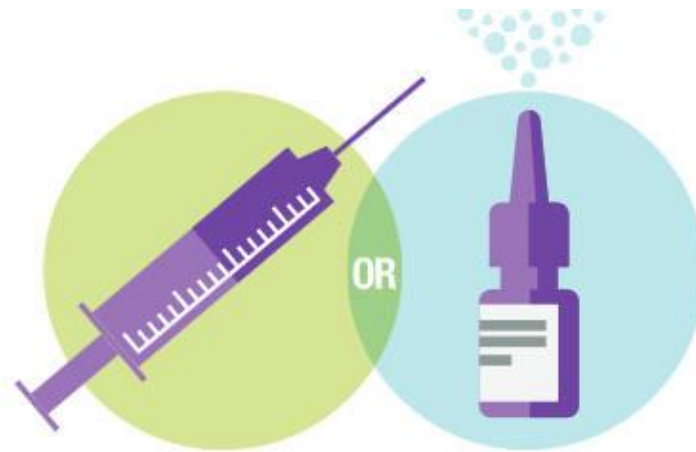


2014-2015 Commercial & MassHealth Flu Reimbursement Program



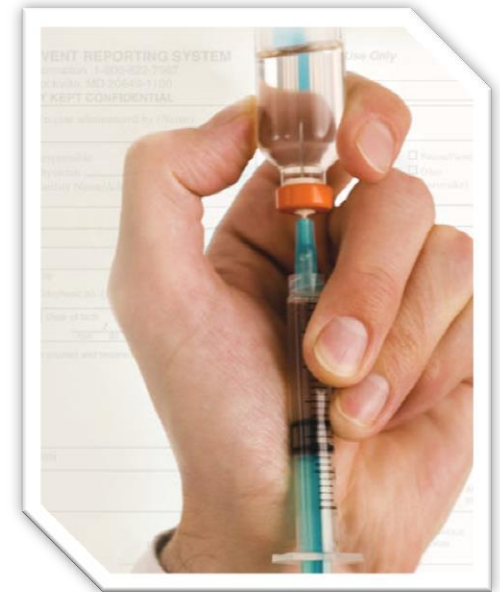
This guide includes:

- ✓ Covered flu services
- ✓ Participating health plans
- ✓ 2014-2015 insurance information form
- ✓ Billing Guidelines
- ✓ Tips & Common Errors
- ✓ MassHealth Vaccine Billing
- ✓ Contracting Process

Covered Flu Services

Public Providers can bill the contracted health plans for the following:

- Administration of the influenza vaccine to individuals ages 6 months and older
- Cost of privately purchased influenza vaccine administered to individuals ages 19 and older
- Administration of the pneumococcal vaccine to Medicare Advantage members
- Medicare Part B Billing (discussed in Medicare section)



Participating Health Plans

- Aetna
- Blue Cross Blue Shield of Massachusetts
- BMC Healthnet
- Celticare
- Cigna
- Harvard Pilgrim
- Health New England
- Fallon
- MassHealth*
- Neighborhood Health Plan
- Network Health
- Tufts
- Unicare

Please Note: Rates of coverage and covered services may vary by health plan. Please refer to the rate chart for specific coverage by plan.

**If you are eligible and choose to complete MassHealth's provider enrollment process*

Participating Medicare Advantage Plans

Fallon

Health
New
England



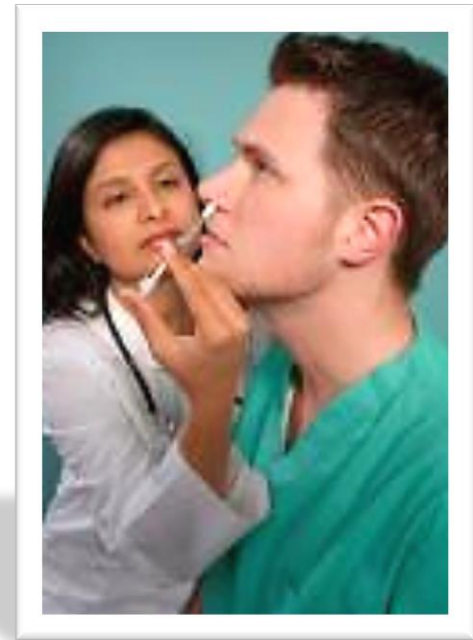
Cigna

Tufts

Blue
Cross

Vaccine Administration Reimbursement

- Administration rate has increased to a rate between \$13.76-\$25.28
- Influenza vaccines administered to individuals ages 6 months and older
- Pneumococcal vaccine administered to individuals enrolled in Medicare or a Medicare Advantage plan



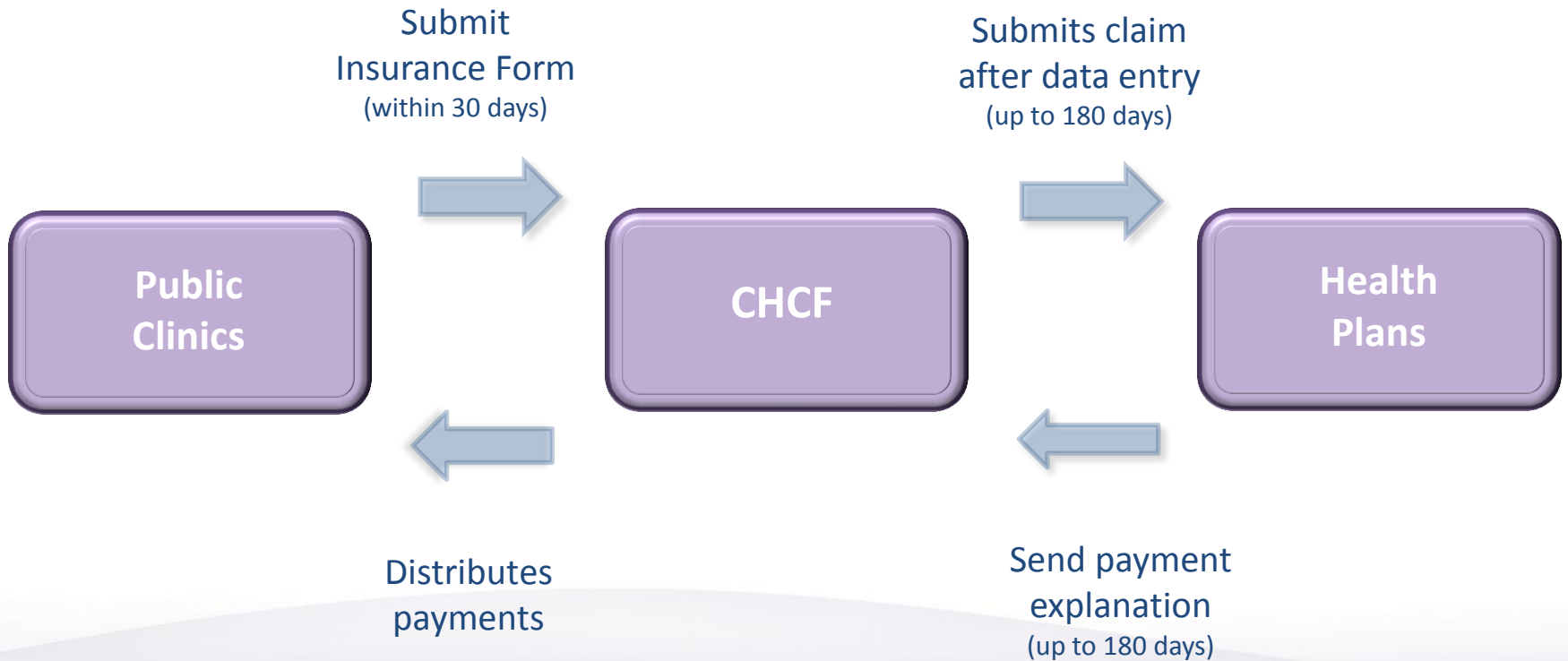
Vaccine Cost Reimbursement



- Intramuscular
 - IIV3, IIV4
- Intranasal
 - IIV4
- Intradermal
- High Dose
- Pneumococcal

Reimbursement Process:

For a 10% fee of paid claims, CHCF electronically bills the participating health plans



Insurance Form Instructions:

- Complete one insurance form for each individual who receives a vaccination
- All components of this form are required, however:
 - Public clinics may add a line to show that the patient's parent or guardian's signature indicates permission to vaccinate in addition to permission to bill the insurance company
 - A screening form with or without space for a signature may be added to the form if space permits
 - Clinical section may be resized to include space for vaccine information stickers
- Submit a **copy** of the complete form via trackable mail carrier
 - Keep the original for your records
- When submitting claims sort claims by health plan and billing service (i.e.: commercial health plan claims, Medicare claims, MassHealth claims)

Insurance Form – Top Half

Record information about the individual receiving the vaccine here. Record information *exactly* as it appears on their insurance card.

Information about the person to receive vaccine (please print): ***Required Fields**

Name: (Last, First, MI)*	Date of birth: * ____/____/____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone: * ()

Include any prefix or suffix including letters with the insurance ID number. Record Medicare information if applicable.

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

+ If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____/____/____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address: * (If different from address above)		
City:*	State:*	Zip: * ()
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

Determine if the individual receiving the vaccine is not the insurance subscriber. Be sure to include subscriber date of birth.

I give permission for my insurance company to be billed.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

Signature of individual to be vaccinated. **MUST BE SIGNED TO BILL.**

Provider Information

Provider Name: _____ MDPH Provider PIN#: _____
Provider Address: _____

Record the name of your board of health/school/VNA here. Use the provider name and address that you submit on your contract. Do **NOT** put the location of your flu clinic.

Number assigned to you by DPH upon enrollment in their flu program. If you do not have a DPH pin number contact us and we will provide you with one.

Clinical Information Section

For children 18 years of age and younger:

- Is Vaccine for Children (VFC) Program eligible:
- Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
 - Does not have health insurance
 - Is American Indian (Native American) or Alaska Native
- Is not VFC-eligible:
- Has health insurance and is not American Indian (Native American) or Alaska Native

Only fill out if the individual being vaccinated is 18 or younger

For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vax Type	Vaccine Mfg	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV3				0.25 0.5	No	Yes No	IM	R Arm L Arm R Leg L Leg		
	ccIIV3	Novartis			0.5	No	Yes	IM	R Arm L Arm		
	IIV3 Intraderma	Sanofi Pasteur			0.1	No	Yes	Intradermal	R Arm L Arm		
	IIV3 High Dose	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm		
	IIV4				0.25 0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg		
	RIV3	Protein Sciences			0.5	No	Yes	IM	R Arm L Arm		
	LAIV4	Med-Immune			0.2	Yes No	Yes	Intranasal	NA		
	PPV23	Merck			0.5	Yes No	N/A	IM SC	R Arm L Arm		

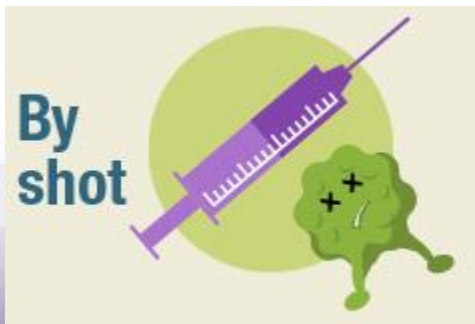
Indicate the vaccine administered. For your claim to be submitted you MUST provide: date of service, vaccine type & lot #, state supplied info, preservative free info, and injection route info.

Billing Guidelines

- ✓ Write legibly and ask patient to re-write if illegible
 - ✓ Include a copy of insurance card if possible
 - ✓ Ask patient to show all of their insurance cards
 - ✓ Have vaccine recipient or parent/legal guardian sign the form
 - ✓ Determine if patient is the subscriber and fill in subscriber information if applicable
 - ✓ **SUBMIT CLAIM WITHIN 30 DAYS OF DATE OF SERVICE**
- ∅ DO NOT write “signature on file” on signature line
 - ∅ DO NOT leave name of insurance company line blank
 - ∅ DO NOT put the flu clinic site address as your provider address
 - ∅ DO NOT leave state supplied or preservative free fields blank
 - ∅ DO NOT leave date of service field blank

NEW! Requirements

- Providers **must** submit the **invoice** for any privately purchased vaccines
 - We will not submit your privately purchased vaccine claims until we have a copy of your invoice
 - You do not need to send a copy with every claims submission
- Only **ONE** flu vaccination can be submitted per claim
 - If a second dose is administered this must be clearly indicated on a second claim form copy
- Providers **must** accurately complete the vaccine type section
 - Reimbursement rates differ by vaccine type; make sure claims are correctly indicated



or



Tips for Success

- ✓ Submit a photocopy of insurance card
 - We check eligibility but if any information is missing or transposed we may not be able to look up the patient and submit a claim
- ✓ Enroll as a provider with MassHealth & Medicare
 - The more payers you are able to submit claims to the more reimbursement you can receive
- ✓ Contract with us to bill all of your claims for MassHealth & Medicare
 - If bill your MassHealth claims and determine after checking eligibility that the patient has another HMO we can bill the appropriate insurance company
 - If we check a patient's eligibility and determine the patient has Medicare coverage we can automatically submit your claim to Medicare
- ✓ Submit claims within 30 days and keep track of what claims you have submitted
 - If we do not receive claims within 30 days of the date of service we cannot guarantee they will be submitted before the filing limit deadline
 - We cannot determine if you have already submitted a claim during the flu season

MassHealth Vaccine Billing

- In order for us to bill MassHealth on your behalf you must first enroll in the MassHealth vaccine program to become a MassHealth Provider
 - The application and additional information can be found here:
<http://www.mass.gov/eohhs/gov/newsroom/mashealth/providers/mashealth-flu-and-adult-vaccine-program.html>
- Upon enrollment you must send us a copy of your enrollment confirmation letter that includes your MassHealth PID number and your contract effective date with MassHealth
- You must also check the box on our Vaccine Reimbursement Contract that indicates you would like us to bill your MassHealth claims
 - If you would like to add this service to an already existing contract please contact us to update your contracted services
- You are responsible for maintaining your MassHealth enrollment status
- MassHealth will pay you directly and can choose if you would like us to invoice you for the 10% fee or remove it from your commercial payment



Contracting Process

- If you completed a contract in the 2013-2014 flu season you do **NOT** need to complete a new contract
- You will need to sign a new contract if:
 - You are a newly contracted provider
 - You would like to add MassHealth or Medicare Part B billing services
 - You would like to update your MassHealth or Medicare Part B fee payment option
- To receive a contract call (800) 890-2986
- You will need to submit two signed originals and one UMW-9 to:

University of Massachusetts Medical School
Center for Health Care Financing
529 Main St. 3rd Floor
Charlestown, MA 02129
Attn: Vaccine Reimbursement Program