CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13547	**Date: December 18, 2025**
	Change Request 14254

SUBJECT: Revisions to Publication 100-04, Medicare Claims Processing Manual, Chapters 9, 18, and Publication 100-02, Medicare Benefit Policy Manual, Chapter 13 To Include Updated Information

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Publication 100-04, Medicare Claims Processing Manual, Chapter 9 and Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, to align with the current policy.

EFFECTIVE DATE: January 20, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 20, 2026

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	13/80/80.1 RHC and FQHC Cost Report Requirements
R	13/220/220.1/Preventive Health Services in RHCs
R	13/220/220.3/Preventive Health Services in FQHCs
R	13/50/50.1/ RHC Services

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 13547	Date: December 18, 2025	Change Request: 14254

SUBJECT: Revisions to Publication 100-04, Medicare Claims Processing Manual, Chapters 9, 18, and Publication 100-02, Medicare Benefit Policy Manual, Chapter 13 To Include Updated Information

EFFECTIVE DATE: January 20, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 20, 2026

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Publication 100-04, Medicare Claims Processing Manual, Chapters 9, 18, and Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, to align with the current policy.

II. GENERAL INFORMATION

A. Background: The purpose of this change request is to revise Publication 100-02, Medicare Benefit Policy Manual, Chapter 13, Sections 50.1, 80.1, 220.1 and 220.3.

B. Policy: There are no policy changes associated with this instruction.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14254 - 02.1	Contractors shall be in compliance with the updates to CMS Publication 100-02, Chapter 13, sections 50.1, 80.1, 220.1 and 220.3.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. 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

VI. CONTACTS

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

VII. 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 Benefit Policy Manual

Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents

(Rev. 13547; Issued:12-18-25)

50.1 - RHC Services

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

RHC services include:

- Physicians' services, as described in section 110;
- Services and supplies incident to a physician's services, as described in section120;
- Services of NPs, PAs, and CNMs, as described in section 130;
- Services and supplies incident to the services of NPs, PAs, and CNMs, asdescribed in section 140;
- CP and CSW services, as described in section 150;
- MFT and MHC services, as described in section 150;
- Services and supplies incident to the services of CPs and CSWs, as described in section 160;
- Services and supplies incident to the services of MFTs and MHCs, as described in section 160;
- Visiting nurse services to patients confined to the home, as described in section190;
- Certain care management services, as described in section 230; and
- Certain virtual communication services, as described in section 240.

RHC services also include certain preventive services when specified in statute or whenestablished through the National Coverage Determination (NCD) process and not specifically excluded (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B, COVID-19 vaccinations, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19;
- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.
- Drugs Covered as Additional Preventive Services (DCAPS) and related supply and administration fees.

The professional component of the IPPE, AWV, and other qualified preventive services is paid based on the AIR.

80.1 - RHC and FQHC Cost Report Requirements

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

RHCs are required to file a cost report annually in order to determine their payment rate and reconcile interim payments, including adjustments for GME payments, bad debt, influenza, pneumococcal, hepatitis B and COVID-19 vaccines, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration. If in its initial reporting period, the RHC submits a budget that estimates the allowable costs and number of visits expected during the reporting period. The A/B MAC calculates an interim rate based on a percentage of the per-visit limit, which is then adjusted when the cost report is filed.

FQHCs are required to file a cost report annually and are paid for the costs of GME, bad debt, influenza, pneumococcal, hepatitis B and COVID-19 vaccines, and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration through the cost report. All FQHCs, including an FQHC that does not have GME costs, bad debt, or costs associated with influenza,

pneumococcal, hepatitis B and COVID-19 vaccines, or covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration, must file a cost report.

The RHC and FQHC cost reports were updated to reflect costs related to COVID-19 shots and COVID-19 monoclonal antibody products and their administration, and to include hepatitis B vaccines with the other Part B vaccines (influenza, pneumococcal and COVID-19).

Effective for dates of service on or after July 1, 2025, RHCs and FQHCs, shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B and COVID-19 -- on the claim at the time of service. Although paid at the time of service, payments for these services must be annually reconciled with the RHC or FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report. This includes any in-home additional costs, if applicable. See section 220.1 and 220.3 of this Chapter for more information.

Note: Until the end of the calendar year in which the Emergency Use Authorization (EUA) declaration for drugs and biological products with respect to COVID-19 ends, CMS covers and pays for these infusions or injections the same way it covers and pays for COVID-19 vaccines when furnished consistent with the EUA. That is, for RHCs and FQHCs COVID-19 monoclonal antibody products (when purchased from the manufacturer) and their administration are paid at 100 percent of reasonable cost through the cost report. Effective January 1 of the year following the year in which the EUA declaration ends, CMS will cover and pay for monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 in the same way we pay for other Part B drugs and biological products. For RHCs, payment is through the All-Inclusive Rate and for FQHCs payment is through the FQHC Prospective Payment System.

RHCs and FQHCs must maintain and provide adequate cost data based on financial and statistical records that can be verified by qualified auditors.

RHCs and FQHCs are allowed to claim bad debts in accordance with 42 CFR 413.89. RHCs may claim unpaid coinsurance and deductible, and FQHCs may claim unpaid coinsurance. RHCs and FQHCs that claim bad debt must establish that reasonable efforts were made to collect these amounts Coinsurance or deductibles that are waived, either due to a statutory waiver or a sliding fee scale, may not be claimed.

220.1 - Preventive Health Services in RHCs

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

Influenza (G0008), Pneumococcal (G0009), and COVID-19 (90480) Vaccines, and Certain COVID-19 Monoclonal Antibody Products

Prior to July 1, 2025, influenza, pneumococcal, COVID-19 vaccines, and their administration were not paid at the time of service and were paid at 100 percent of reasonable cost through the cost report.

Effective for dates of service on or after July 1, 2025, RHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, and COVID-19 -- on the claim at the time of service. A visit/encounter is not required for these services; however, if reported on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines or their administration.

Although paid at the time of service, payments for these services must be annually reconciled with the RHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1

through July 31 of the following year. RHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: An additional payment for influenza, pneumococcal, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E.

Covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

Hepatitis B Vaccine (G0010)

Prior to January 1, 2025, hepatitis B vaccine and its administration was included in the RHC visit and was not separately billable. The cost of the vaccine and its administration could be included in the line item for the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the RHC provides. The beneficiary coinsurance and deductible were waived.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the RHC AIR.

Effective for dates of service on or after July 1, 2025, RHCs shall report all Part B preventive vaccines and their administration – including hepatitis B on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance and deductible do not apply to these vaccines or their administration.

Note: An additional payment for hepatitis B vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for RHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

Although paid at the time of service, payments for these services must be annually reconciled with the RHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, two visits may be billed. The beneficiary coinsurance and deductible are waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a face-to-face personalized prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. A Social Determinants of Health (SDOH) risk assessment and Advance Care Planning (ACP) can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

More information regarding the SDoH risk assessment is available on the CMS website: https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

More information regarding ACP is available on the CMS website: https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)

Diabetes self-management training or medical nutrition therapy provided by a registered dietician or nutritional professional at an RHC may be considered incident to a visit with an RHC practitioner provided all applicable conditions are met. DSMT and MNT are not billable visits in an RHC, although the cost may be allowable on the cost report. RHCs cannot bill a visit for services furnished by registered dieticians or nutritional professionals. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their AIR. The beneficiary coinsurance and deductible apply.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible apply.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

Drugs Covered as Additional Preventive Services (DCAPS)

DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims Processing Manual (100-04), Chapter 18, Section 250. The beneficiary coinsurance and deductible are waived.

These services are separately billable and are paid on a claim-by-claim basis. Therefore, they do not affect any other claims billed on the same day.

Coding for DCAPS drugs and related supply and administration fees is listed on the CMS webpage:

- The coding and other guidance for Part B coverage and payment of PrEP for HIV is located at https://www.cms.gov/medicare/coverage/prep. The HCPCS code for the injection of PrEP for HIV is G0012.

NOTE: Hepatitis C Screening (G0472) is a technical service only and therefore it is not paid as part of the RHC visit.

220.3 - Preventive Health Services in FQHCs

(Rev. 13547; Issued: 12-18-25; Effective: 01-20-26; Implementation: 01-20-26)

FQHCs must provide preventive health services on site or by arrangement with another provider. These services must be furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, CSW, MFT or MHC. Section 330(b)(1)(A)(i)(III) of the Public Health Service (PHS) Act required preventive health services can be found at http://bphc.hrsa.gov/policies regulations/legislation/index.html, and include:

- prenatal and perinatal services;
- appropriate cancer screening;
- well-child services;
- immunizations against vaccine-preventable diseases;
- screenings for elevated blood lead levels, communicable diseases, and cholesterol;
- pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
- voluntary family planning services; and
- preventive dental services.

NOTE: The cost of providing these services may be included in the FQHC cost report but they do not necessarily qualify as FQHC billable visits or for the waiver of the beneficiary coinsurance.

Influenza (G0008), Pneumococcal (G0009), and COVID-19 (90480) Vaccines and Certain COVID-19 Monoclonal Antibody Products

*Prior to July 1, 2025, i*nfluenza, pneumococcal, and COVID-19 vaccines and their administration *were not paid at the time of service and were* paid at 100 percent of reasonable cost through the cost report. The cost *was* included in the cost report and no visit *was* billed. FQHCs must *have* include*d* these charges on the claim if furnished as part of an encounter. The beneficiary coinsurance *was* waived.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, and COVID-19 -- on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines or their administration.

Although paid at the time of service, payments for these services must be annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing to reflect the seasonal influenza virus vaccines and their applicable payment allowances that are effective August 1 through July 31 of the following year. FQHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season.

Note: An additional payment for influenza, pneumococcal, COVID-19 vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E.

Covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID-19 and their administration are paid at 100 percent of reasonable cost through the cost report. Monoclonal antibody products used for the treatment or for post-exposure prophylaxis of COVID-19 (when they are not purchased by the government) and their administration are paid through the cost report until the end of the calendar year in which the Emergency Use Authorization declaration for drugs and biological products with respect to COVID-19 ends.

Hepatitis B Vaccine (G0010)

Prior to January 1, 2025, hepatitis B vaccine and its administration was included in the FQHC visit and was not separately billable. The cost of the vaccine and its administration could be included in the line item for the otherwise qualifying visit. A visit could not be billed if vaccine administration was the only service the FQHC provides. The beneficiary coinsurance was waived.

Effective January 1, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the FQHC PPS rate.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – including hepatitis B, on the claim at the time of service. A visit/encounter is not required for these services; however, if a visit occurs on the same day, the vaccines and administrations shall receive a separate payment. Coinsurance does not apply to these vaccines.

Although paid at the time of service, payments for these services must be annually reconciled with the FQHC's actual vaccine and vaccine administration costs, to ensure these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Note: An additional payment for hepatitis B vaccine administration in the home can be made, provided that a home visit meets all the requirements of both part 405, subpart X, for FQHC services provided in the home, and § 410.152(h)(3)(iii) for the in-home additional payment for Part B preventive vaccine administration. See Pub. 100-02, Chapter 15, Section 50.4.4.2.E for more information.

Initial Preventive Physical Exam (G0402)

The IPPE is a face-to-face one-time exam that must occur within the first 12 months following the beneficiary's enrollment. The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Annual Wellness Visit (G0438 and G0439)

The AWV is a personalized face-to-face prevention visit for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months. Social Determinants of Health (SDOH) assessments and Advance Care Planning (ACP) can be furnished as a part of the AWV. The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate. The beneficiary coinsurance is waived.

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (97802 and 97803)

DSMT and MNT furnished by certified DSMT and MNT providers are billable visits in FQHCs when they are provided in a one-on-one, face-to-face encounter and all program requirements are met. Other diabetes counseling or medical nutrition services provided by a registered dietician at the FQHC may be considered incident to a visit with an FQHC provider. The beneficiary coinsurance is waived for MNT services and is applicable for DSMT.

DSMT must be furnished by a certified DSMT practitioner, and MNT must be furnished by a registered dietitian or nutrition professional. Program requirements for DSMT services are set forth in 42 CFR 410 Subpart H for DSMT and in Part 410, Subpart G for MNT services, and additional guidance can be found at Pub. 100-02, chapter 15, section 300.

Screening Pelvic and Clinical Breast Examination (G0101)

Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Screening Papanicolaou Smear (Q0091)

Screening Papanicolaou smear can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Prostate Cancer Screening (G0102)

Prostate cancer screening can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Glaucoma Screening (G0117 and G0118)

Glaucoma screening for high risk patients can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance applies.

Lung Cancer Screening Using Low Dose Computed Tomography (LDCT) (G0296)

LDCT can be billed as a stand-alone visit if it is the only medical service provided on that day with an FQHC practitioner. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance is waived.

Drugs Covered as Additional Preventive Services (DCAPS)

DCAPS drugs, and any supply and administration fee, are paid at 100 percent of the Medicare payment amount. The Medicare payment amount for DCAPS drugs, and any supply and administration fee, is described in the Medicare Claims Processing Manual (100-04), Chapter 18, Section 250. The beneficiary coinsurance and deductible are waived.

These services are separately billable and are paid on a claim-by-claim basis. Therefore, they do not affect any other claims billed on the same day.

Coding for DCAPS drugs and related supply and administration fees is listed on the CMS webpage:

- The coding and other guidance for Part B coverage and payment of PrEP for HIV is located at

https://www.cms.gov/medicare/coverage/prep. The HCPCS code for the injection of PrEP for HIV is **G0012**.

NOTE: Hepatitis C Screening (GO472) is a technical service only and therefore not paid as part of the FQHC visit.