CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**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, 18, 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	9/ Table of Contents
R	9/60/60.2/ Billing for FQHC Claims Paid under the PPS
R	9/60/60.3/Payments for FQHC PPS Claims
R	9/70/70.3/Preventive Vaccines
R	18/10/10/2/Billing Requirements
R	18/10/10.2.2.1/ Payment for Pneumococcal Pneumonia Virus, Influenza Virus, Hepatitis B Virus and COVID-19 Vaccines and Their Administration on Institutional Claims
R	18/10/10.2.2.2/Special Instructions for Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)

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. 100-04	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: This CR revises Publication 100-04, Medicare Claims Processing Manual, Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers and Chapter 18 - Preventive and Screening Services to include current payment policies.

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 - 04.1	Contractors shall be in compliance with the updates to CMS Publication 100-04, Chapter 9, sections 60.2, 60.3, 70.3 AND CMS Publication 100-04, Chapter 18, sections 10.2, 10.2.2.1 and 10.2.2.2.	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 Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

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

60.2 - Billing for FQHC Claims Paid under the PPS

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

CMS established five FQHC payment specific codes to be used by FQHCs submitting claims under the PPS. When reporting an encounter/visit for payment, the FQHC must bill on the claim (77X TOB) a FQHC specific payment code.

FQHC Specific Payment Codes

G0466 – FQHC visit, new patient
A medically necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

G0467 – FQHC visit, established patient
A medically necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

G0468 – FQHC visit, IPPE or AWV
A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

G0469– FQHC visit, mental health, new patient
A medically necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

G0470 – FQHC visit, mental health, established patient
A medically necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

FQHCs must use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or 0519.

NOTE: Revenue code 0519 is used for Medicare Advantage (MA) Supplemental claims only.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must report HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges. The additional services reported on the claim that are part of the FQHC encounter, will not be paid. The payment for these services is included in the payment under the FQHC payment code.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit. The link below contains the list of the qualifying visits for each payment specific code:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

For example:

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS
0521	G0467 - FQHC *Specific* Payment code *(FSPC)*		10/01
0521	99213 - Qualifying visit *(QV)*		10/01

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

For example:

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS
0521	G0468 – *FSPC*		10/01
0521	G0439 – *QV*		10/01
0900	G0470 - *FSPC*		10/01
0900	90832 – QV		10/01

When submitting a claim for a subsequent illness or injury, the FQHC reports G0467 for a medical visit), with modifier 59. A qualifying visit is still required when reporting modifier 59 with G0467.

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS
0521	G0468 - FSPC		10/01
0521	G0439 - QV		10/01
0521	G0467 - FSPC	59	10/01
0900	99211 - QV		10/01

FQHCs must report all services that occurred on the same day on one claim. FQHCs may submit claims that span multiple days of service.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

Beginning in 2020, FQHCs must report HCPCS codes for COVID-19 vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall pay for the COVID-19 vaccines and their administration through the cost report.

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. Therefore, FQHCs must report HCPCS codes for the hepatitis B vaccine and their administration on a FQHC claim, and these HCPCS codes will be considered informational only.

Effective for dates of service on or after July 1, 2025, FQHCs shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B, and COVID-19 -- on the claim for payment 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 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: FQHCs can bill HCPCS code M0201 for an in-home additional payment for influenza, pneumococcal, hepatitis B, COVID-19 vaccine administration, 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.

60.3 - Payments for FQHC PPS Claims

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

Payment for FQHC PPS claims is made by comparing the adjusted FQHC PPS rate to the total submitted covered charges reported for the specific payment codes G0466, G0467, G0468, G0469, and G0470.

To calculate payment, follow the steps below:

Step 1: Determine the lesser of the provider's submitted charges for the specific payment code(s) and the fully adjusted PPS rate.

Step 2: Determine if preventive services for which the coinsurance is waived are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.
(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: If no preventive services are present, use the lesser of the providers charge for the specific payment code(s) or the PPS rate as the Step 3 total.

Step 4: Multiply the total from Step 3 by 80%.
Step 3 total * 80% = Step 4 total

Note: If no preventive services are present, contractors will pay this amount and skip step 5.

Step 5: Add the charges for the approved preventive services to the total from step 4.
Contractors will pay this amount.
Step 4 total + preventive services charges = Medicare Payment

Note: If the charges for the approved preventive services are greater than the total payment amount identified in Step 1 (i.e., the lesser of the charges for the specific payment code or the PPS rate), pay 100% of the total payment amount determined in Step 1 and do not apply coinsurance. (Please see example 3)

To calculate coinsurance, follow the steps below:
Step 1: Determine the lesser of the submitted charges for the G-code (s) and the PPS rate.

Step 2: Determine if approved preventive services (i.e., preventive services for which coinsurance is waived) are present.

Step 3: Subtract the charges for the preventive services from the lesser of the provider's charge for the specific payment code(s) or the PPS Rate.
(Lesser of the provider's charge for the specific payment code or the PPS rate) - (Preventive services charges) = Step 3 total

Note: If no approved preventive services are present, use the lesser the provider's charge for the specific payment code(s) or the PPS rate as the Step 3 total.

Step 4: Multiply the total from Step 3 by 20%.
Step 3 total * 20% = Coinsurance

Example: Payment based on the charges
PPS rate = 160.00

Note: The examples below may vary by description or HCPCS.
Provider's actual charge for the specific payment code, G0467 = $150

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0467 - FQHC Specific Payment Code (FSPC)		10/01	150.00	150.00
0521	99213 - Qualifying Visit (QV)		10/01	135.00	135.00
0300	36415 - Venipuncture (VP)		10/01	25.00	25.00
0001				310.00	310.00

The comparison is between the PPS rate and the provider's $150 actual charge for the specific payment code, G0467. In this case, the sum of the line items exceeds the provider's actual charge for the payment code.

Payment based on the provider's charge of 150.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0467 - FSPC		10/01	150.00	150.00	120.00	30.00
0521	99213 - QV		10/01	135.00	135.00	CO 97*	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = 150.00 (charges) * 80%

Coinsurance = 150.00 (charges) * 20%

For service lines that do not receive payment, group code CO- contractual obligation and the appropriate claim adjustment reason code (CARC) will be used.

* CARC 97 – the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Example: Payment based on the charges with approved preventive service

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = $150
Preventive Service (PS) = 135.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	150.00	150.00
0521	G0439 - PS		10/01	135.00	135.00
0300	36415 - VP		10/01	25.00	25.00
0001				310.00	310.00

Payment based on the provider's actual charge of 150.00 for the specific payment code, G0468.

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FSPC		10/01	150.00	150.00	147.00	3.00
0521	G0439 - PS		10/01	135.00	135.00	CO 97*	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 135.00 (preventive service G0439)) * 80% + 135.00 preventive service.
Coinsurance = (150.00 (charges) – 135.00 (preventive service G0439)) * 20%

- PS – Preventive Service -These are approved preventive services where the coinsurance is waived based on the USPSTF recommendation.

Example: Payment based on the charges when preventive service is greater than G-code

PPS rate = 160.00

Provider's actual charge for the specific payment code, G0468 = $150 Preventive Service = 155.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	150.00	150.00
0521	G0439 - PS		10/01	155.00	155.00
0300	36415 - VP		10/01	25.00	25.00
0001				330.00	330.00

Payment based on charges of 150.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FPSC		10/01	150.00	150.00	150.00	0

0521	G0439 - PS		10/01	155.00	155.00	CO 97*	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0001				330.00	330.00		

Payment = (150.00 (charges) * 100% = 150.00

Since the charges for the preventive service, G0439 are greater than the provider's actual charge for the specific payment code G0468, Medicare pays 100% of the provider's actual charge for the specific payment code, G0468.

Reporting Multiple G-codes

When a FQHC reports multiple specific payment codes (G-codes) on the same day, the total payment amount will be determined by comparing the sum of the charges for all the G-codes reported to the PPS rate. When a qualified mental health visit occurs on the same day as a qualified medical visit, the G-codes will be totaled separately (see example 8).

Listed below is the order in which payment will be applied when multiple G-codes are reported on the same day:

Medical visits:

- G0468-IPPE or AWV
- G0466-Medical, new patient
- G0467-Established patient

Mental health visits:

- G0469-Mental health, new patient
- G0470- Mental health, established patient

When G0466 (Medical, new patient) and G0468 (IPPE or AWV) are reported together, the add-on payment will be applied to G0468.

Example: Payment based on PPS rate with multiple G-codes and preventive services

Because this scenario does not qualify for an exception to a per diem payment, the system will calculate and apply a PPS rate to only one of the specific payment codes. However, the FQHC may list its actual charges for both specific payment codes, and the comparison would be between the PPS rate and the total of the provider's charges for the specific payment codes. Payment would be based on the lesser amount.

PPS RATE, reflecting a 1.3416 adjustment for new patients or a visit including an IPPE or AWV = 215.00

Total of provider charges for the specific payment codes (170.00 + 65.00) = 235.00
Provider's charge for the Preventive Service = 135.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	170.00	170.00
0521	G0438 - PS		10/01	135.00	135.00
0300	36415 - VP		10/01	25.00	25.00
0521	G0466 - FSPC		10/01	65.00	65.00
0521	92004 - Ophthalmo-		10/01	45.00	45.00

	logical Exam				
0001				440.00	440.00

Payment based on adjusted PPS rate of 215.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FSPC		10/01	170.00	170.00	199.00	16.00
0521	G0438 - PS		10/01	135.00	135.00	CO 97	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0521	G0466 - FSPC		10/01	65.00	65.00	CO 97	0
0521	92004 - Ophthalmo-logical Exam		10/01	45.00	45.00	CO 97	0
0001				440.00	440.00		

Payment = (215.00 (PPS rate) – 135.00 (preventive service G0438) * 80% + 135.00 preventive service

Coinsurance = (215.00 (PPS rate) – 135.00 (preventive service G0438)) * 20%

Reporting Multiple Preventive Services

When multiple preventive services are reported on the same day, the coinsurance will be determined by carving out the total preventive services charges.

Example: Payment based on PPS rate with multiple G-codes and multiple preventive services

PPS RATE =225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00

Total Preventive Services (135.00 +60.00) =195.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	140.00	140.00
0521	G0439 - PS		10/01	135.00	135.00
0300	36415 - VP		10/01	25.00	25.00
0521	G0467 - FSPC		10/01	75.00	75.00
0521	97802 - PS		10/01	60.00	60.00
0521	G0466 - FSPC		10/01	55.00	55.00
0521	92004 - Ophthalmological Exam		10/01	45.00	45.00
0001				535.00	535.00

Payment based on PPS rate of 225.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FSPC		10/01	140.00	140.00	219.00	6.00
0521	G0439 - PS		10/01	135.00	135.00	CO 97	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0521	G0467 - FSPC		10/01	75.00	75.00	CO 97	0
0521	97802 - PS		10/01	60.00	60.00	CO 97	0

0521	G0466 - FSPC		10/01	55.00	55.00	CO 97	0
0521	92004 - Ophthalmo-logical Exam		10/01	45.00	45.00	CO 97	0
0001				535.00	535.00		

Payment = (225.00 – (135.00 +60.00)) * 80% + 135.00 + 60.00

Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

Influenza and Pneumococcal Pneumonia Vaccination (PPV) ***(Prior to July 1, 2025)***
Flu and PPV vaccines and their administration will continue to be paid through the cost report. However, these services should be reported on the claim for information purposes only. Flu and PPV vaccines and their administration codes will not be carved out of the coinsurance calculation. *See section 60.2 for updates regarding billing requirements for Medicare Part B preventive vaccines and their administration.*

Example: Payment based on charges with Flu and Flu administration code services

PPS rate = 160.00

Preventive Service = 135.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	150.00	150.00
0521	G0438 - PS		10/01	135.00	135.00
0636	90655 - Vaccine		10/01	15.00	15.00
771	G0008 - Admin Vaccine		10/01	5.00	5.00
0001				305.00	305.00

Payment based on charges of 150.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FSPC		10/01	150.00	150.00	150.00	0
0521	G0438 - PS		10/01	135.00	135.00	CO 97	0
0636	90655 - Vaccine ****		10/01	15.00	15.00	CO 246***	0
0771	G0008 Admin Vaccine ****		10/01	5.00	5.00	CO 246	0
0001				305.00	305.00		

Because flu and PPV are reported on the claim for information purposes only, G0438 remains as the only service payable on this claim. Because the claim consists solely of preventive services for which coinsurance is waived, the contractor will pay 100% of the provider's actual charge for the specific payment code, G0468.

*** CARC 246- This non-payable code is for required reporting only.

**** Flu/PPV are reported on the claim for information purposes only, the payment and coinsurance are not impacted by the charges associated with the Flu/PPV vaccine and their administration code.

Hepatitis B (prior to January 1, 2025)

Hepatitis B should be reported on the claim and is included in the claim payment. These services will be carved out of the coinsurance calculation.

Effective January 1, 2025, Hepatitis B is treated like flu, PPV and COVID. *See section 60.2 for updates regarding billing requirements for Medicare Part B preventive vaccines and their administration.*

Example: Payment based on charges with Hepatitis B

PPS rate= 160.00

Preventive Services = 20.00 (15.00 +5.00)

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0467 - FSPC		10/01	150.00	150.00
0521	99213 - E&M		10/01	135.00	135.00
0300	36415 - VP		10/01	5.00	5.00
0636	90746 - PS Vaccine		10/01	15.00	15.00
771	G0010 - PS Admin Vaccine		10/01	5.00	5.00
0001				310.00	310.00

Payment based on charges of 150.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0467 - FSPC		10/01	150.00	150.00	124.00	26.00
0521	99213 - E&M		10/01	135.00	135.00	CO 97	0
0300	36415 - VP		10/01	5.00	5.00	CO 97	0
0636	90746 - PS Vaccine		10/01	15.00	15.00	CO 97	0
0771	G0010 - PS Admin Vaccine		10/01	5.00	5.00	CO 97	0
0001				310.00	310.00		

Payment = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 80% + 20.00 preventive

Coinsurance = (150.00 (charges) – 20.00 (preventive service 90746 + G0010)) * 20%

Mental Health Services

Qualified mental health visits billed under revenue code 0900 receive an additional payment when billed on the same day as a medical visit.

Example: Mental Health Services

PPS RATE for G0468: $225.00

PPS rate for G0470: $160

Total of provider's actual charges for the specific payment codes representing medical visits (140.00 + 75.00 + 55.00) = 270.00- This does not include charges for G0470

Provider's charge for the specific payment code representing mental health services = 159.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	140.00	140.00
0521	G0439 - PS		10/01	135.00	135.00
0300	36415 - VP		10/01	25.00	25.00
0521	G0467 - FSPC		10/01	75.00	75.00
0521	97802 - PS		10/01	60.00	60.00
0521	G0466 - FSPC		10/01	55.00	55.00
0521	92004 - Ophthalmo-logical Exam		10/01	45.00	45.00
0900	G0470 - FSPC		10/01	159.00	159.00
0900	90832 - Psychotherapy		10/01	139.00	139.00
0636	J3490 - Injection		10/01	15.00	15.00
0001				848.00	848.00

Payment based on PPS rate of 225.00 for the specific payment codes describing the medical visits and based on the provider's actual charges for the specific payment code describing the mental health visit.

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FSPC		10/01	140.00	140.00	219.00	6.00
0521	G0439 - PS		10/01	135.00	135.00	CO 97	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0521	G0467 - FSPC		10/01	75.00	75.00	CO 97	0
0521	97802 - PS		10/01	60.00	60.00	CO 97	0
0521	G0466 - FSPC		10/01	55.00	55.00	CO 97	0
0521	92004 - Ophthalmo-logical Exam		10/01	45.00	45.00	CO 97	0
0900	G0470 - FSPC		10/01	159.00	159.00	127.20	31.80
0900	90832 - Psychotherapy		10/01	139.00	139.00	CO 97	0
0636	J3490 - Injection		10/01	15.00	15.00	CO 97	0
0001				848.00	848.00		

For Medical visit with revenue code 052X
Payment = (225.00 – (135.00 +60.00)) * 80% + 135.00 + 60.00
Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

For Mental Health visit with revenue code 0900
Payment = 159.00 *80% = 127.20
Coinsurance =159.00 * 20% = 31.80

Modifier 59

Medicare allows for an additional payment when an illness or injury occurs after the initial visit, and the FQHC bills these visits with the specific payment codes and modifier 59. Services billed with a modifier 59 will be paid an additional per diem rate

Example: Modifier 59

PPS rate for G0468 = 225.00

Total G code charges (140.00 + 75.00 + 55.00) = 270.00 – This does not include charges for G0470 and G-code charges for modifier 59

Total mental Health Services = 159.00

PPS rate for G0467 (billed with Modifier 59) = 160.00

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge
0521	G0468 - FSPC		10/01	140.00	140.00
0521	G0438 - PS		10/01	135.00	135.00
0300	36415 - VP		10/01	25.00	25.00
0521	G0467 - FSPC		10/01	75.00	75.00
0521	97802 - PS		10/01	60.00	60.00
0521	G0466 - FSPC		10/01	55.00	55.00
0521	92004 - Ophthalmological Exam		10/01	45.00	45.00
0900	G0470 - FSPC		10/01	159.00	159.00
0900	90832 - Psychotherapy		10/01	139.00	139.00
0636	J3490 - Injection		10/01	15.00	15.00
0521	G0467 - FSPC	59	10/01	165.00	165.00
0521	99211 - E&M		10/01	105.00	105.00
0001				1118.00	1118.00

Payment based on PPS rate of 225.00 for the G-codes, based on the charges for the mental health visit and based on the PPS rate for G0467 billed with modifier 59.

Appropriate Rev Code	Appropriate HCPCS Code	MOD	DOS	Total Charge	Covered Charge	Payment	Coinsurance
0521	G0468 - FSPC		10/01	140.00	140.00	219.00	6.00
0521	G0438 - PS		10/01	135.00	135.00	CO 97	0
0300	36415 - VP		10/01	25.00	25.00	CO 97	0
0521	G0467 - FSPC		10/01	75.00	75.00	CO 97	0
0521	97802 - PS		10/01	60.00	60.00	CO 97	0
0521	G0466 - FSPC		10/01	55.00	55.00	CO 97	0
0521	92004 - Ophthalmological Exam		10/01	45.00	45.00	CO 97	0
0900	G0470 - FSPC		10/01	159.00	159.00	127.20	31.80
0900	90832 - Psychotherapy		10/01	139.00	139.00	CO 97	0
0636	J3490 - Injection		10/01	15.00	15.00	CO 97	0
0521	G0467 - FSPC	59	10/01	165.00	165.00	128.00	32.00
0521	99211 - E&M		10/01	105.00	105.00	CO 97	0
0001				1118.00	1118.00		

For Medical visit with revenue code 052X
Payment = (225.00 – (135.00 +60.00)) * 80% + 135.00 + 60.00
Coinsurance = (225.00 (PPS rate) – (135.00 + 60.00)) * 20%

For Mental Health visit with revenue code 0900
Payment = 159.00 *80% = 127.20
Coinsurance =159.00 * 20% = 31.80

For G0467 billed with modifier 59
Payment = 160.00 * 80% = 128.00
Coinsurance = 160.00 * 20% = 32.00

70.3 - Preventive Vaccines

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

*Prior to July 1, 2025, i*nfluenza virus, pneumococcal, *and* COVID-19 vaccines *and their administration* did not count as RHC/FQHC visits. The cost for these vaccines *and their administration* was included in the cost report and a visit was not billed for these services. RHCs did not report vaccines on the claim, TOB 71X. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code would be reported on the claim, TOB 77X, for informational and data collection purposes only. Coinsurance and deductible did not apply to these vaccines.
Prior to January 1, 2025, payment for the hepatitis B vaccine *and its administration* was included in the RHC all-inclusive and the FQHC PPS rate. The charges of the vaccine and its administration were included in the line item for the otherwise qualifying visit. A visit could not be billed if the vaccine and its administration was the only service the RHC/FQHC provides.
Effective January 1, 2025 through June 30, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the RHC all-inclusive and FQHC PPS rate. The cost for these vaccines and their administration is included in the cost report and a visit is not billed for these services. RHCs do not report vaccines on the claim, TOB 71x. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code should be reported on the claim, TOB 77x, for informational and data collection purposes only. Coinsurance and deductible do not apply to these vaccines. Effective for dates of service on or after July 1, 2025, RHCs (bill type 71x) and FQHCs (bill type 77x), shall report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B and COVID-19 -- on the claim. 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. 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.

- *Each year, CMS updates the Seasonal Influenza Vaccines Pricing webpage 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 and FQHCs must refer to this webpage to ensure they are billing the appropriate HCPCS codes for the applicable influenza season. See the CMS Seasonal Influenza Vaccines Pricing webpage: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/vaccine-pricing*
- *Payment for the vaccine products is based on 95% of the Average Wholesale Price. See the CMS webpage with the ASP pricing files: https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files*
- *Payment for the vaccine administration is based on the National Vaccine Administration Fee Schedule. See the CMS webpage for the geographically adjusted payment rates for preventive vaccine administration: https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing*

Note: RHCs and FQHCs can bill HCPCS code M0201 for an in-home additional payment for influenza, pneumococcal, hepatitis B, COVID-19 vaccine administration, 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.

Additional information on vaccines can be found in Chapter 18, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, COVID-19, influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 13.

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.

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents

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

10.2 - Billing Requirements

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

A. Edits Not Applicable to Claims for Pneumococcal, Influenza, Hepatitis B or COVID-19 Vaccines and Administration

The Common Working File (CWF) and shared systems bypass all Medicare Secondary Payer (MSP) utilization edits in CWF on all claims when the only service provided is pneumococcal, influenza, hepatitis B or COVID-19 vaccine and/or their administration. This waiver does not apply when other services, (e.g., office visits), are billed on the same claim as pneumococcal, influenza, hepatitis B or COVID-19 vaccinations. If the provider knows, or has reason to believe that a particular group health plan covers preventive vaccines and their administration, and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

First claim development alerts from CWF are not generated for pneumococcal, influenza, hepatitis B or COVID-19 vaccine. However, first claim development is performed if other services are submitted along with pneumococcal, influenza, hepatitis B or COVID- 19 vaccines.

See Pub. 100-05, Medicare Secondary Payer Manual, chapters 4 and 5, for responsibilities for MSP development where applicable.

B Institutional Claims

Chapter 25 of this manual provides general billing instructions that must be followed for institutional claims.

The following "providers of services" may administer and submit institutional claims to the A/B MACs (A) for these vaccines:

Hospitals;

Critical Access Hospitals (CAHs); Skilled Nursing

Facilities (SNFs); Home Health Agencies (HHAs);

Hospices;

Comprehensive Outpatient Rehabilitation Facilities (CORFs);

Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities; and

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), effective for dates of service on or after July 1, 2025.

Other billing entities that may submit institutional claims are:

Independent Renal Dialysis Facilities (RDFs).

Effective for dates of service on or after July 1, 2025, RHCs and FQHCs *shall* submit institutional claims for pneumococcal, influenza, hepatitis B and COVID-19 vaccinations, with or without a visit/encounter or qualifying visit on the same day. (See §10.2.2.2 of this chapter for special instructions for independent RHCs and freestanding FQHCs.)

Institutional providers should bill for the vaccines and their administration on the same bill. Separate bills for vaccines and their administration are not required. The only exceptions to this rule occur when the vaccine is administered during the course of an otherwise covered home health visit since the vaccine, or its administration is not included in the visit charge. (See §10.2.3 of this chapter).

C Professional Claims

Billing for Additional Services

If a physician sees a beneficiary for the sole purpose of administering a Medicare covered preventive vaccine, they may not routinely bill for an office visit. However, if the beneficiary actually receives other services constituting an "office visit" level of service, the physician may bill for a visit in addition to the vaccines and their administration, and Medicare will pay for the visit in addition to the vaccines and their administration if it is reasonable and medically necessary.

Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary for the administration of the vaccines, but must submit an unassigned claim on the beneficiary's behalf. Effective for claims with dates of service on or after February 1, 2001, per §114 of the Benefits Improvement and Protection Act of 2000, all drugs and biologicals must be paid based on mandatory assignment. Therefore, regardless of whether the physician and supplier usually accept assignment, they must accept assignment for the vaccines, may not collect any fee up front, and must submit the claim for the beneficiary.

Entities, such as local health facilities, that have never submitted Medicare claims must obtain a National Provider Identifier (NPI) for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the Healthcare Common Procedure Coding System (HCPCS) code for the vaccine, and the physician or supplier (e.g., a drugstore) who actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration. This procedure results in contractors receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza virus vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the Form CMS-1500. When billing for the influenza virus vaccine only, billers should list only HCPCS code 90658 in block 24D of the Form CMS-1500. The same applies for the other Medicare covered preventive vaccinations.

In situations such as a public health emergency when vaccines are supplied at no charge to providers, entities shall submit claims for the administration of the vaccine only. For example, a provider or supplier may only submit a claim for the HCPCS code for the administration of the vaccine. If the billing systems providers and suppliers use will not allow submission of only the vaccine or only the administration, $.01 should be submitted as the charge for the service that was not provided.

The contractor shall deny claims for vaccine reimbursement costs when the vaccine has been provided at no charge to providers and suppliers.

10.2.2.1 - Payment for Pneumococcal Pneumonia Virus, Influenza Virus, Hepatitis B Virus and COVID-19 Vaccines and Their Administration on Institutional Claims

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

Payment for Vaccines

Payment for these vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than Indian Health Service (IHS) Hospitals, IHS CAHs, and Critical Access Hospitals (CAHs)	012x, 013x	Reasonable cost

IHS Hospitals	012x, 013x	95% of the AWP
IHS CAHs	012x, 085x	95% of the AWP
CAHs Method I and Method II (other than professional revenue codes)	012x, 085x	Reasonable cost
Skilled Nursing Facilities	022x, 023x	Reasonable cost
Home Health Agencies	034x	Reasonable cost
Hospices	081x, 082x	95% of the AWP
Comprehensive Outpatient Rehabilitation Facilities	075x	95% of the AWP
Independent Renal Dialysis Facilities (RDFs)	072x	95% of the AWP
Hospital-based Renal Dialysis Facilities (RDFs)	072x	Reasonable cost
Rural Health Clinics (RHCs)	71x	95% of the AWP (effective for dates of service on or after July 1, 2025) *then subsequently settled through the cost report.*
Federally Qualified Health Centers (FQHCs)	77x	95% of the AWP (effective for dates of service on or after July 1, 2025) *then subsequently settled through the cost report.*

Payment for Vaccine Administration

Payment for the administration of pneumococcal, influenza, hepatitis B and COVID-19 vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than IHS Hospitals, IHS CAHs, and CAHs	012x, 013x	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS
IHS Hospitals	012x, 013x	MPFS
IHS CAHs	012x, 085x	MPFS
CAHs Method I and Method II (other than professional revenue codes)	012x, 085x	Reasonable cost
CAHs Method II (Professional Revenue Codes 096x, 097x, 098x)	085x	MPFS
Skilled Nursing Facilities	022x, 023x	MPFS
Home Health Agencies	034x	OPPS
Hospices	081x, 082x	MPFS
Comprehensive Outpatient Rehabilitation Facilities	075x	MPFS
Independent RDFs	072x	MPFS
Hospital-based RDFs	072x	Reasonable cost
Rural Health Clinics (RHCs)	*71x*	*National Fee Schedule for Vaccine Administration* *(effective for dates of service on or after July 1, 2025)*
Federally Qualified Health Centers (FQHCs)	77x	*National Fee Schedule for Vaccine Administration* (effective for dates of service on or after July 1, 2025)

10.2.2.2- Special Instructions for Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)

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

Prior to July 1, 2025, pneumococcal, influenza and COVID-19 vaccines *and their administration did* not count as RHC/FQHC visits. The cost for these vaccines *and their administration was* included in the cost report and a visit was not billed for these services. RHCs did not report vaccines on the claim, TOB 71x. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code would be reported on the claim, TOB 77x, for informational and data collection purposes only. Coinsurance and deductible did not apply to these vaccines.

Prior to *January* 1, 2025, payment for the hepatitis B vaccine was included in the RHC all- inclusive and FQHC PPS rate. RHCs/FQHCs *did* not bill for a visit when the only service involved was the administration of the hepatitis B vaccine. However, the charges 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/FQHC provides.

Effective January 1, 2025 through June 30, 2025, payment for the hepatitis B vaccine and its administration is through the cost report and no longer included in the RHC all-inclusive and FQHC PPS rate. The cost for these vaccines and their administration is included in the cost report and a visit is not billed for these services. RHCs do not report vaccines on the claim, TOB 71x. However, for FQHCs, if there was another reason for the visit, the vaccine and the administration code should be reported on the claim, TOB 77x, for informational and data collection purposes only. Coinsurance and deductible do not apply to these vaccines.

Effective for dates of service on or after July 1, 2025, RHCs (bill type 71x) and FQHCs (bill type 77x), *shall* report all Part B preventive vaccines and their administration – pneumococcal, influenza, hepatitis B and COVID-19 -- on the claim. 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. 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.

Note: An additional payment for influenza, pneumococcal, hepatitis B, 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 and Pub. 100-04 for more information.