Medicare.
- In most cases you will still bill Medicare. If they pay for the service you are expected to reimburse the client promptly.
- You do not need to bill Medicare if the client does not provide you the information needed to bill or asks you not to bill Medicare on their behalf.

### Client Protection

- Completing and signing the ABN form allows clients to make an informed decision and the care they will receive.
- And confirms that he/she fully understands that the services may not be covered and he or she will be expected to pay.
- Services billed and denied by Medicare because they are considered not medically necessary or are not covered may not be billed to the client if the ABN form is not signed and filed in the client's record.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 68-70

# Medicare Part B Coverage

Many **LHJ services** are covered under **Medicare Part B**

Typically covered at **80%** of Medicare **allowed amount**

- Clients are expected to pay 20% for most services.

Immunizations are covered under Medicare Part B and D

- Covered at **100%** - no out of pocket cost for clients
- Mandatory Assignment

Many of the services you will bill for are covered under Medicare Part B benefits.

Medicare Part B services are typically reimbursed at 80% of Medicare's **allowed amount**.

Medicare beneficiaries may receive certain immunizations at no out of pocket cost under the Medicare Part B and D plans.

Enrolled providers must agree to accept assignment when billing Medicare. This means that you will accept Medicare's allowed amount, not charge the client and the payments will come directly to you. Some services may be billed to the client. For example, office visits or other health services may be subject to a deductible or cost share such as a 20% coinsurance.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 47-48

# Medicare Part D Coverage

- Prescription Drug Plan
- Need a pharmacy license to bill.
- Example of Part D services
  - Services can be billed through a third party.
    - TransactRx

Medicare Part D is the prescription or pharmacy benefits for Medicare.

Requires a pharmacy license to bill Medicare for services or products under Part D benefits.

You can work with a third party to bill under the pharmacy benefits. One example is TransactRx. This allows you to provide vaccinations to your Medicare clients in your facility using their part D benefits without requiring your LHJ to have a pharmacy license.

# TransactRx

## Services

- Submit all Medicare Part D covered vaccines with one contract.
- TransactRx contracts with over 90% of Part D plans.
- Offer access to eligibility and claim submission
- TransactRx is paid by the plans
- Contract is between TransactRx and the Part D plans
- No set up cost
- No cost for part D claims
- Part B claims may be submitted for a fee

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## TransactRx Services

- Submit all Medicare part D covered vaccines with one contract.
- TransactRx contracts with over 90% of part d plans.
- Offer access to eligibility and claim submission.
- TransactRx is paid by the plans.
- Contract is between transactRx and the part D plans.
- No set up cost.
- No cost for part D claims.
- Additionally, part B claims may be submitted for a fee.

# TransactRx Process

## Process

- LHJ contact TransactRx
- TransactRx provides access to the patients Part D benefits.
- Real-time eligibility is confirmed
- Real-time vaccine reimbursement estimate
- Claim is submitted
- Reimbursed 2x/month
  - Check for a small fee
  - EFT for FREE

## Covered Vaccines

- Zostavax
- Adacel
  - Td
- Tdap
- Twinrix
- Hep A
- Hep B
- <http://www.transactrx.com/>

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The typical process when working with TransactRx.

- Contact TransactRx.
- TransactRx will provide access to their benefits under Medicare Part D.
- You can confirm eligibility in Real-time - This a quick and easy process. Only 4 fields are required; Name, date of birth, gender and last 4 digits of the patients SS number. The response will tell you if the patient has part D benefits that can be accessed through TransRx or not.
- Real-time vaccine reimbursement estimate - You can submit a vaccine coverage inquiry and get an immediate claims benefit response that tells you how much to collect from the client and how much will be reimbursed to the provider. This takes the guess work out of the check out process and allows you to collect the patient balance up front.
- Submit the claims easily. After you have received the vaccine reimbursement estimate and provided the service, you can submit the claims with one final click of the button. You can also pend a claim for 24 hours and then go back in and submit the claim after providing the services.
- Expect to be reimbursed 2x/month from TransactRx
  - You can receive your payment as a check for a small fee
  - Or electronically through an EFT for FREE

Here are some of the most common covered vaccines.

- Zostavax
- Adacel
- Td
- Tdap
- Twinrix
- Hep A
- Hep B

# TransactRx Report

Here's an example of the patient financial responsibility report generated from TransactRx.

Vaccine Administration Report Printed: 05/22/2013 7:17

**PRESCRIPTION**

Rx Number 1250339	Date of Service 05/03/2013
Account Benton Franklin Health District	Physician [REDACTED]
Site BFHD - Benton County Building	
Patient [REDACTED]	Date of Birth [REDACTED] Soc. Sec. # 2263
Product Zostavax 15,400 PFLU/0.65M Vial	Qty 1.00 Days Supply 1

**CLAIM**

PBM Medco Health Solutions, Inc.	Plan First Health Part D Premier (PDP)	
Card ID [REDACTED]	Group ID CVTYRTL	Claim Status SUBMITTED
	PCN MEDDPRIME	Relationship 1
BIN 610014		

Product Bill Amount	Admin Fee Bill Amount	Total Bill Amount	Collect from Patient
192.27	35.60	227.87	6.60
Product Covered	Admin Fee Covered	Total Covered Amt	Reimb to Provider
181.51	18.00	199.51	192.91

I acknowledge that I have received the medication/vaccine listed above and all information is accurate.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient/Plan Participant

**RESPONSE MESSAGE**

Response Message:

Here's an example of the patient financial responsibility report generated from TransactRx.

The request is for zostavax coverage. The report shows the amount billed for the vaccine and administration.

Then it shows

- The expected covered amount.
- Amount to collect from the client.
- Amount that should be paid to the provider.

# Medicare Part C Medicare Advantage (MA) Plans

## Third party payer – primary to Medicare

- Coordinated care plans (HMO, PPO, PACE)

## Out-of-Network

- Plan must reimburse at least the Medicare rate
- Medicare rules for billing the client (balance billing)

## In-Network

- Negotiated rate with the plan
- MA plan rules for billing the client (balance billing)

## Physician services provided in a health professional shortage are subject to a 10% payment “bonus”

More information and payment rates (as of 12/26/12) <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf>

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Medicare Part C coverage includes both A and B benefits and often includes additional coverage for vision, hearing, wellness, oral health and prescription drug coverage. Coverage from these plans vary and cost an additional fee above the current part B premium of \$104.95/month for 2013. Many Medicare beneficiaries have the cost taken directly from the social security or disability benefits.

- Providers must bill Part C plans.
- Even if you are Out-of-Network with the Part C plan, the plan must reimburse at least the Medicare rate. However, the plan determines how much the client is expected to pay, not Medicare.
- Part C insurers are third party payers and are typically primary to Medicare; meaning they are billed first.
- They may be coordinated care plans like HMO, PPO, PACE – Programs of All-inclusive Care for the Elderly; or private fee for service plans commonly called Medicare Advantage plans which are the ones you will most likely see.
- Providers that do not accept assignment can bill up to 15% above Medicare’s payment amount. Providers that are contracted directly with the health plan can bill their usual and customary charge for the service. However, the payment may go directly to the client. In these cases, the ABN form should be signed and the fee should be collected at the time of service. *Mass Immunizers must accept assignment with Medicare to be reimbursed.*

Also, physician services provided in a health professional shortage are subject to a 10% payment “bonus”. You can look up your region online to find out if you qualify for the 10% increase.

More information and payment rates (as of 12/26/12) <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf>

# Medicare Providers

## Physicians

MD

DO

## Non-Physician Practitioners (NPPs)

Advanced  
Nurse  
Practitioners

Physician  
Assistants

Certified  
Nurse  
Midwife

Nurse  
Practitioners

Clinical  
Nurse  
Specialists

Clinical  
Social  
Workers

Registered  
Dietician

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Who can enroll with and bill Medicare?

While this is not a complete list, Medicare has a very specific list of non-physician practitioners they enroll.

Many of you provide services under standing orders, and do not have a physician on site full time so you may not qualify to enroll with Medicare for all services.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 49-51

# Provider Reimbursement

## Physicians Up to 100% of allowed amount Includes "Incident to"

- Physician or NPP must perform face-to-face consultation.
- Physician or NPP must be on-site.

## NPPs May be 85% of allowed amount

## Maximize revenue

- Contract all providers, even if the reimbursement is less.
- Bill NPPs services under the physician whenever possible.

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## Provider Reimbursement

Here's some general guidance around billing and payments options. Medicare enrolls physician and non-physician practitioners and the reimbursement rates may vary.

- Claims submitted using the physician's NPI are typically processed at 100% of Medicare's allowed amount. This means that the provider may collect up to 100% of that rate. Again, many Medicare covered services are reimbursed at 80% of the allowed amount and members are expected to pay the remaining 20%.
- Incident to services are similar to standing orders except the following requirements apply:
  1. The physician or NPP must initiate the care plan with a face-to-face consultation.
  2. The physician or NPP must be on-site.
- Those submitted using the NPI of a non-physician practitioner (NPP) may be subject to a 15% reduction. That means that members can only be billed 85% of the allowed amount.

Here are some ways to maximize revenue.

- Contract all NPPs
  - You can provide more access to services and more services can be billed even if reimbursement is 15% less.
- Bill NPPs services under physicians NPI whenever possible. If your services are typically provided under standing orders and meet the criteria for "incident to" billing meaning the physician that conducted the initial evaluation is onsite and a treatment plan is on file you can bill under the physician. Not all services are subject to the reduction, but if you are running into this, consider reviewing your encounter form or superbill to indicate that the physician is onsite so the services can be billed appropriately with little effort or interruption to the flow.

# Medicare Enrollment Application Fee

Jeannie Hampton

• Grays Harbor Public Health and Social Services

**Effective for applications received after March 25, 2011**

**Current Fee: \$532**

## Who pays?

- Any provider that submits an enrollment application.
  - New enrollees
  - Re-enrolling
  - Re-validating
  - Adding a new practice location

## Revalidation

- CMS requires the provider to verify that their current enrollment information is accurate.

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# Hardship Waiver

Fee would impose a significant financial hardship
Can take up to 60 days
Denied requests
Fee must be paid within 30 days
Failure to pay the fee timely may result in revocation of the provider's Medicare billing privileges

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Providers that believe the application fee would impose a significant financial hardship can request an exception.

- The process can take up to 60 days.
- Denied requests must be paid promptly, preferably within 30 days.
- All fees must be paid within 30 days unless a hardship waiver is filed.
- Failure to pay the fee timely may result in revocation of the provider's Medicare billing privileges.
- Each hardship waiver request is reviewed and considered on a case by case basis.
- Submit documentation supporting the request at the time the enrollment application is submitted, otherwise it will be returned to you.

# Hardship Waiver Request

Information on the income distribution of patients

Payor mix

Evidence that the facility is located in a medically underserved area and/or serves a medically underserved population

Amount of bad debt expenses

Amount of charity care/financial assistance furnished to patients.

CMS Fact Sheet: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf>

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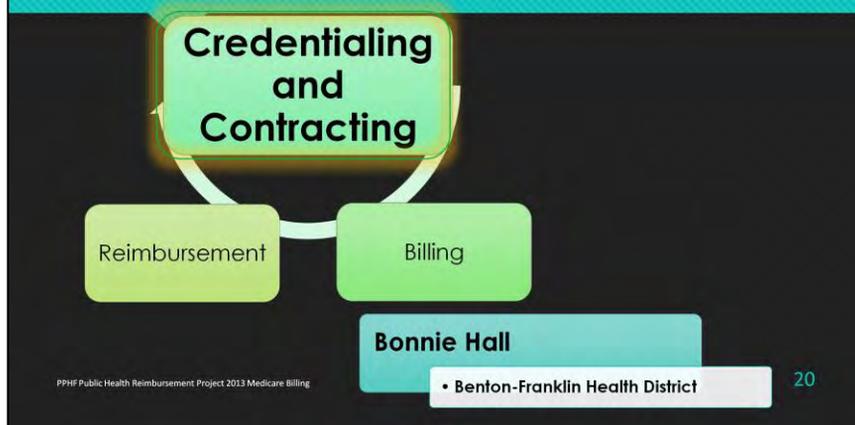
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Suggested elements to include in the request:

- Information on the income distribution of patients.
- Payor mix information.
- Evidence that the facility is located in a medically underserved area and/or serves a medically underserved population.
- Amount of bad debt expenses.
- Amount of charity care/financial assistance furnished to patients.

Website: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf>

# Billing Cycle



Credentiaing and contracting are done at the same time with Medicare. You will still need to

- Gather Provider Information
- Submit Application
- Give Yourself Plenty of Time – this process can often take several months to complete.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 49-51

# Medicare Enrollment

## Most Common Agreement Types for LHJs

Mass Immunizer

Clinic/Group  
Practice

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Credentialing and Contracting with Medicare is referred to as Provider Enrollment. The first thing to do is decide how you will enroll.

- Mass Immunizer- You bill Medicare for influenza, pneumococcal and hepatitis B (if high risk requirements are met) vaccines only.
- Clinic/Group Practice (Facility, clinic or provider) – You provide and bill for clinical services.

Some things to consider when deciding how to enroll with Medicare are; what types of billable services you provide, and your relationship with your medical provider. For example, if your medical provider is not physically on site, and available on-call only, then you will likely only qualify as a mass immunizer. Read the descriptions of the different supplier types before beginning the enrollment process.

# LHJs - Mass Immunizers

Enter into an agreement with Medicare to bill for **specific immunizations**

- Influenza
- Pneumococcal

Exempt from HIPAA electronic billing requirement

- But may be filed electronically

Intended for **large groups** of individuals receiving the **immunizations**

- Clinics, pandemic, epidemic

Agency must accept assignment on vaccine

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LHJs that enroll as a mass immunizer:

1. Enter into an agreement with Medicare to bill for specific immunizations
  - Influenza
  - Pneumococcal
  - Hepatitis B – must meet high risk criteria
2. Exempt from HIPAA electronic billing requirement
  - But may be filed electronically
3. Intended for large groups of individuals receiving the immunizations
  - mass clinics, pandemic situations
4. Agency must accept assignment on vaccine which means the LHJ accepts Medicare's allowed amount as payment in full.

## LHJs - Clinic/Group Practice

**Enroll under a physician or other qualified health care practitioner (ARNP or PA)**

**Clinics, group practices, and suppliers may enroll**

**May be required to bill electronically**

**Bill for all Medicare covered services**

**Assistance and administrative services in WA are provided by Noridian Administrative Services, LLC**

# Enrolling Through PECOS

Link to PECOS	• <a href="https://pecos.cms.hhs.gov/pecos/login.do">https://pecos.cms.hhs.gov/pecos/login.do</a>
LHJ Authorized User (UA)	• Register • User ID/Password
NPI	• You may need to apply for one
Provider Type	• Mass immunizer • Group Practice/Clinic
Provider Interactive Enrollment "Interview"	• Forms • Documentation • <a href="https://www.noridianmedicare.com/partb/enroll/partb_ple/index.html">https://www.noridianmedicare.com/partb/enroll/partb_ple/index.html</a>
Submit	• Submit information • Mail signed certified statement to <b>NORIDIAN</b> – not Medicare

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Medicare enrollment can be completed on paper using for 855B or electronically using the CMS Provider Chain and Ownership System or PECOS. <https://pecos.cms.hhs.gov/pecos/login.do>

Some advantages for using the online enrollment process include:

- Typically takes less time
  - You will access current forms/information
  - You can check and update information online
- 
- Start by registering or logging on to PECOS and set up an authorized user ID.
  - You must have an NPI to enroll with Medicare – online or on paper.
  - Select your provider type. Medicare refers to this as “supplier” type – Mass Immunizer, Group Practice/Clinic or whatever classification best describes the services you provide.
  - There is a variety of forms and documentation needed to enroll with Medicare. You can access the provider interactive enrollment interview to help you prepare for enrolling.
  - Even though you submit your application information online, you will be required to mailed a signed certified statement to Noridian –not Medicare.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp49-50

## Paper Enrollment

- Complete the paper enrollment form (855B) for each supplier type (Clinic/Group Practice, Mass Immunizer, Pharmacy)
- The date the signed certification statement is received affects the billing effective date. (online/paper)
- [Medicare Claims Processing Manual](#) available online

**SECTION 2: IDENTIFYING INFORMATION**

**A. Type of Supplier**  
 Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.  
 Your organization must meet all Federal and State requirements for the type of supplier checked below.

**TYPE OF SUPPLIER: (Check one only)**

<input type="checkbox"/> Ambulance Service Supplier <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Clinic/Group Practice <input type="checkbox"/> Hospital Department(s) <input type="checkbox"/> Independent Clinical Laboratory <input type="checkbox"/> Independent Diagnostic Testing Facility <input type="checkbox"/> Intensive Cardiac Rehabilitation <input type="checkbox"/> Mammography Center	<input type="checkbox"/> Mass Immunization (Roster Biller Only) <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical/Occupational Therapy Group in Private Practice <input type="checkbox"/> Portable X-ray Supplier <input type="checkbox"/> Radiation Therapy Center <input type="checkbox"/> Other (Specify): _____
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**B. Supplier Identification Information**

**1. BUSINESS INFORMATION**

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service  
 \_\_\_\_\_

Tax Identification Number  
 \_\_\_\_\_

Other Name _____	Type of Other Name <input type="checkbox"/> Former Legal Business Name <input type="checkbox"/> Doing Business As Name <input type="checkbox"/> Other (Specify): _____
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## Paper Enrollment

- Complete the paper enrollment form (855B) for each supplier type (Clinic/Group Practice, Mass Immunizer, Pharmacy)
- The date the signed certification statement is received establishes the billing effective date. (online/paper)

Additional forms that may be needed are the:

- 855R – Reassignment (when a provider is moving to another practice)
- 855I – Individual provider form

We have provided the link to the claims processing manual on this slide. Additionally this link will take you out to the website where you can download the actual form.

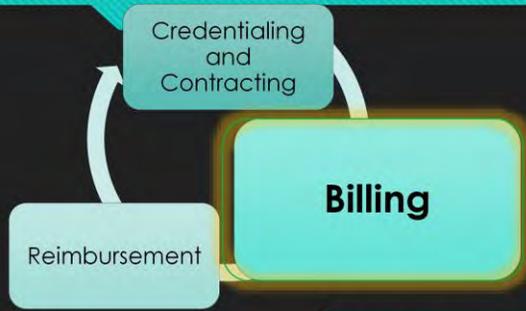
<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf>

It would be a good idea to complete a paper version of this form in preparation for enrolling. Instructions are include

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html>

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. P 51

# Billing Cycle



Jessica Syska

• Jefferson County Public Health

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Billing Medicare

# Medicare and Immunizations

## Immunizations are under Medicare Part B and D

- Covered at 100% so no out of pocket cost for clients (first dollar coverage)
- Part B – Influenza and pneumococcal
  - Other services may be covered if medically necessary. Medicare does not cover preventive immunizations (polio, diphtheria, etc.)
- Part D – hepatitis B (and others depending on Part D plan)
- Mandatory assignment

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Immunizations are covered under Medicare Part B and D.

Medicare beneficiaries may receive certain immunizations at no out of pocket cost under the Medicare Part B and D plans.

Under Medicare Part B, your clients may receive influenza and pneumococcal immunizations. Providers may be paid for these services up to the full amount Medicare allows. That means that you cannot charge Medicare beneficiaries for the vaccine or administration. Other services may be covered if medically necessary - directly related to the treatment of an injury or direct exposure to a disease or condition.

Under Medicare Part D, your clients may receive hepatitis B in addition to other services depending on the plan they choose.

# Coding for Immunizations

- Administration of PPV, influenza, and hepatitis B vaccines,
- HCPCS codes G0009, G0008, and G0010
- Reimbursed at the same rate as code 90741-90474

	90471	90472	90473	90474
Participating	\$26.05	\$12.63	\$26.05	\$12.63
Non-Participating	\$24.75	\$12.00	\$24.75	\$12.00

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Though not reimbursed directly through the Medicare Physician Fee Schedule, the administration of influenza, pneumococcal and hepatitis B vaccines, are reimbursed at the same rate as HCPCS code 90741/2. Here are the 2013 reimbursement rates for participating or those providers that accept assignment and non-participating providers meaning those that do not accept assignment. Again, if you choose to not accept assignment, Medicare may pay the client directly for the service and often pay at a higher rate.

Roster billers should not list additional services on the roster bill. All other covered services, including office visits, are subject to more comprehensive billing requirements

Enrolled providers may bill for additional services when administering vaccines.

For example, you can bill for administering the influenza vaccine and also bill for other services you performed during the same visit. You should always justify each additional service with an appropriate diagnosis code.

# Medicare Codes

## G Codes

- Administration of vaccine

## Q Codes

- Multi-dose Influenza vaccines

## GA Modifier

- Indicates waiver of liability statement is on file

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Medicare uses specific codes to identify and report vaccine administration.

G Codes are used to report the administration of vaccine.

Q Codes –are used to report the administration of multi-dose influenza vaccines.

And the GA Modifier is used to indicate that a waiver of liability statement or the ABN form is on file.

# Influenza Virus Vaccinations

Procedure Code	Description
90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and above, for intramuscular use
90660	Influenza vaccine, live, for intranasal use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increase antigen content, for intramuscular use. (High Dose)
G0008	Administration of influenza virus vaccine

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Here are some examples of CPT/procedure codes that could be used for Influenza vaccine.

Coding for an Influenza vaccine using split virus, preservative free vaccine for an individual over 3yrs old would be:

Procedure code 90656 and administration code G0008. If it is the policy of your agency to bill an office visit with immunizations than you could also use code 99211-25 to bill that service.

Depending on how you are contracted with Medicare the office visit may or may not be a covered service – you may need to have an ABN form on file if you know it will be considered a non-covered service.

Don't forget to report the administration of each vaccine. That means that for each vaccine you provide include the correct administration code. The administration codes vary depending on the vaccine given.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 65-67 (note table on p67 should read "Multi-Dose Influenza Vaccinations.")

# Influenza Virus Vaccinations

Diagnosis Code	Description
<b>V04.81</b>	Influenza vaccination with dates of service 10/01/2003 and later
<b>V06.6</b>	Influenza and pneumococcal (Effective October 1, 2006, providers must report diagnosis code V06.6 on claims when the purpose of the visit was to receive both vaccinations during the same visit)

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Here are some examples of diagnosis / ICD-9 codes you could use for Influenza vaccination.

For example using the scenario from the previous slide of billing for Influenza vaccination you would use diagnosis code V04.81 for both the 90656, the G0008 and the 99211-25 procedure codes.

You can find more information on billing and coding for Influenza and Pneumococcal Vaccinations in the LHJ Immunization Billing Resource Guide.

[http://www.jeffersoncountypublichealth.org/pdf/LHJ\\_Billing\\_Resource\\_Guide.pdf](http://www.jeffersoncountypublichealth.org/pdf/LHJ_Billing_Resource_Guide.pdf)

## Mass Immunizers = Roster Billers

Bill for **specific immunizations**.

- Influenza
- Pneumococcal

May be billed electronically or on CMS 1500 Claim form.

Medicare may not be billed for services that are provided to at no cost to clients without Medicare.

Clients cannot be charged due to the LHJs failure to collect and record accurate coverage information (name, birth date, HIC number).

Agency must accept assignment on vaccine.

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Mass Immunizers bill using a streamlined billing process called Roster Billing.

LHJs that roster bill

- Bill for specific immunizations:
  - Influenza
  - Pneumococcal
  - Hepatitis B
- May be billed electronically or on CMS 1500 Claim form.
- Medicare may not be billed for services that are provided to at no cost to clients without Medicare.
- Clients cannot be charged due to the LHJs failure to collect and record accurate coverage information (name, birth date, HIC number).
- Agency must accept assignment on vaccine.

Guide to mass immunizer billing – fact sheet [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mass Immunize Roster Bill factsheet ICN907275.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mass%20Immunize%20Roster%20Bill%20factsheet%20ICN907275.pdf)

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 51-62

# Submitting Claims

## 3 Most Common Ways to Submit Roster Claims to Medicare

### Electronically

- Clinic Billing System

### Paper

- One CMS claim form and attach roster

### Online Data Entry

- EDI
- Clearinghouse

More information available online at:

[LHJ Immunization Billing Resource Guide](#)

[CMS](#)

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The 3 Most Common Ways to Submit Roster Claims to Medicare are

**Electronically using your Clinic Billing System-** This allows you to bill roster claims just like any other claim you would submit to Medicare electronically.

**Paper -** You would complete one CMS claim form and attach roster that identifies the clients you immunized. Do not include any other services on the roster. It is worth noting that you may be charged a fee for mailed copies.

**Online Data Entry –** You can enter your claim data manually into an online portal. For example a CMS approved electronic Data Interchange (EDI) like or PC-ACE Pro32 or an online claim data entry tool offered by a clearinghouse like Office Ally.

PC-ACE Pro32 – WA EDISS system for Medicare <http://www.edissweb.com/cgp/software/>

PC-ACE Pro32 User Guide:

[http://www.edissweb.com/docs/shared/pace\\_userguide.pdf#page=2](http://www.edissweb.com/docs/shared/pace_userguide.pdf#page=2)

EDI Enrollment form: [http://medicare.fcso.com/EDI\\_forms/137486.pdf](http://medicare.fcso.com/EDI_forms/137486.pdf)

You can find more information about roster billing, the roster form and the technical components needed to bill in the LHJ Immunization Resource Billing Guide and on the CMS website.

Billing Guide - [http://www.jeffersoncountypublichealth.org/pdf/LHJ\\_Billing\\_Resource\\_Guide.pdf](http://www.jeffersoncountypublichealth.org/pdf/LHJ_Billing_Resource_Guide.pdf)

CMS Billing Guide for Mass Immunizers - [http://www.cms.gov/Outreach-and-Education/Medicare-](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-)

[MLN/MLNProducts/downloads/Mass Immunize Roster Bill factsheet ICN907275.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mass_Immunize_Roster_Bill_factsheet_ICN907275.pdf)



# Electronic Remittance Advice

## Easy Remittance Download

1. Procedure code
2. Billed amount
3. Amount paid
4. Amount applied to the deductible and/or coinsurance
5. Additional information about other coverage filed with CMS

CHECK/EFF #:	883877012										
SEND-PROV	SERV-DATE	POS	PD-PROC/NCOS	PD-NOS	BILLED	ALLOWED	DEDUCT	COINS	PROV-PD		
RARC				SUB-NOS	SUB-PROC	GRS/CARC	CARC-AMT	ASG-Y	MDA-MD1	MD10	
NAME:	REC:										
19927	11 99211GA	1	MF113-2103	0.000	20.00	2	0.00	3	0.00	0.00	
				1.000			20.00				
1992715395	0305	030513	11 90670	1.000	148.16	137.03	0.00	0.00	137.03		
1992715395	0305	030513	11 00099GA	0.000	15.60	0.00	0.00	0.00	0.00	0.00	
				1.000			FR-49		15.60		
PT RESP	35.60										
ADD TO TOTALT PRVY PD											
CLAIM INFORMATION FORWARDED TO:	WV -	5	STATE FOR LIFE								
	60005										
NAME:	REC:										
19927	11 99211GA		ADMT108-16790	0.000	20.00		0.00	0.00	0.00	0.00	
				1.000			FR-49		20.00		
1992715395	0308	030813	11 96471GA	0.000	15.60	0.00	0.00	0.00	0.00	0.00	
M16 9431				1.000			FR-96		15.60		
1992715395	0308	030813	11 90746GA	1.000	45.60	45.60	0.00	0.00	0.00	45.60	
PT RESP	35.60										
ADD TO TOTALT PRVY PD											
CLAIM INFORMATION FORWARDED TO:	VA 878	5	MEDICATED								
	70059										

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You can also get an easy remittance download through the EDI Support Services from CMS. This is probably what many of you are used to seeing.

Here you can see:

- Procedure code
- Billed amount
- Amount paid
- Amount applied to the deductible and/or coinsurance
- Additional information about other coverage filed with CMS.

## Understanding your Remittance Advice

- ID number does not match (re-bill Medicare).
- You bill Medicare and get denied b/c they belong to a managed care plan.

116308141\_ERA\_STATUS\_4010\_20120917

Dear: [REDACTED]

Your Claims have been adjudicated by the Payer. Electronic Payment / Advise Information has been received by Office Ally and summarized as follows.

----- HEALTH CARE CLAIM PAYMENT/ADVISE -----

Check# Payee	Amount Date	# Claims	NPI or TAX ID
314707419 [REDACTED]	0.00 09/13/2012	1	[REDACTED]

Check# Payment Amt	Acct#	Patient ID STATUS	Last,First Index#	Charge Amt Payer
314707419 0.00	607272435	DENIED	[REDACTED]	125.10 9275072 MEDICARE SERVICE

900 42ND STREET SOUTH  
FARGO, ND 581032146  
Tax ID: 45-0373185

Payer claim Control Number: 191224046930

Line Item:	Svc Date	CPT	Charge Amt	Payment Amt	Total Adj Amt	REMARKS
REMARKS	09/12/2011	90862	125.10	0.00	125.10	NO

Reason Code	Adjustment Group	Adj Amt	Translated
HEALTH IDENTIFICATION NUMBER AND NAME DO NOT MATCH	CONTRACTUAL OBLIGATIONS	125.10	PATIENT/INSURED

For best printing results print using: Courier Nm, Regular, Size 8 Font -- with pageSETUP: Landscape Left/Right margins of 0.25

Examples of denial reasons on the remittance advice.

- ID number does not match (re-bill Medicare).

## Understanding your Remittance Advice

-ID number does not match (re-bill Medicare).  
 - You bill Medicare and get denied b/c they belong to a managed care plan.

Remarks	Line Item:	Svc Date	CPT	Charge Amt	Payment Amt	Total Adj Amt	
REMARKS		10/12/2012	Q2038	13.00	0.00	13.00	NO
Reason Code			Adjustment Group			Adj Amt Translated	
			OTHER ADJUSTMENTS			13.00	CHARGES ARE
			COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.				
Remarks	Line Item:	Svc Date	CPT	Charge Amt	Payment Amt	Total Adj Amt	
REMARKS		10/12/2012	G0008	24.00	0.00	24.00	NO
Reason Code			Adjustment Group			Adj Amt Translated	
			OTHER ADJUSTMENTS			24.00	CHARGES ARE
			COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.				
Check#	Payment Amt	Acct#	Patient ID Status	Last,First	Index#	Charge Amt	Payer

Page 1

Examples of denial reasons on the remittance advice.

- You bill Medicare and get denied b/c they belong to a managed care plan. Identify managed care plan and submit claim.

# Online Assistance for LHJs

## Noridian Administrative Services (NAS)

- Independent Contractors (Fee for Service)
- Washington State
  - Process enrollment and claims
  - Assist with inquiries about claims, payments and denials
- Website: <https://www.noridianmedicare.com/>



Website: <https://www.noridianmedicare.com/>

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 64

# Medicare Eligibility Verification

## Call Medicare

- 1-800-Medicare

## Online

- Medicare.gov
- Cortex EDI, Endeavor, Navinet
- Clearinghouse

### Health Maintenance Organization (HMO)

#### Managed Care Organization Benefit Information

Insurer Name: BLUE CROSS BLUE SHIELD OF MICHIGAN Policy Number: H2219  
Effective Date: 01/01/2007 Termination Date: N/A - Benefit is Active

Address 1: 600 E LAFAYETTE BLVD  
Address 2:

City: DETROIT State: MI Zip: 482263027

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There are a few ways you can verify coverage. The method or combination of methods you use is a clinic decision. The most common is the Medicare ID card. Other methods include

- Call Medicare
- Medicare online – Medicare.gov has a free portal to check eligibility and coverage dates
- Medicare Electronic Biller Contractors like Cortex EDI Endeavor and Navinet offer free online software that includes like:
  - Medicare eligibility
  - Medicaid and private insurance eligibility
  - Claim status and inquiry
  - Electronic billing and remittance advice – -May offer auto-posting into your accounts receivable system.
- Many clearinghouses can offer these same functions and provide prompt claim responses.

Many if not all of these resources will provide information about managed care plans. For most LHJs, these tools are used when claims are denied and additional information is needed.

Refer to the Washington State Local Health Jurisdiction Immunization Billing Resource Guide for more information. Pp 64

# What You Can Do Now

## Step 1: Enrollment

- Medicare
- TransactRx
  - Information about Services for Public Health Departments: [Fact Sheet](#)
  - Website : <http://www.transactrx.com/health-department-vaccine-billing>
  - Schedule an online demonstration: <http://www.transactrx.com/online-demos>

So lets review the information we have covered today and see if we can simplify this process. We know that 80 % of the LHJ's reported that they have some type of an electronic practice management system and 77% reported that they have billed Medicare for some services in the past. This tells us that the majority of you are already part way through this process and may just need a little assistance to improve your processes.

**Step 1:** Many of you may be enrolled with Medicare, but if you haven't signed up to use TransactRx yet you can look into this as well. Several vaccines are covered under TransactRx that are not covered under the Part B benefits, and the office visit and vaccine administration is covered as well. The enrollment process for TransactRx is simple, and the site is easy to navigate and use.

Information about Services for Public Health Departments: [Fact Sheet](#)

Website : <http://www.transactrx.com/health-department-vaccine-billing>

Schedule an online demonstration: <http://www.transactrx.com/online-demos>

# What You Can Do Now

## Step 2: Develop a list of services you provide that are covered by Medicare.

- Define the requirements and process needed for each service. Immunizations (Part B and D), Clinic Services.

CPT	Description	Covered	Non-Covered	Notes & Restrictions
90658	Influenza	X		Use CPT Q2038
90714	Td	X		Requires injury diagnosis
90715	Tdap	X		Some plans under Part D only
90732	Pneumococcal	X		
90707	MMR		X	Get ABN form signed
90736	Zostavax	X		Some plans under Part D only
99211	Office Visit		X	Get ABN form signed

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**Step 2:** Develop a list of services you provide that are covered by Medicare. It shouldn't take much time for you to create an internal cheat-sheet of services listing covered and non-covered services. This list will be useful for your front office staff when they are scheduling appointments, quoting fees and registering and receipting your clients. If you need help in creating your list, you can refer to the reimbursement table on the CBA tool to see which services are covered under Part B benefits and check out the list of covered vaccines at the TransactRx website for the services covered under part D. The example on this screen is a portion of the internal list we have created at Benton-Franklin Health District.

## What You Can Do Now

### Step 3: Develop or review your policies for using the Advance Beneficiary Notice (ABN) form.

- Get ABN form signed for all non-covered services and collect at the time of service. Download ABN Form here: <https://www.noridianmedicare.com/partb/forms/docs/cms-r-131.pdf>

### Step 4: Bill Medicare for all covered services & any non-covered services that the client has requested you bill for a denial.

- Remember to use the GA modifier for the non-covered services.

### Step 5: Work the Remittance Advices.

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**Step 3:** Develop and/or review your policies for using the ABN form. If you have not already done so, go to the Medicare website provided and download the ABN form. Benton-Franklin Health District uses a pre-populated form with the services they have already identified as non-covered such as routine tetanus vaccinations and the immunization office visits. When a Medicare clients requests one of these services the clerks refer to the list of services shown earlier and gets the clients signature when they check in. Then when the client leaves, they collect the appropriate amount and bill Medicare for any covered services.

<https://www.noridianmedicare.com/partb/forms/docs/cms-r-131.pdf>

**Step 4:** Bill Medicare for all covered services. You are also required to bill for any non-covered services upon client request. This may be necessary for them to seek reimbursement from their supplemental plans. You can still collect from the client at the time of service as long as you have had the client complete and sign the ABN form. Remember to bill all non-covered services with the GA modifier. This tells Medicare that you informed the client in advance that the service will not be covered and have the signed ABN form on file.

**Step 5:** Work the remittance advices. This is important. This will show you if you are having any billing problems, and will show the patient balances as well. You should not assume that you have to write off any balance that Medicare has not paid. When you provide non-covered services to the client and have billed those with the GA modifier, this will show up as a patient balance rather than a provider write-off. Working the remittance advices diligently will help you streamline your billing and collection process.

The process to bill and collect from Medicare isn't difficult when you have set things up correctly. Creating the list of covered and non-covered services and using the ABN form are a key part of getting your internal process established. Remember if you have questions throughout this process, you can reach out to your mentor to request assistance.

# Reminders

**Submit your Phase 2 Application Packet**

June 14th

**Medicaid Billing Training**

June 25<sup>th</sup> & 26<sup>th</sup>

**Work with Mentors**

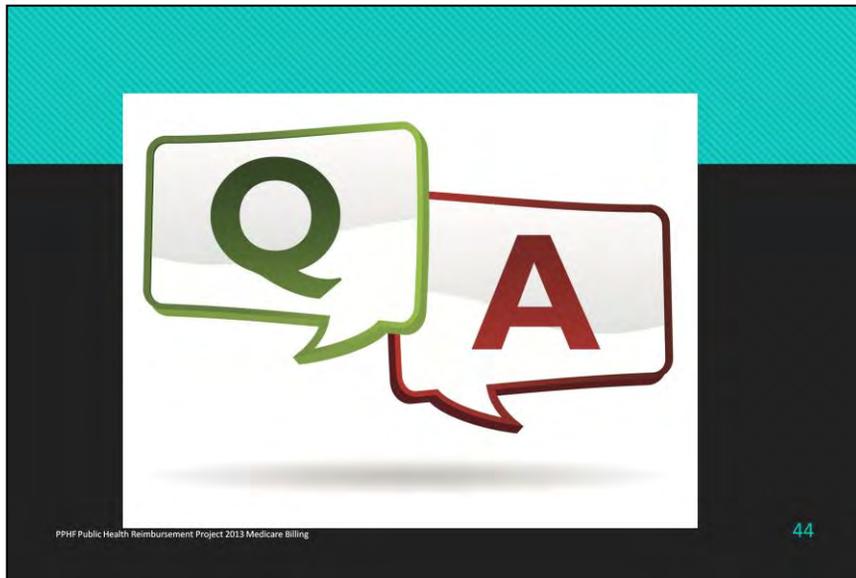
Ongoing

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Application packets were sent to the 21 LHJs that submitted a letter of intent for phase 2 of the project. The applications are due back on June 14<sup>th</sup>. We will send out more information in the coming weeks about implementation. Please contact me if you have questions about the application. Please direct questions about the consolidated contract to Tawney Harper.

Next month on June 25<sup>th</sup> & 26<sup>th</sup>, we will provide training on Medicaid Billing. There are lots of changes happening and in the works at Medicaid and Health Care Authority. This training will provide some information about billing Medicaid, we will also use this time to share updated information about the physician payment increase for immunization administration and LHJs role in Medicaid managed care plans as Medicaid expands and how the expansion is expected to affect clients and public health.



Thank you for joining us today for this training.

Carri Comer

Washington State Department of Health  
Office of Immunization and Child Profile  
Prevention and Public Health Funds  
Reimbursement Grant Coordinator

Project Website:

Phone: (360) 236-3731

Email: [carri.comer@doh.wa.gov](mailto:carri.comer@doh.wa.gov)



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Please contact me if you have questions about this presentation or would like more information.

Thank You.

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ALWAYS WORKING FOR A SAFER AND  
**HEALTHIER WASHINGTON**

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