

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 3429</b>	<b>Date: December 22, 2015</b>
	<b>Change Request 9357</b>

**Transmittal 3403, dated November 9, 2015, is being rescinded and replaced by Transmittal 3429, dated December 22, 2015, for the following reasons:**

**The New Influenza Virus Vaccine Code 90630 was effective August 1, 2015, and remains in effect. In order to address claims processing issues that were brought to the attention of the Centers for Medicare & Medicaid Services (CMS), business requirements 9357.6 and 9357.7 have been revised to indicate that coinsurance and deductible do not apply for professional claims with the influenza virus vaccine code 90630. Additionally, the original business requirement 9357.8 has been revised and 9357.9 was added. Medicare Administrative Contractors (MACs) have been instructed to process and pay for professional claims with dates of service on or after August 1, 2015. All other information remains the same.**

**SUBJECT: New Influenza Virus Vaccine Code**

**I. SUMMARY OF CHANGES:** This CR provides instructions for payment and CWF edits to be updated to include influenza virus vaccine code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015, processed on or after April 4, 2016.

**EFFECTIVE DATE: August 1, 2015**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: December 11, 2015- For requirement 9357.8; April 4, 2016 - For all other requirements**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)**

R=REVISED, N=NEW, D=DELETED

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	18/Table of Contents
<b>R</b>	18/1.2/Table of Preventive and Screening Services
<b>R</b>	18/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
<b>R</b>	18/10.4.1/CWF Edits on AB MAC (A) Claims
<b>R</b>	18/10.4.2/CWF Edits on AB MAC (B) Claims

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/10.4.3/CWF Crossover Edits for A/B MAC (B) Claims

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**



Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
	<a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html</a> to determine the payment rate for influenza virus vaccine code 90630.									
9357.3	Contractors shall pay for influenza virus vaccine code 90630 to hospitals (12X and 13X), SNFs (22X and 23X), HHA (34X), hospital-based RDFs (72X), and CAHs (85X) based on reasonable cost. Coinsurance and deductible do not apply.	X		X		X				
9357.4	Contractors shall pay for influenza virus vaccine code 90630 to IHS Hospitals (12X, 13X), and IHS CAHs (85X), based on the lower of the actual charge or 95% of the Average Wholesale Price (AWP). Coinsurance and deductible do not apply.	X				X				
9357.5	Contractors shall pay for influenza virus vaccine code 90630 to CORFs (75X), and independent RDFs (72X), based on the lower of the actual charge or 95% of the AWP. Coinsurance and deductible do not apply.	X				X				
9357.6	Contractors shall add influenza virus vaccine code 90630 to existing influenza virus vaccine edits. Coinsurance and deductible do not apply.		X			X			X	
9357.7	Effective for claims with dates of service on or after August 1, 2015, contractors shall process and pay for professional claims with influenza virus vaccine code 90630. Coinsurance and deductible do not apply.		X							
9357.8	Until systems are implemented, contractors shall hold institutional claims containing code 90630 with dates of service on or after August 1, 2015, received before April 4, 2016.	X		X						
9357.9	Once the system changes described in this instruction are implemented, contractors shall release the held claims, appending condition code 15.	X		X						

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
9357.10	MLN Article: A provider education article related to this instruction will be available at <a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/">http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X		

### IV. SUPPORTING INFORMATION

#### Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

#### Section B: All other recommendations and supporting information: N/A

### V. CONTACTS

**Pre-Implementation Contact(s):** William Ruiz, 410-786-9283 or [william.ruiz@cms.hhs.gov](mailto:william.ruiz@cms.hhs.gov) (For institutional claims), Dennis Savedge, 410-786-0140 or [dennis.savedge@cms.hhs.gov](mailto:dennis.savedge@cms.hhs.gov) (For practitioner claims)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

### VI. FUNDING

#### Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Claims Processing Manual

## Chapter 18 - Preventive and Screening Services

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- 10.4.1 - CWF Edits on A/B MAC *(A)* Claims
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- 10.4.3 - CWF Crossover Edits for A/B MAC *(B)* Claims

## 1.2 – Table of Preventive and Screening Services

(Rev. 3429, Issued: 12-22-15; Effective: 08-01-15; Implementation: 12-11-15 for requirement 9357.8; April 4, 2016 for all other requirements)

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	<b>*Not Rated</b>	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	<b>B</b>	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	<b>A</b>	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	<b>B</b>	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	<b>*Not Rated</b>	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	<b>*Not Rated</b>	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	<b>B</b>	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	<b>B</b>	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	A	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	A	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	A	WAIVED
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	A	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED

<b>Service</b>	<b>CPT/ HCPCS Code</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	<b>A</b>	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	<b>B</b>	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	<b>B</b>	WAIVED
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	G0202	Screening mammography, producing direct 2-D digital image, bilateral, all views		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	<b>B</b>	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77083	Radiographic absorptiometry (e.g., photo densitometry, radiogrammetry), 1 or more sites		WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED

**NOTE:** For Colorectal Cancer Screening, effective January 1, 2015, when anesthesia service 00810 is performed in conjunction with screening colonoscopy services G0105 or G0121, coinsurance and deductible will be waived for anesthesia service 00810 when modifier 33 is entered on the anesthesia claim.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia code 00810 should be submitted with only the PT modifier and only the deductible will be waived.

Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	<b>A</b>	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	<b>*Not Rated</b>	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	<b>A</b>	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	<b>D</b>	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	<b>I</b>	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90630	<i>Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use</i>	<b>B</b>	<i>WAIVED</i>
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED
	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED
	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED

<b>Service</b>	<b>CPT/ HCPCS Code</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	<b>B</b>	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	<b>A</b>	WAIVED
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED

<b>Service</b>	<b>CPT/ HCPCS Code</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	<b>A</b>	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	<b>B</b>	WAIVED
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening	<b>A</b>	WAIVED
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening		WAIVED
Smoking Cessation	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	<b>A</b>	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPS, first visit	<b>*Not Rated</b>	WAIVED
	G0439	Annual wellness visit, including PPS, subsequent visit		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating	Coins./ Deductible
Intensive Behavioral Therapy for Obesity	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	B	WAIVED
	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	B	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		

**10.2.1 - Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes**  
*(Rev. 3429, Issued: 12-22-15; Effective: 08-01-15; Implementation: 12-11-15 for requirement 9357.8; April 4, 2016 for all other requirements)*

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

**HCPCS Definition**

- 90630 *Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use*
- 90653 Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use
- 90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 – 64;
- 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;
- 90660 Influenza virus vaccine, live, for intranasal use;
- 90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
- 90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- 90669 Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
- 90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
- 90672 Influenza virus vaccine, live, quadrivalent, for intranasal use
- 90673 Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic

**HCPCS Definition**

	free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use;
90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for 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;
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. The administration of the vaccines is billed using:

**HCPCS Definition**

G0008	Administration of influenza virus vaccine;
G0009	Administration of pneumococcal vaccine; and
*G0010	Administration of hepatitis B vaccine.
*90471	Immunization administration. (For OPPS hospitals billing for the hepatitis B vaccine administration)
*90472	Each additional vaccine. (For OPPS hospitals billing for the hepatitis B vaccine administration)

**\* NOTE:** For claims with dates of service prior to January 1, 2006, OPPS and non-OPPS hospitals report G0010 for hepatitis B vaccine administration. For claims with dates of service January 1, 2006 until December 31, 2010, OPPS hospitals report 90471 or 90472 for hepatitis B vaccine administration as appropriate in place of G0010. Beginning January 1, 2011, providers should report G0010 for billing under the OPPS rather than 90471 or 90472 to ensure correct waiver of coinsurance and deductible for the 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.

<b>ICD-9-CM Diagnosis Code</b>	<b>Description</b>
V03.82	Pneumococcus
V04.81**	Influenza
V06.6***	Pneumococcus and Influenza
V05.3	Hepatitis B

\*\*Effective for influenza virus claims with dates of service October 1, 2003 and later.

\*\*\*Effective October 1, 2006, providers may report ICD-9-CM diagnosis code V06.6 on claims for pneumococcus and/or influenza virus vaccines when the purpose of the visit was to receive both vaccines.

**NOTE:** ICD-10-CM diagnosis code Z23 may be used for an encounter for immunizations effective with the implementation of ICD-10.

If a diagnosis code for pneumococcus, hepatitis B, or influenza virus vaccination is not reported on a claim, contractors may not enter the diagnosis on the claim. Contractors must follow current resolution processes for claims with missing diagnosis codes.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the A/B MAC (A or B) may correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is V04.81 and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine. Effective October 1, 2006, A/B MACs (B) should follow the instructions in Pub. 100-04, Chapter 1, Section 80.3.2.1.1 (A/B MAC (B) Data Element Requirements) for claims submitted without a HCPCS code.

Claims for hepatitis B vaccinations must report the I.D. Number of the referring physician. In addition, if a doctor of medicine or osteopathy does not order the influenza virus vaccine, the A/B MACs (A) claims require:

- UPIN code SLF000 to be reported on claims submitted prior to May 23, 2008, when Medicare began accepting NPIs, only
- The provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2008, when NPI requirements were implemented.

#### **10.4.1 - CWF Edits on A/B MAC (A) Claims**

*(Rev. 3429, Issued: 12-22-15; Effective: 08-01-15; Implementation: 12-11-15 for requirement 9357.8; April 4, 2016 for all other requirements)*

In order to prevent duplicate payment by the same A/B MAC (A), CWF edits by line item on the A/B MAC (A) number, the beneficiary Health Insurance Claim (HIC) number, and the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688 and the pneumococcal procedure codes 90669, 90670, or 90732, and the administration codes G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688 and it already has on record a claim with the same HIC number, same A/B MAC (A) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.

If CWF receives a claim with HCPCS codes 90669, 90670, or 90732 and it already has on record a claim with the same HIC number, same A/B MAC (A) number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same HIC number, same A/B MAC (A) number, same date of service, and same procedure code, CWF rejects the second claim submitted when all four items match.

CWF returns to the A/B MAC a reject code “7262” for this edit. A/B MACs (A) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

#### **10.4.2 - CWF Edits on A/B MAC (B) Claims**

*(Rev. 3429, Issued: 12-22-15; Effective: 08-01-15; Implementation: 12-11-15 for requirement 9357.8; April 4, 2016 for all other requirements)*

In order to prevent duplicate payment by the same A/B MAC (B), CWF will edit by line item on the A/B MAC (B) number, the HIC number, the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688 and it already has on record a claim with the same HIC number, same A/B MAC (B) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS codes 90669, 90670, or 90732 and it already has on record a claim with the same HIC number, same A/B MAC (B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same HIC number, same A/B MAC (B) number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the A/B MAC (B) a specific reject code for this edit. A/B MACs (B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

In order to prevent duplicate payment by the centralized billing contractor and local A/B MAC (B), CWF will edit by line item for carrier number, same HIC number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688 and it already has on record a claim with a **different** A/B MAC (B) number, but same HIC number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS codes 90669, 90670, or 90732 and it already has on record a claim with the same HIC number, different A/B MAC (B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different A/B MAC *(B)* number, but the same HIC number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for this edit. A/B MACs *(B)* must deny the second claim. For the second edit, the reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

MSN: 7.2 – “This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.”

Claim adjustment reason code 18 – duplicate claim or service

### **10.4.3 - CWF Crossover Edits A/B MAC *(B)* Claims**

*(Rev. 3429, Issued: 12-22-15; Effective: 08-01-15; Implementation: 12-11-15 for requirement 9357.8; April 4, 2016 for all other requirements)*

When CWF receives a claim from the A/B MAC *(B)*, it will review Part B outpatient claims history to verify that a duplicate claim has not already been posted.

CWF will edit on the beneficiary HIC number; the date of service; the influenza virus procedure codes *90630*, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, or 90688; the pneumococcal procedure codes 90669, 90670, or 90732; and the administration code G0008 or G0009.

CWF will return a specific reject code for this edit. Contractors must deny the second claim and use the same messages they currently use for the denial of duplicate claims.