CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13720	**Date: May 7, 2026**
	Change Request 14449

SUBJECT: Updates to Chapter 18, Preventive and Screening Service

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 18 of the Internet-Only Manual (IOM) to: (1) replace all references to Type of Bill (TOB) 73X with TOB 77X for Federal Qualified Health Centers (FQHCs), and (2) update FDA Certification Data in Section 20.1.2.

EFFECTIVE DATE: June 9, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 9, 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	18/10/10.1.4/COVID-19 Vaccine
R	18/10/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
R	18/10/10.2.5.2/MAC (Part B) Payment Requirements
R	18/10/10.3.1.1/Centralized Billing for Influenza Virus and Pneumococcal Vaccines to A/B MACs (B)
R	18/20/20.1.2/FDA Certification Data
R	18/20/20.4.2/A/B MAC (A) Requirements for Nondigital Screening Mammographies
R	18/30/30.4.1/Payment Method for RHCs and FQHCs
R	18/40/40.6/Revenue Code and HCPCS Codes for Billing
R	18/50/50.3/Payment Method - A/B MACs (A) and (B)
R	18/50/50.4/HCPCS, Revenue, and Type of Service Codes
R	18/70/70.1.1.1/Additional Coding Applicable to Claims Submitted to A/B MACs (A)
R	18/70/70.1.1.2/Special Billing Instructions for RHCs and FQHCs
R	18/80/80.3/A/B MAC (A) Billing Requirements
R	18/110/110.3/Payment
R	18/120/120.1/Coding and Payment of DSMT Services
R	18/240/Prolonged Preventive Services Codes

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: 13720	Date: May 7, 2026	Change Request: 14449

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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update Chapter 18 of the Internet-Only Manual (IOM) to: (1) replace all references to Type of Bill (TOB) 73X with TOB 77X for Federal Qualified Health Centers (FQHCs), and (2) update FDA Certification Data in Section 20.1.2. This CR also updates the hyperlinks to correct the page not found error.

B. Policy: There is no new policy 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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14449.1	Medicare contractors shall be aware of the manual updates in Pub. 100-04, Chapter 18.	X	X							

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

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 18 - Preventive and Screening Services

10.1.4 – COVID-19 Vaccine

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

The COVID-19 vaccine and its administration are covered when furnished in compliance with any applicable State law. Effective dates for each COVID-19 vaccine can be found at *https://www.cms.gov/monoclonal*.

The COVID-19 vaccine is administered according to manufacturer's recommendations for each specific vaccine during the public health emergency declared in 2020. This recommendation is subject to change.

10.2.1 - Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

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;
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, 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

90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use

90671 Pneumococcal conjugate vaccine, 15 valent (PCV15), 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 free, for intramuscular use

90674 Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

90677 Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use

90682 Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic 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

90694 Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for us 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.

90756 Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

90759 Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use

Note: COVID-19 vaccine and administration HCPCS are temporarily posted at: *https://www.cms.gov/monoclonal.*

Note: For the Medicare-covered codes for the influenza vaccines approved by the Food and Drug Administration (FDA) for the current influenza vaccine season, please go to: *https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price*.

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:** 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.

NOTE: COVID-19 vaccine and administration HCPCS are temporarily posted at: *https://www.cms.gov/monoclonal*.

The following diagnosis code must be reported. 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.

ICD-10-CM Diagnosis Code	**Description**
Z23	Encounter for Immunization

NOTE: ICD-10-CM diagnosis code Z23 is to be used for all encounters for preventive vaccine immunizations, including COVID-19 immunizations.

The following condition code must be reported on institutional claims when diagnosis code Z23 is required for a vaccination.

Condition Code	**Description**
A6	*Vaccine / Medicare 100% Payment*

All claims must have the appropriate diagnosis code, procedure, and admin code to process correctly.

10.2.5.2 - MAC (Part B) Payment Requirements

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

Payment for Medicare covered preventive vaccines, including the recently developed COVID-19 vaccines, follows the same standard rules that are applicable to any injectable drug or biological.

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of Medicare covered preventive vaccines, must accept assignment for the vaccine.

Prior to March 1, 2003, the administration of pneumococcal, influenza virus, and hepatitis B vaccines, (HCPCS codes G0008, G0009, and G0010), though not reimbursed directly through the MPFS, were paid at the same rate as HCPCS code 90782 on the MPFS for the year that corresponded to the date of service of the claim.

For dates of service on or after March 1, 2003 through December 31, 2021, payment rates for HCPCS G0008, G0009, and G0010 were paid at the same rate as similar services on the MPFS determined through notice-and-comment rulemaking. These payment amounts were determined on an annual basis and MACs were notified accordingly.

Beginning January 1, 2022, the national payment rate for HCPCS G0008, G0009, and G0010 is $30. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for HCPCS G0008, G0009, and G0010 are available of the CMS website: *https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.*

Beginning January 1, 2022 and through the end of the calendar year in which the PHE for COVID-19 ends, the national payment rate for the administration of COVID-19 vaccines is $40. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for the administration of COVID-19 vaccines are available of the CMS website: *https://www.cms.gov/monoclonal*.

Effective January 1 of the year following the year in which the PHE for COVID-19 ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program.

MACs (Part B) may not apply the limiting charge provision for pneumococcal, influenza virus , hepatitis B, or COVID-19 vaccines and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Social Security Act (the Act.)

The vaccine and administration of the pneumococcal and influenza virus, and COVID-19 vaccine is covered in §1861(s)(10)(A) of the Act; §1861(s)(10)(B) includes the hepatitis B vaccine and administration rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent Health Professional Shortage Area (HPSA) incentive payment or the 5 percent Physician Scarcity Area (PSA) incentive payment.

No Legal Obligation to Pay

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 16.) Thus, for example, Medicare may not pay for influenza virus vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128(b)(6)(A) of the Act.) When an employer offers free vaccinations to its employees, it must also offer the free vaccination to an employee who is also a Medicare beneficiary. It does not have to offer free vaccinations to its non-Medicare employees.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as PHCs) may bill Medicare for pneumococcal, hepatitis B, influenza virus, and COVID-19 vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries. Government entities may NOT bill Medicare for vaccine products during a public health emergency when vaccines are provided at no charge to Medicare and non-Medicare beneficiaries.

10.3.1.1 - Centralized Billing for Influenza Virus and Pneumococcal Vaccines to A/B MACs (B)

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

C. Enrollment

COVID-19 Mass Immunizer Centralized Biller Enrollment
For more information on enrolling as a COVID-19 mass immunizer centralized biller go to: *https://www.cms.gov/medicare/payment/covid-19-vaccine-toolkit/medicare-billing-covid-19-vaccine-shot-administration.*

F. Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments vary based on the geographic locality where the service was performed.

The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, prior to March 1, 2003, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated contractor must pay per the correct MPFS file for each calendar year based on the date of service of the claim. Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471.

Effective for claims with dates of service January 1, 2020 through December 31, 2021, the payment rates for G0008, G0009, and G0010, rather than being linked to the MPFS payment rate for 90471, they were to be paid at the same rate as they had been in 2019.
Beginning January 1, 2022, the national payment rate for HCPCS G0008, G0009, and G0010 is $30. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for HCPCS G0008, G0009, and G0010 are available of the CMS website: *https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price*.

Beginning January 1, 2022 and through the end of the calendar year in which the PHE for COVID-19 ends, the national payment rate for the administration of COVID-19 vaccines is $40. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for the administration of COVID-19 vaccines are available of the CMS website: *https://www.cms.gov/monoclonal*.

Effective January 1 of the year following the year in which the PHE for COVID-19 ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

In order to pay claims correctly for centralized billers, the designated contractor must have the correct name and address, including ZIP code, of where the service was provided.

The following remittance advice and Medicare Summary Notice (MSN) messages apply:

> **Claim adjustment reason code 16**, “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code,
>
> **Remittance advice remark code MA114**, “Missing/incomplete/invalid information on where the services were furnished.”
>
> **MSN 9.4** - “This item or service was denied because information required to make payment was incorrect.”

The payment rates for the vaccines must be determined by the standard method used by Medicare for reimbursement of drugs and biologicals. (See chapter 17 for procedures for determining the payment rates for vaccines.)

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers Medicare covered preventive must accept assignment for the vaccine. In addition, as a requirement for both centralized billing and roster billing, providers must agree to accept assignment for the administration of the vaccines as well. This means that they must agree to accept the amount that Medicare pays for the vaccine and the administration. Also, since there is no coinsurance or deductible for the influenza, pneumococcal, and COVID-19 vaccine benefits, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

I. Provider Education Instructions for All MACs (Part B)

By XXXX of every year, all MACs (Part B) must publish in their bulletins and put on their Web sites the following notification to providers. Questions from interested providers should be forwarded to Novitas, the designated processing Part B MAC for the centralized billing workload at the address below. MACs (Part B) must enter the name of the assigned processing contractor where noted before sending.

NOTIFICATION TO PROVIDERS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and pneumococcal pneumonia virus (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in influenza and pneumococcal centralized billing must contact Novitas, to begin centrally billing for influenza and pneumococcal vaccines.

Applications to become a mass immunizer centralized biller for the COVID-19 vaccine is an ongoing enrollment. Individuals and entities can submit a request to become a centralized mass immunizer at any time. For more information on enrolling as a COVID-19 mass immunizer centralized biller go to: *https://www.cms.gov/medicare/payment/covid-19-vaccine-toolkit/medicare-billing-covid-19-vaccine-shot-administration*.

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

CRITERIA FOR CENTRALIZED BILLING

- To qualify for centralized billing, an individual or entity providing mass vaccination services for influenza virus, pneumococcal, and COVID-19 vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.

- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.

- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore.

  NOTE: The practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is [Fill in name of contractor.]

- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.

- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.

- Centralized billers must submit their claims on roster bills in an approved electronic format. **Paper claims will not be accepted.**

- Centralized billers must obtain certain information for each beneficiary including name, MBI number, date of birth, sex, and signature. [The designated Part B MAC] must be contacted prior to submitting claims for verification of billing requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the contractor will not be able to process incomplete or incorrect claims.

- Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary by the Part B MAC. Beneficiaries are sometimes confused when they receive an MSN from a Part B MAC other than the MAC that normally processes their claims which results in unnecessary beneficiary inquiries. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing Part B MAC. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. [The designated Part B MAC] can provide this information.

- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from [The designated Part B MAC]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [The designated Part B MAC].

  NOTE: Influenza/Pneumococcal Mass Immunizer Centralized Billers **DO NOT** need to enroll separately as a COVID-19 Mass Immunizer Centralized Biller to administer COVID-19 vaccine shots.

- If an individual or entity's request for centralized billing of influenza, pneumococcal, and/or COVID-19 vaccines is approved, the approval is ongoing. Claims will not be processed for any influenza, pneumococcal, or COVID-19 centralized biller without approval from the designated Part B MAC.

- Each year the centralized biller must contact the designated Part B MAC to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.

- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

- The information in items 1 through 8 below must be included with the individual or entity's annual request to participate in centralized billing:

  1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;

  2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;

  3. Estimates for the number of beneficiaries who will receive COVID-19 vaccinations (if applicable);

4. The approximate dates for when the vaccinations will be given;

5. A list of the states in which influenza, pneumococcal, and COVID-19 vaccination clinics will be held;

6. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);

7. Whether the nurses who will administer the influenza, and pneumococcal, and COVID-19 vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza, pneumococcal, and COVID-19 vaccinations;

8. Names and addresses of all entities operating under the corporation's application (not clinic locations);

9. Contact information for designated contact person for centralized billing program.

20.1.2 - FDA Certification Data

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

The FDA furnishes data to CMS on a weekly basis, which specify the certification of facilities under the MQSA. This data *is* contained in *the* "MQSA file".

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. The new digital mammography codes have a higher payment rate. In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, CMS relies upon the FDA certification data contained in the MQSA file. The FDA sends an updated file via the CMS Mainframe Telecommunications System (CMSTS), formerly Network Data Mover, on a weekly basis.

*T*he MQSA file shows:

- Name of Facility,
- *Address,*
- Certification number of the facility,
- *Type of certification indicator (film, digital and three-dimensional (3-D) imaging)*,
- Effective and Expiration dates of each certification,
- Letter "T" to designate the facility as terminated,

Some mammography facilities are certified to perform film, digital *and 3-D* mammography. In this case, the facility's *information will appear on the MQSA file with the appropriate indicator field(s) populated.*

NOTE: The FDA does not issue printed certification. Refer to the MQSA file for proof of types of mammography the facility is certified to perform.

If the MQSA file appears to be in error, contact your regional office mammography coordinator. The coordinators will contact the FDA to research the apparent error.

20.4.2 - A/B MAC (A) Requirements for Nondigital Screening Mammographies

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

The A/B MAC (A) will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code 77067* (G0206*);
- Presence of high risk diagnosis code indicator where appropriate;
- Date of last screening mammography; and
- Age of beneficiary.

The A/B MACs (A) must accept revenue code 0403 for bill types 13X, 22X, 23X, 71X, *77X*, or 85X.
* For claims with dates of service January 1, 2017 thru December 31, 2017 providers report HCPCS code G0206. For claims with dates of service January 1, 2018 and later, providers report CPT code 77067.

30.4.1 - Payment Method for RHCs and FQHCs

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

The professional component of a screening Pap smear furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or *77X* for the professional component along with revenue code 052X. See Chapter 9, for RHC and FQHC bill processing instructions.

The technical component of a screening Pap smear is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the A/B MAC (B) on Form CMS-1500.

If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the A/B MAC (A) under bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 311. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

40.6 - Revenue Code and HCPCS Codes for Billing

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

A. Billing to the A/B MAC (B)

Code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination) is used.

Effective for services on or after January 1, 1999, a covered evaluation and management (E/M) visit and code G0101 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

B. Billing to the A/B MAC (A)

The applicable bill types for a screening pelvic examination (including breast examination) are 12X, 13X, 22X, 23X, and 85X. The applicable revenue code is 0770. (See §70.1.1.2 for RHCs and FQHCs.) Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.

The professional component of a screening pelvic examination furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or *77X* for the professional component along with revenue code 052X.

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the A/B MAC (B) on the ASC X12 837 professional claim format or hardcopy Form CMS-1500.

If the technical component of a screening pelvic examination is furnished within a provider-based RHC/FQHC, the provider of that service bills the A/B MAC (A) under bill type 12X, 13X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770. Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.

50.3 - Payment Method - A/B MACs (A) and (B)

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

Screening PSA tests (G0103) are paid under the clinical diagnostic lab fee schedule.

Screening PSA tests (Effective 01/01/23 (0359U)) new codes are contractor-priced (where applicable) until they are nationally priced and undergo the CLFS annual payment determination process.

Screening rectal examinations (G0102) are paid under the MPFS except for the following bill types identified (A/B MAC (A) only). Bill types not identified are paid under the MPFS.

12X = Outpatient Prospective Payment System *(PPS)*
13X = Outpatient *PPS*
14X-=Outpatient *PPS*
71X = Included in All Inclusive Rate
77X = Included in *FQHC PPS*
85X = Cost (Payment should be consistent with amounts paid for code 84153 or code 86316.)

Effective 4/1/06 the type of bill 14X is for non-patient laboratory specimens.

The RHCs and FQHCs should include the charges on the claims for future inclusion in encounter rate calculations.

50.4 - HCPCS, Revenue, and Type of Service Codes

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

The appropriate bill types for billing the A/B MAC (A) on Form CMS-1450 or its electronic equivalent are 12X, 13X, 14X, 22X, 23X, 71X, *77X*, 75X, and 85X. Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

The HCPCS code G0102 - for prostate cancer screening digital rectal examination.

- A/B MAC (B) TOS is 1
- A/B MAC (A) revenue code is 0770

The HCPCS code G0103 - for prostate cancer screening PSA tests

- A/B MAC (B) TOS is 5
- A/B MAC (A) revenue code is 030X

The HCPCS code 0359U – (PROSTATE CANCER), ANALYSIS OF ALL PROSTATE-SPECIFIC ANTIGEN (PSA) STRUCTURAL ISOFORMS BY PHASE SEPARATION AND IMMUNOASSAY, PLASMA, ALGORITHM REPORTS RISK OF CANCER. Effective 01/01/23.

- A/B MAC (B) TOS is 5
- A/B MAC (A) revenue code is 030X

70.1.1.1 - Additional Coding Applicable to Claims Submitted to A/B MACs (A)

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

A. Type of Bill

The applicable A/B MAC (A) claim bill types for screening glaucoma services are 13X, 22X, 23X, 71X, *77X*, 75X, and 85X. (See instructions below for rural health clinics (RHCs) and federally qualified health centers (FQHCs).)

B. Revenue Coding

The following revenue codes should be reported when billing for screening glaucoma services: Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), and skilled nursing facilities (SNFs) bill for this service under revenue code 0770. CAHs electing the optional method of payment for outpatient services also report this service under revenue codes 096X, 097X, or 098X. Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 0770. (See instructions below for RHCs and FQHCs.)

70.1.1.2 - Special Billing Instructions for RHCs and FQHCs

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

Screening glaucoma services are considered RHC/FQHC services. For claims with dates of service before April 1, 2005, RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or *77X* along with revenue code 0770 and HCPCS codes G0117 or G0118 and RHC/FQHC revenue code 0520 or 0521 to report the related visit. Reporting of revenue code 0770 and HCPCS codes G0117 and G0118 in addition to revenue code 0520 or 0521 is required for this service in order for CWF to perform frequency editing. Payment should not be made for a screening glaucoma service unless the claim also contains a visit code for the service. A/B MACs (A) must edit to assure payment is not made for revenue code 0770. The claim must also contain a visit revenue code (0520 or 0521). Payment is made for the screening glaucoma service under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0770.

Screening glaucoma services furnished within an RHC/FQHC by a physician or nonphysician are considered RHC/FQHC services. For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the A/B MAC (A) under bill type 71X or *77X* for the service. Payment is made under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the service. Use revenue code 0520 or 0521, as appropriate.

80.3 - A/B MAC (A) Billing Requirements

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

A/B MACs (A) will pay for IPPE or EKG only when the services are submitted on one of the following TOBs: 12X, 13X, 22X, 71X, *77X* and 85X.

Type of facility and setting determines the basis of payment:

- For the IPPE or the screening EKG tracing only performed on a 12X and 13X TOB, hospital inpatient Part B and hospital outpatient, for hospitals subject to the outpatient prospective payment system (OPPS), under the OPPS. Hospitals not subject to OPPS shall be paid under current methodologies.

- For services performed on an 85X TOB, Critical Access Hospitals (CAHs), pay on reasonable cost.

- For services performed in a skilled nursing facility, TOB 22x, make payment for the technical component of the EKG based on the MPFS.

- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

- For services performed on a 12X TOB, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.

- For services performed on a 13X TOB, IHS hospitals, payment is made based on the all-inclusive rate (AIR).

- For services performed on an 85X TOB, IHS CAHs, payment is made based on an all-inclusive facility specific per visit rate.

All CAHs are paid for the technical or facility component of the IPPE itself. They are also paid for the technical component of the EKG, the tracing only, if the EKG is performed. Only CAHs paid under the optional method are paid for the professional component of the IPPE itself (in addition to the facility payment) for charges under revenue code 0960. If the EKG is performed, CAHs paid under the optional method may also be paid for the interpretation of the EKG (in addition to the payment for the tracing) when billed under revenue codes 0985 or 0986.

110.3 - Payment

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

If the screening is provided in a physician office, the service is billed to the A/B MAC (B) using the HCPCS code identified in section 110.3.2 below. Payment is under the Medicare Physicians Fee Schedule (MPFS).

A/B MACs (A) shall pay for the AAA screening only when the services are performed in a hospital, including a critical access hospital (CAH), Indian Health Service (IHS) Facility, Skilled Nursing Facility (SNF), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC) and submitted on one of the following types of bills (TOBs): 12X, 13X, 22X, 23X, 71X, *77X*, 85X.

The following describes the payment methodology for AAA Screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12X, 13X	OPPS
Method I and Method II Critical Access Hospitals (CAHs)	12X and 85X	101% of reasonable cost

Facility	Type of Bill	Payment
IHS providers	13X, revenue code 051X	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12X, revenue code 024X	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85X, revenue code 051X	101% of the all-inclusive facility specific per visit rate
IHS CAHs	12X, revenue code 024X	101% of the all-inclusive facility specific per diem rate
SNFs **	22X, 23X	Non-facility rate on the MPFS
RHCs*	71X, revenue code 052X	All-inclusive encounter rate
FQHCs*	77X, revenue code 052X	*FQHC PPS*
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	94% of provider submitted charges or according to the terms of the Maryland Waiver

* If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the A/B MAC (A) using TOBs 71X and *77X*, respectively, and the appropriate site of service revenue code in the 052X revenue code series.

If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the A/B MAC (B) under the practitioner's ID following instructions for submitting practitioner claims to the Medicare A/B MAC (B).

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the A/B MAC (A) under the base provider's ID, following instructions for submitting claims to the A/B MAC (A) from the base provider.

** The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22X bill type. Screening services provided by other provider types must be reimbursed by the SNF.

120.1 - Coding and Payment of DSMT Services

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

The following HCPCS codes are used to report DSMT:

- G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes.

- G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

The type of service for these codes is 1.

Payment to physicians and providers for outpatient DSMT is made as follows:

Type of Facility	**Payment Method**	**Type of Bill**
Physician (billed to the A/B MAC (B))	MPFS	NA
Hospitals subject to OPPS	MPFS	12X, 13X
Method I and Method II Critical Access Hospitals (CAHs) (technical services)	101% of reasonable cost	12X and 85X
Indian Health Service (IHS) providers billing hospital outpatient Part B	OMB-approved outpatient per visit all inclusive rate (AIR)	13X
IHS providers billing inpatient Part B	All-inclusive inpatient ancillary per diem rate	12X
IHS CAHs billing outpatient Part B	101% of the all-inclusive facility specific per visit rate	85X
IHS CAHs billing inpatient Part B	101% of the all-inclusive facility specific per diem rate	12X
FQHCs*	*FQHC PPS* with other qualified services. Separate visit payment available with HCPCS.	*77X*
Skilled Nursing Facilities **	MPFS non-facility rate	22X, 23X
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	94% of provider submitted charges in accordance with the terms of the Maryland Waiver	12X, 13X

Type of Facility	Payment Method	Type of Bill
Home Health Agencies (can be billed only if the service is provided outside of the treatment plan)	MPFS non-facility rate	34X

* Effective January 1, 2006, payment for DSMT provided in an FQHC that meets all of the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB *77X*, with HCPCS G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

** The SNF consolidated billing provision allows separate part B payment for training services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22 bill type. Training services provided by other provider types must be reimbursed by X the SNF.

NOTE: An ESRD facility is a reasonable site for this service, however, because it is required to provide dietician and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement. Likewise, an RHC is a reasonable site for this service, however it must be provided in an RHC with other qualifying services and paid at the all-inclusive encounter rate.

Deductible and co-insurance apply.

240 - Prolonged Preventive Services Codes

(Rev. 13720; Issued: 05-07-26; Effective: 06-09-26; Implementation: 06-09-26)

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services (PPS) may be reported as an add-on to a covered preventive service that is payable from the Medicare Physician Fee Schedule. PPS codes are treated as a preventive service and both coinsurance and deductible do not apply when billed with a covered preventive service which is part of a particular subset of procedure codes listed at *https://www.cms.gov/medicare/payment/fee-schedules/physician/preventive-services*.

Effective for claims with dates of service on or after September 30, 2024:

A. Contractors shall accept and pay for PrEP for HIV claims using antiretroviral drugs (HCPCS J0739, J0799, J0750, or J0751) approved by the US Food and Drug Administration (FDA) to prevent HIV infection in individuals at increased risk of HIV acquisition using one of the diagnosis codes listed in 250.2(D).

Contractors shall accept and pay for up to (8) counseling sessions related to PrEP for

HIV medications every 12 months using HCPCS G0011or G0013.

Contractors shall not apply the deductible or co-insurance for PrEP claims for HIV prevention medications or related services, including counseling, HIV and HBV screening.

B. *Contractors shall pay for code G0011 on 085X TOB claims submitted with revenue code 96x, 97x, or 98x.*

NOTE: Payment is based on 115% of the Medicare Physician Fee Schedule.

C. *Contractors shall pay code G0011 on Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) claims. RHCs shall bill G0011 with a -CG Modifier and payment is at the all-inclusive rate (AIR). FQHCs shall bill G0011 along with the appropriate FQHC specific payment code (G0466 or G0467). Payment is at the lessor of charges or the FQHC PPS rate. PrEP for HIV Counseling HCPCS Code G0011 is considered a visit for RHCs and FQHCs when furnished by an RHC or FQHC Practitioner.*

D. *Contractors shall accept and pay up to eight HIV screening tests (codes G0432 - Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening; G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening; G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening; G0475 - Hiv antigen/antibody, combination assay, screening; or 80081 – Organ Disease Oriented Panel) every 12 months when providing individual counseling for PrEP for HIV.*

E. *Contractors shall accept and pay a single Hep B Virus (HBV) screening test (codes G0499, 87340, 87341, 86704, 86706) for individuals being assessed for or using PrEP to prevent HIV. This is a once per life-time allowance.*

NOTE: *A single (one-time) screening for HBV is available under this NCD. NCD 210.6 Screening for Hepatitis B Virus (HBV) Infection is a separate benefit and continues to apply to eligible beneficiaries*

F. *Contractors shall only allow payment for supplying fees if billed on the same claim as the payable covered drug. RHCs and FQHCs do not need to enroll as a Medicare Part B pharmacy supplier or a DMEPOS pharmacy supplier to bill for PrEP for HIV drugs.*

G. *Deductible and coinsurance do not apply.*