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## *Guidelines for Payment of Vaccines (Pneumococcal Pneumonia Virus (PPV), Influenza Virus, and Hepatitis B Virus) and Their Administration at Renal Dialysis Facilities (RDFs)*

**Note:** This article was updated on February 12, 2013, to reflect current Web addresses. This article was previously updated on February 12, 2013, to reflect current Web addresses. This article was previously revised on September 5, 2007 to refer providers to CR5037 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R921CP.pdf>). CR5037 allows the reporting of diagnosis code V06.6 in place of V03.82 and V04.81 when reporting Influenza Virus and/or PPV vaccines when the purpose of the visit was to receive both vaccines. In addition, CR5037 requires Medicare carriers/FIs to accept claims containing CPT code 90660 for the Influenza Virus vaccine (live for intranasal usage). The related MLN Matters article may be viewed at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm5037.pdf> on the CMS website. All other information remains unchanged.

### Provider Types Affected

Freestanding and provider-based renal dialysis facilities (RDFs) that bill Medicare Fiscal Intermediaries (FI) for vaccines and vaccine administration

### Provider Action Needed



#### **STOP – Impact to You**

CR 3936 clarifies Medicare processing and payment of claims by Medicare FIs to RDFs for virus and pneumococcal pneumonia vaccines and their administration. **FIs pay** for PPV, influenza, and Hepatitis B virus vaccines provided by freestanding Renal Dialysis Facilities (RDFs) based on the lower of the actual charge or 95 percent of the average wholesale price (AWP). Provider-based RDF payment is based on reasonable cost. Deductible and coinsurance do not apply. Vaccine administration payments to freestanding RDFs are based on the Medicare Physician Fee Schedule according to its rate associated with code 90782 for services provided prior to March 1, 2003 and on code

#### Disclaimer

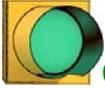
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90471 for services provided on or after March 1, 2003. Payments to provider-based RDFs are made on a reasonable cost basis.



**CAUTION – What You Need to Know**

Be cognizant of the applicable HCPCS codes and their definitions. Also, these clarifications apply to affected services provided on or after January 1, 2006.



**GO – What You Need to Do**

Use the appropriate codes when billing for the vaccines, see information listed within this article.

**Background**

The goal for CR 3936 is to clarify payment rules for vaccines furnished to End Stage Renal Disease (ESRD) patients (PPV, Influenza Virus, and Hepatitis B Virus) and its administration provided by RDFs (Type of bill 72X). The Medicare program covers **influenza virus and pneumococcal pneumonia vaccines and their administration** when furnished to eligible beneficiaries in accordance with coverage rules.

Payment may be made for both the **vaccine and the administration**. The costs associated with the syringe and supplies are included in the administration fee and thus **HCPCS code A4657 should not be billed for these vaccines**.

Vaccines and their administration are reported using separate codes. The following codes are for reporting the vaccines only:

HCPCS	Definition
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use;
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use;
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use <b>(Discontinued December 31, 2003)</b> ;
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use;
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;

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HCPCS	Definition
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use; and
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.

The following codes are for reporting administration of the vaccines only:

HCPCS	Definition
G0008	Administration of influenza virus vaccine;
G0009	Administration of pneumococcal vaccine; and
G0010	Administration of hepatitis B vaccine.

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim, the applicable following diagnosis code may be used.

Diagnosis Code	Description
V03.82	PPV
V04.8*	Influenza
V04.81**	Influenza
V05.3	Hepatitis B.

### Additional Information

The revised portions of the Medicare Claims Processing Manual are attached to CR3936, which is the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R610CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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