CMS Releases Pricing and Codes for 2011 – 2012 Flu Vaccine Given After September 1, 2011

NOTE: The 2012 – 2013 flu shot codes can be found here.

_____

Today the Centers for Medicare and Medicaid Services (CMS) released the new pricing for flu shots for Medicare patients for the 2011-2012 flu season. The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. When the vaccine is furnished in the hospital outpatient department, payment for the vaccine is based on reasonable cost.

What do Medicare patients have to pay for the flu shot?

Annual Part B deductible and coinsurance amounts **do not apply** for the influenza virus and the pneumococcal vaccinations. All physicians, non-physician practitioners, and suppliers who administer these vaccinations must take assignment on the claim for the vaccine. **Do not collect from Medicare patients for the vaccine or the administration of a flu shot.**

What will Medicare pay for the flu

shot?

The payment allowances below reflect the annually updated payment allowance for the listed CPT codes and Q-codes when the vaccines are furnished outside the hospital outpatient department.

Allowables Effective for Dates of Service between September 1, 2011 and August 31, 2012

CPT 90654: $18.383
CPT 90655: $15.705
CPT 90656: $12.375
CPT 90657: $6.653
CPT 90660: $22.316
CPT 90662: $30.923

Q2035 (Afluria): $11.543
Q2036 (Flulaval): locally priced
Q2037 (Fluvirin): $13.652
Q2038 (Fluzone): $13.306
Q2039 (N.O.S.): locally priced

How should the flu shot be coded?

1. Choose the Q code or CPT code that is appropriate for the brand of vaccine you are giving or the special circumstances (pediatric dose, regular dose, high dose, preservative free, etc.)
2. Use the Administration Code G0008
3. Use the Diagnosis Code: V04.81

Choose one code for the vaccine:

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 older, for intramuscular use

90657 – Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use

90660 – Influenza virus vaccine, live, for intranasal use

90662 – Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

Q2035 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)

Q2036 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)

Q2037 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirun)

Q2038 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)

Q2039 – Influenza virus vaccine, split virus, when administered to individuals3 years of age and older, for intramuscular use (Not Otherwise Specified)

How many flu shots will Medicare

pay for?

Medicare will pay for one flu shot per influenza season in the fall or winter. Medicare may cover additional seasonal influenza virus vaccinations if medically necessary.

What is different if the patient gets the flu shot somewhere besides the physician's office?

Institutional Providers: Additional Billing Information

Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs) 12X, 13X
CAHs: Method I and II and IHS CAHs 85X
IHS Hospitals 12X, 13X
Skilled Nursing Facilities (SNFs) 22X, 23X
Home Health Agencies (HHAs) 34X
Comprehensive Outpatient Rehabilitation Facilities (CORFs) 75X

Revenue Codes: 0636 – vaccine
0771 – administration

Rural Health Clinics (RHCs) 71X

Federally Qualified Health Centers (FQHCs) – 77X (for dates of service on or after April 1, 2010)

Do providers that only provide immunizations need to enroll in the Medicare Program?

Yes. Providers must enroll in the Medicare Program even if immunizations are the only service they will provide to

beneficiaries. They should enroll as provider specialty type 73, Mass Immunization Roster Biller, by completing Form CMS-855I for individuals or Form CMS-855B for a group.

Click **here** to locate these forms.

What is a mass immunizer?

A mass immunizer offers seasonal influenza virus and/or pneumococcal vaccinations to a large number of individuals and may be a traditional Medicare provider or supplier or a nontraditional provider or supplier (such as a senior citizens' center, a public health clinic, or a community pharmacy). Mass immunizers must submit claims for immunizations on roster bills and must take assignment on both the vaccine and its
administration. A mass immunizer should enroll with the Medicare Contractor prior to influenza season.

What is Roster Billing?

(Influenza & Pneumococcal Vaccinations Only)

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs. (Medicare has not developed roster billing for hepatitis B or other vaccinations.) Roster billing can also substantially lessen the administrative burden on physician practices by allowing them to submit one claim for all of the Medicare beneficiaries that received either the PPV or influenza vaccine on a given day. Medicare will often refer to these providers, who utilize roster billing, as "Mass Immunizers."

For Medicare Part B submission, physician practices and other "Mass Immunizers" must submit a separate pre-printed CMS-1500 paper claim form or bill electronically for each type of

vaccination (either influenza or PPV) and attach a roster list containing information for 2 or more Medicare beneficiaries. When “mass immunizers” choose to conduct roster billing electronically, they are required to use the HIPAA-adopted ASC X12N 837 claim standard. Local Medicare Carriers may offer low or no-cost software to help providers utilize roster billing electronically, however, this software is not currently available nationwide so check with your local carrier for specifics in your area.

All entities that submit claims on roster bills must accept assignment.

Roster bills submitted by providers to a Medicare carrier must contain more than one patient and the date of service for each vaccination administered must be the same. (Medicare policy was changed July 1, 1998, and the requirement that a minimum of five beneficiaries be vaccinated per day in order to roster bill was reduced to two beneficiaries per day.)

To further minimize the administrative burden of roster billing, the following blocks can be preprinted on a CMS-1500:

Block 1: Medicare
Block 2: See Attached Roster
Block 11: None
Block 20: No

Block 21: V04.81 for influenza or V03.82 for pneumococcal
Block 24B: ALL entities should use POS code “60” for roster billing. (POS code “60” = Mass
Immunization Center.)

Block 24D: Use appropriate vaccine and administration codes (separate line items for each)

Block 24E: Use “1” for lines 1 and 2
Block 24F: Use the unit cost of the particular vaccine (Contractors will replicate the claim for

each beneficiary listed on the roster.)
Block 27: Yes
Block 29: $0.00
Block 31: Signature
Block 32: Enter the name, address and zip code of the location where service was provided
Block 32a: NPI of the service facility
Block 33: Provider Identification Number or NPI when required
Block 33a: NPI of the billing provider or group

A separate CMS-1500 for each type of vaccination must have an attached roster that includes the
following information:
• Patient Name and Address
• Health Insurance Claim Number
• Date of Birth
• Sex
• Date of Service
• Provider’s Name and Identification Number
• Signature or stamped “Signature on File”
• Control number for the contractor

A “signature on file stamp” or notation qualifies as a signature on a roster claim form in cases where the provider has access to a signature on file in the beneficiary’s record (e.g., when the vaccine is administered in a physician’s office).

The format of the beneficiary roster can be modified to meet the needs of individual providers. It is the responsibility of the carrier to develop suitable roster formats that meet provider and carrier needs and contain the minimum data necessary to satisfy claims processing requirements for these claims.

Medicare Releases New Product-Specific HCPCS Codes for Flu Shots Billed After January 1, 2011

NOTE: The 2012 – 2013 flu shot codes can be found here.

For flu shot updates for the 2011-2012 influenza season, click here.

Changes in Flu Shot Codes When Billing On/After January 1, 2011

CMS has created specific HCPCS codes and payment allowances to replace CPT code 90658 for Medicare billing purposes for the 2010-2011 influenza season. Note that these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when **CPT code 90658 will no longer be recognized.**

- Q2035 (locally priced)
  - **Afluria** vacc, 3 yrs & >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
- Q2036 ($7.439 national allowable)

        - **Flulaval** vacc, 3 yrs & >, im
        - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
    - Q2037 ($13.253 national allowable)
        - **Fluvirin** vacc, 3 yrs & >,im
        - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
    - Q2038 ($12.593 national allowable)
        - **Fluzone** vacc, 3 yrs & >, im
        - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
    - Q2039 (locally priced)
        - **NOS** flu vacc, 3 yrs & >, im
            - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

Other information:

- For dates of service between October 1, 2010 and December 31, 2010, the CPT 90658 and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the CPT 90658 and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary on any date between October 1, 2010 and December 31, 2010, the provider may either bill Medicare immediately using CPT 90658, or hold the claim and wait until January 1, 2011 to bill Medicare using the most appropriate Q-code. If a claim has already

been submitted and processed using CPT 90658, then there is no need to use the Q-code for that same service. For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.

- For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for CPT 90655 is $14.858.
- Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR7324. However, they will adjust such claims that you bring to their attention.

For additional information on providing the flu shot, see my previous post **here**.

Providing and Billing for the

Flu Vaccine: Guidance from CMS, the CDC and the Affordable Care Act

Update posted 8-14-2012: For flu shot updates for the 2012-2013 influenza season, click here.

****

Update posted 9-22-2011: For flu shot updates for the 2011-2012 influenza season, click here.

****

Update Posted 12-20-2010 – Medicare posted code changes for flu vaccines billed to Medicare after January 1, 2011. Click here for the changes.

For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for CPT 90655 is $14.858.

****

It's that time again, and despite delayed deliveries to some hospitals and practices, the word on the street is that there will be enough flu vaccine (171 million doses) this year for all who want a flu shot.

Image via Wikipedia

The Center for Disease Control (CDC) recommends that everyone 6 months and older get a flu shot. Each year's flu vaccine

cocktail is unique and this season's (2010-2011) flu vaccine will protect against three different flu viruses: an H3N2 virus, an influenza B virus and the H1N1 virus that caused so much illness last season.

The Affordable Care Act and the Influenza Vaccine

Just in time for flu season is the Affordable Care Act's emphasis on preventive care. The ACA states:

> *This influenza season, children 6 months through 18 years, certain high-risk adults 19 through 49 years, and adults 50 years and older who are enrolled in **new** group and individual health plans will be eligible to receive the seasonal flu vaccine **without cost-sharing** when provided by an in-network provider. Beginning in the plan year that starts after March 2, 2011, all adults 19-49 years of age will be eligible to receive the seasonal flu vaccine with no cost-sharing requirements when provided by an in-network provider.*

This is great news for the patient and for healthcare in general. You may consider it good news or bad news, depending on your view of the whole flu shot process. Here's how it works in many practices:

1. The vaccine is ordered in the spring, with everyone trying hard to guess correctly how many patients will want flu shots in 6 months.
2. The vaccine arrives in the fall and the first hurdle is pricing it, as you will have to decide how much to mark it up to cover the cost of the ordering, handling and stocking and possibly a teeny profit.
3. The administration of the vaccine also has to be priced to cover the cost of supplies (syringe, alcohol swab, sometimes a bandaid, printed Vaccine Administration Sheets) and the cost of labor (assessing the patient to

make sure they can get the flu shot, giving the shot, and documenting the lot numbers in case of a recall.)

4. The next decision is disbursement. Do you have a flu shot clinic and have people get in line for the flu shot, or do you take flu shot appointments, do you give flu shots during regular appointments, or some combination thereof? What about drive-through flu clinics? Do people sit in the parking lot for 15 minutes to make sure there are no bad after-effects? How do you let patients know about your flu shot plans without costly postcards or advertisements?
5. Then, there is policy setting for patients whose insurance covers the flu shot and for patients whose insurance does not. Do you collect and refund if necessary, or do you not collect and bill the patient after insurance responds (Jaws theme music here, please.)

Does Medicare pay for flu shots?

Medicare pays 100% of the allowable for influenza vaccine (and pneumococcal vaccines) and the administration of the vaccines without any out-of-pocket costs to the patient. One flu vaccine is allowable per flu season, but Medicare will pay for a second flu shot if a physician determines and documents the medical necessity. A physician's order is not necessary and a physician's supervision is not necessary – that's why patients are able to get a flu shot at the drugstore. A patient can receive a flu shot twice in one calendar year by getting a flu shot late in one season and getting a flu shot early in the next season.

How should a provider that is not enrolled in Medicare bill for the flu

vaccine?

CMS typically does not allow non-enrolled providers to treat Medicare beneficiaries, however, CMS is allowing them to give flu shots this year. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare Program.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine.

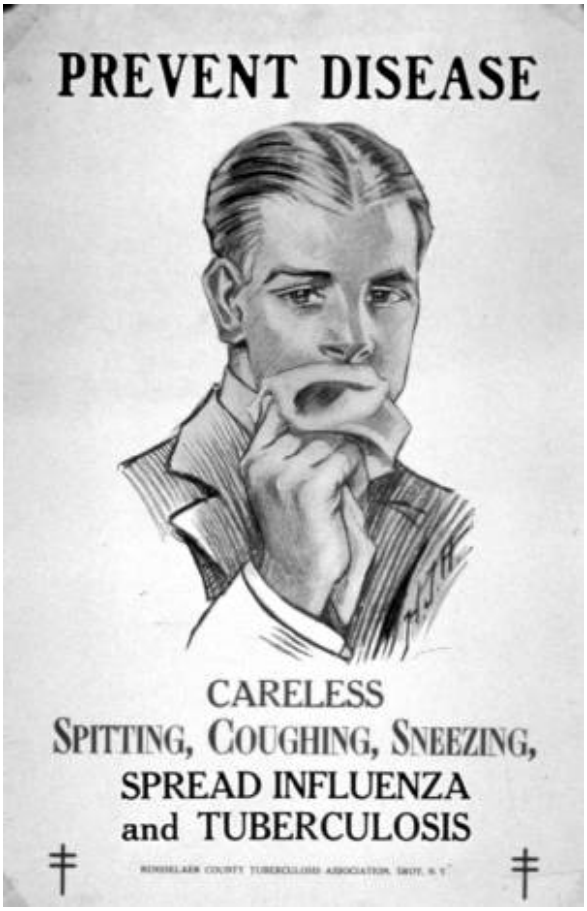

Image via Wikipedia

To request reimbursement, the beneficiary will need to obtain and complete form **CMS 1490S**. So the beneficiary may receive reimbursement, you will need to provide the beneficiary with a

receipt for the flu vaccine that has the following information written or printed on it:

”¢ The doctor’s or provider’s name and address
”¢ Service provided (“flu vaccine”)
”¢ Date flu vaccine received
”¢ Amount paid

What codes are used for flu shots?

For flu vaccine and vaccine administration, the following codes are used.

Effective September 1, 2009, (no 2010 changes have been announced) the Medicare Part B payment allowances for influenza vaccines are as follows:

- For HCPCS 9**0655**, the payment will be $15.447: Influenza virus vaccine, split virus, preservative free, for children 6- 35 months of age, for intramuscular use
- For HCPCS code **90656**, the payment will be $12.541: Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- For HCPCS code **90657**, the payment will be $15.684: Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
- For HCPCS code **90658**, the payment will be $11.368: Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- HCPCS **90660** (FluMist, a nasal influenza vaccine) may be covered if the local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the Average Wholesale Price (AWP), the Medicare Part B payment allowance for CPT 90660 is $22.316 (effective September 1, 2009).

G0008 is the Medicare HCPCS for Administration of influenza virus vaccine, including FluMist. Other payers usually require use of 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 for administration of the vaccine.

The associated ICD-9 codes for flu shots are:

V04.81 Influenza
V06.6 Pneumococcus and Influenza (both vaccines at one visit)

Other resources:

- Get your practice and your staff ready for flu season by following the guidelines I write about **here**.
- Free downloads from the CDC **here.**
- MedLine Plus Articles, Downloads and Resources **here**
- Article: **Mandating Influenza Vaccine – One Hospital's Experience** (MedScape free account required)
- National Foundation for Infectious Diseases: **Influenza**
- National Influenza Vaccine Summit: **Prevent Influenza**
- Vaccine Education Center at Children's Hospital of Philadelphia (CHOP) -Influenza: What You Should Know (pdf) **EnglishSpanish**
- Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B) is available **here** (pdf.)
- For information on roster billing (billing for many patients at one time) see the Medicare Claims Processing Manual for Preventive and Screening Services (Chapter 18) **here** (pdf) Section 10-3.

NOTE: Beneficiaries have been advised to contact the Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine.

Related articles

- Providing and Billing for the Flu Vaccine: Guidance from CMS, the CDC and the Affordable Care Act (managemypractice.com)

Announcement From WHO: World Now at the Start of 2009 Influenza Pandemic

Statement to the press by WHO Director-General Dr Margaret Chan
11 June 2009
World now at the start of 2009 influenza pandemic
Dr Margaret Chan
Director-General of the World Health Organization

Ladies and gentlemen,

In late April, WHO announced the emergence of a novel influenza A virus.

This particular H1N1 strain has not circulated previously in humans. The virus is entirely new.

The virus is contagious, spreading easily from one person to another, and from one country to another. As of today, nearly 30,000 confirmed cases have been reported in 74 countries.

This is only part of the picture. With few exceptions, countries with large numbers of cases are those with good surveillance and testing procedures in place.

Spread in several countries can no longer be traced to clearly-defined chains of human-to-human transmission. Further spread is considered inevitable.

I have conferred with leading influenza experts, virologists, and public health officials. In line with procedures set out in the International Health Regulations, I have sought guidance and advice from an Emergency Committee established for this purpose.

On the basis of available evidence, and these expert assessments of the evidence, the scientific criteria for an influenza pandemic have been met.

I have therefore decided to raise the level of influenza pandemic alert from phase 5 to phase 6.

The world is now at the start of the 2009 influenza pandemic.

We are in the earliest days of the pandemic. The virus is spreading under a close and careful watch.

No previous pandemic has been detected so early or watched so closely, in real-time, right at the very beginning. The world can now reap the benefits of investments, over the last five years, in pandemic preparedness.

We have a head start. This places us in a strong position. But it also creates a demand for advice and reassurance in the midst of limited data and considerable scientific uncertainty.

Thanks to close monitoring, thorough investigations, and frank reporting from countries, we have some early snapshots depicting spread of the virus and the range of illness it can cause.

We know, too, that this early, patchy picture can change very quickly. The virus writes the rules and this one, like all influenza viruses, can change the rules, without rhyme or

reason, at any time.

Globally, we have good reason to believe that this pandemic, at least in its early days, will be of moderate severity. As we know from experience, severity can vary, depending on many factors, from one country to another.

On present evidence, the overwhelming majority of patients experience mild symptoms and make a rapid and full recovery, often in the absence of any form of medical treatment.

Worldwide, the number of deaths is small. Each and every one of these deaths is tragic, and we have to brace ourselves to see more. However, we do not expect to see a sudden and dramatic jump in the number of severe or fatal infections.

We know that the novel H1N1 virus preferentially infects younger people. In nearly all areas with large and sustained outbreaks, the majority of cases have occurred in people under the age of 25 years.

In some of these countries, around 2% of cases have developed severe illness, often with very rapid progression to life-threatening pneumonia.

Most cases of severe and fatal infections have been in adults between the ages of 30 and 50 years.

This pattern is significantly different from that seen during epidemics of seasonal influenza, when most deaths occur in frail elderly people.

Many, though not all, severe cases have occurred in people with underlying chronic conditions. Based on limited, preliminary data, conditions most frequently seen include respiratory diseases, notably asthma, cardiovascular disease, diabetes, autoimmune disorders, and obesity.

At the same time, it is important to note that around one third to half of the severe and fatal infections are occurring

in previously healthy young and middle-aged people.

Without question, pregnant women are at increased risk of complications. This heightened risk takes on added importance for a virus, like this one, that preferentially infects younger age groups.

Finally, and perhaps of greatest concern, we do not know how this virus will behave under conditions typically found in the developing world. To date, the vast majority of cases have been detected and investigated in comparatively well-off countries.

Let me underscore two of many reasons for this concern. First, more than 99% of maternal deaths, which are a marker of poor quality care during pregnancy and childbirth, occurs in the developing world.

Second, around 85% of the burden of chronic diseases is concentrated in low- and middle-income countries.

Although the pandemic appears to have moderate severity in comparatively well-off countries, it is prudent to anticipate a bleaker picture as the virus spreads to areas with limited resources, poor health care, and a high prevalence of underlying medical problems.

Ladies and gentlemen,

A characteristic feature of pandemics is their rapid spread to all parts of the world. In the previous century, this spread has typically taken around 6 to 9 months, even during times when most international travel was by ship or rail.

Countries should prepare to see cases, or the further spread of cases, in the near future. Countries where outbreaks appear to have peaked should prepare for a second wave of infection.

Guidance on specific protective and precautionary measures has been sent to ministries of health in all countries. Countries

with no or only a few cases should remain vigilant.

Countries with widespread transmission should focus on the appropriate management of patients. The testing and investigation of patients should be limited, as such measures are resource intensive and can very quickly strain capacities.

WHO has been in close dialogue with influenza vaccine manufacturers. I understand that production of vaccines for seasonal influenza will be completed soon, and that full capacity will be available to ensure the largest possible supply of pandemic vaccine in the months to come.

Pending the availability of vaccines, several non-pharmaceutical interventions can confer some protection.

WHO continues to recommend no restrictions on travel and no border closures.

Influenza pandemics, whether moderate or severe, are remarkable events because of the almost universal susceptibility of the world’s population to infection.

We are all in this together, and we will all get through this, together.

Thank you.