

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal: 12974</b>	<b>Date: November 21, 2024</b>
	<b>Change Request 13860</b>

**SUBJECT: Manual Update for Pneumococcal Vaccine for 21-Valent Conjugate Vaccine**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Chapter 18, sections 1.2, 10.2.1, 10.4.1, 10.4.2, and 10.4.3 of the Medicare Claims Processing Manual Pub. 100-04 to include the Pneumococcal Vaccine 21.

**EFFECTIVE DATE: June 17, 2024**

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

**IMPLEMENTATION DATE: February 26, 2025**

*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.*

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	18/1/1.2/Table of Preventive Screening Services
R	18/10/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
R	18/10/10.4.1/CWF Edits on MAC (Part A) Claims
R	18/10/10.4.2/CWF Edits on MAC (Part B) Claims
R	18/10/10.4.3/CWF Crossover Edits for A/B MAC (B) Claims

**III. FUNDING:**

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

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

**IV. ATTACHMENTS:**

**Business Requirements  
Manual Instruction**

# Attachment - Business Requirements

<b>Pub. 100-04</b>	<b>Transmittal: 12974</b>	<b>Date: November 21, 2024</b>	<b>Change Request: 13860</b>
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**II. GENERAL INFORMATION**

**A. Background:** The purpose of this Change Request (CR) is to update Chapter 18, sections 1.2, 10.2.1, 10.4.1, 10.4.2, and 10.4.3 of the Medicare Claims Processing Manual Pub. 100-04 to include the Pneumococcal Vaccine 21 code 90684.

**B. Policy:** NA

**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	
13860.1	The Medicare Contractors shall be aware of the manual updates in Pub 100-04:  Chapter 18, sections 1.2, 10.2.1, 10.4.1, 10.4.2, and 10.4.3.	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:
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**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**

### **Table of Contents**

*(Rev.12974; Issued: 11-21-24)*

**1.2 – Table of Preventive and Screening Services**

*(Rev.12974; Issued: 11-21-24; Effective: 01-17-24; Implementation: 02-26-25)*

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	<b>*Not Rated</b>	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived

<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
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Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	<b>B</b>	WAIVED
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	<b>B</b>	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	<b>A</b>	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	<b>B</b>	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>

	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	<b>*Not Rated</b>	WAIVED
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Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	<b>*Not Rated</b>	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	<b>B</b>	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
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	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	<b>B</b>	WAIVED
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	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A	WAIVED

	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	A	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	A	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	A	WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	A	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED

	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	<b>A</b>	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	<b>B</b>	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	<b>B</b>	WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	77067	Screening mammography, bilateral (2-view study of each breast), including computer- aided detection (CAD) when performed		WAIVED

Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	<b>B</b>	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED

<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment.		WAIVED

	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
<p><b>NOTE:</b> Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.</p>				
<p>Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.</p>				
<p>For dates of service in calendar year (CY) 2023 through CY 2026, when the PT modifier is appended to at least one code on the claim to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, contractors shall continue to waive deductible, and shall apply a reduced coinsurance of 15% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service in CY 2027 through CY 2029, contractors shall continue to waive deductible and shall apply a reduced coinsurance of 10% for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim. For dates of service on or after January 1, 2030, contractors shall continue to waive deductible and shall waive coinsurance for all procedure codes that meet the requirements stated above and are performed on that date of service and billed on the same claim.</p>				
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED

	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	<b>*Not Rated</b>	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	<b>A</b>	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
	81528	Oncology (colorectal) screening, quantitative real - time target and signal amplification of 10 DNA markers		WAIVED
	G0327	Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk		WAIVED
	G0102	Prostate cancer screening; digital rectal examination	<b>D</b>	Not Waived

Prostate Cancer Screening	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived

Influenza Virus Vaccine		For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to: <a href="https://www.cms.gov/medicare/payment/prior-coverage/rt-b-drugs/vaccine-pricing">https://www.cms.gov/medicare/payment/prior-coverage/rt-b-drugs/vaccine-pricing</a>		
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	B	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED

	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6- 35 months of age, for intramuscular use		WAIVED

	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED

	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED

	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED

	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use		WAIVED
	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Pneumococcal Vaccine	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	<b>B</b>	WAIVED
	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use		WAIVED
	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use		WAIVED
	<i>90684</i>	<i>Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use</i>		<i>WAIVED</i>
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>

Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	<b>A</b>	WAIVED
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	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED

	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	<b>A</b>	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	<b>B</b>	WAIVED

<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening	A	WAIVED
	G0433	Infectious agent antigen detection by enzyme- linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED

	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV- 2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	A	WAIVED
<b>Service</b>	<b>CPT/ HCPCS</b>	<b>Long Descriptor</b>	<b>USPSTF Rating</b>	<b>Coins./ Deductible</b>
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	*Not Rated	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED

Intensive Behavioral	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	<b>B</b>	WAIVED
Therapy for Obesity	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	<b>B</b>	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		
COVID-19 Vaccine	See link	<i>For the Medicare-covered codes for the COVID vaccines approved by FDA for the current vaccine season, please go to: <a href="https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing">https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing</a></i>		WAIVED

### 10.2.1 - Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes (Rev.12974; Issued: 11-21-24; Effective: 01-17-24; Implementation: 02-26-25)

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
- 90684 Pneumococcal conjugate vaccine, 21 valent (PCV21), 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 use in individuals 2 years or older, for subcutaneous or intramuscular use;
- 90739 Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use
- 90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
- 90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use; and
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.
- 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/medicare/payment/part-b-drugs/vaccine-pricing>

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/flu-provider>

The following codes are for reporting administration of the vaccines only. The administration of the vaccines is billed using:

<b>HCPCS</b>	<b>Definition</b>
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/medicare/payment/part-b-drugs/vaccine-pricing>

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.

<b>ICD-10-CM Diagnosis Code</b>	<b>Description</b>
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.

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

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

***(Rev.12974; Issued: 11-21-24; Effective: 01-17-24; Implementation: 02-26-25)***

In order to prevent duplicate payment by the same MAC (Part A), CWF edits by line item on the MAC (Part A) number, the Medicare Beneficiary Identifier (MBI) number, and the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and the pneumococcal procedure codes 90670, 90671, 90677, **90684**, or 90732, and the administration code, G0008 or G0009 .

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.
2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, **90684**, or 90732 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.
3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and same procedure code, the second claim submitted *to CWF rejects* when all four items match.

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

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

***(Rev.12974; Issued: 11-21-24; Effective: 01-17-24; Implementation: 02-26-25)***

In order to prevent duplicate payment by the same MAC (Part B), CWF will edit by line item on the MAC (Part B) number, the MBI number, the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal procedure codes 90670, 90671, 90677, **90684**, or 90732; and the administration code G0008 or G0009.

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF will reject.
2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, **90684**, or 90732 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.
3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and same procedure code, the second claim submitted *to CWF will reject*.

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

In order to prevent duplicate payment by the centralized billing contractor and local MAC (Part B), CWF will edit by line item for MAC (Part B) number, same MBI number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal virus procedure codes 90670, 90671, 90677, **90684**, or 90732; and the administration code G0008 or G0009.

**1.** If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with a different MAC (Part B) number, but same MBI number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, **90684**, or 90732 and it already has on record a claim with the same MBI number, different MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.
3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different MAC (Part B) number, but the same MBI number, same date of service, and same procedure code, the second claim submitted *to CWF will reject*.

CWF will return a specific reject code for these edits. MACs (Part B) must deny the second claim. The reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

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

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

### **EDITS FOR CLAIMS SUBMITTED TO THE CENTRALIZED BILLING PROCESSING MAC (PART B) AND THE LOCAL MAC (PART B)**

In order to prevent duplicate payment by the centralized billing contractor and local MAC (Part B), CWF will edit by line item for MAC (Part B) number, same MBI number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal virus procedure codes 90670, 90671, 90677, **90684**, or 90732; and the administration code G0008 or G0009.

- 1) If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with a different MAC (Part B) number, but same MBI number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.
- 2) If CWF receives a claim with HCPCS codes 90670, 90671, 90677, **90684**, or 90732 and it already has on record a claim with the same MBI number, different MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.
- 3) If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different MAC (Part B) number, but the same MBI number, same date of service, and same procedure code, the second claim submitted *to CWF will reject*.

CWF will return a specific reject code for these edits. MACs (Part B) must deny the second claim. The reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

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

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

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

***(Rev.12974; Issued: 11-21-24; Effective: 01-17-24; Implementation: 02-26-25)***

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

CWF will edit on the beneficiary MBI number; the date of service; the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal procedure codes 90670, 90671, 90677, **90684**, or 90732; and the administration code G0008 or G0009.

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