CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11355	**Date: April 14, 2022**
	Change Request 12634

SUBJECT: Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates

I. SUMMARY OF CHANGES: This change request (CR) will update the claims processing and benefits policy manual to add data for claims processing of novel Coronavirus (COVID-19). Additional updates to Chapter 18, Section 10 of the claims processing manual include:

- removing duplicate data

- revising the centralized billing enrollment process to streamline provider enrollment

- reordering and/or removing data

EFFECTIVE DATE: May 16, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 16, 2022

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/Table of Contents
R	18/10/1.2/Table of Preventive and Screening Services
R	18/10/Pneumococcal Pneumonia, Influenza Virus, Hepatitis B, and Coronavirus Disease (COVID-19) Vaccines and Administration
R	18/10/10.1/Coverage Requirements
N	18/10/10.1.4/COVID-19 Vaccine
R	18/10.2/Billing Requirements
R	18/10.2/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes
N	18/10/10.2/10.2.1.1/Claims Received with Missing Data
R	18/10/10.2/10.2.2/Claims Submitted to MACs Using Institutional Formats
R	18/10/10.2/10.2.2.1/Payment for Pneumococcal Pneumonia Virus, Influenza Virus, Hepatitis B Virus and, COVID-19 Vaccines and Their Administration on Institutional Claims
R	18/10/10.2/10.2.2.2/Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)
R	18/10/10.2/10.2.3/Institutional Claims Submitted by Home Health Agencies and Hospices
R	18/10/10.2/10.2.4/Payment Procedures for Renal Dialysis Facilities (RDF)
R	18/10/10.2/10.2.4.1 - Hepatitis B Vaccine Furnished to ESRD Patients
R	18/10/10.2/10.2.5/Claims Submitted to MACs (Part B)
R	18/10/10.2/10.2.5.1/MAC (Part B) Indicators for the Common Working File (CWF)
R	18/10/10.2/10.2.5.2/MAC (Part B) Payment Requirements
R	18/10/10.3/Simplified Roster Claims for Mass Immunizers
R	18/10/10.3/10.3.1/Roster Claims Submitted to MACs (Part B) for Mass Immunization
R	18/10/10.3/10.3.1.1/Centralized Billing for Influenza, Pneumococcal and COVID-19 Virus Vaccinations to MACs (Part B)
R	18/10/10.3/10.3.2 - Claims Submitted to MACs (Part A) for Mass Immunizations of Influenza, Pneumococcal, and/or COVID-19 Virus Vaccinations
R	18/10/10/3/10.3.2/10.3.2.1 - Simplified Billing for Influenza, Pneumococcal and COVID-19 Virus Vaccination Services by HHAs
R	18/10/10.3/10.3.2/10.3.2.2 - Hospital Inpatient Roster Billing
R	18/10/10.3/10.3.2.3 - Electronic Roster Claims
D	18/10/10.4/CWF Edits

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/10/10.4/10.4.1 – CWF Edits on MAC (Part A) Claims
R	18/10/10/4/10.4.2/CWF Edits on MAC (Part B) Claims
R	18/10/10.4/10.4.3/CWF Crossover Edits for MAC (Part B) Claims
D	18/10/10.5/Medicare Summary Notice (MSN)

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: 11355	Date: April 14, 2022	Change Request: 12634

SUBJECT: Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates

EFFECTIVE DATE: May 16, 2022

**Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: On March 11, 2020, the World Health Organization declared the Novel Coronavirus Disease COVID-19 as an infectious disease. On March 13, 2020, a national emergency was declared in the United States concerning the COVID-19 pandemic.

In response to the COVID-19 public health emergency, CMS created new Category II Healthcare Common Procedure Coding System (HCPCS) codes for COVID-19 vaccines and their administration. The purpose of this change request (CR) is to establish payment processing instructions for the COVID-19 (hereafter referred to as COVID-19) vaccines and their administration. Medicare payments for the COVID-19 vaccines and their administration will be made in the same manner as influenza and pneumococcal vaccines. This manual instruction will also remove duplicate data/language, update outdated language, and streamline the approval process for Medicare centralized billers for flu, pneumococcal, and COVID-19 in Medicare Claims Processing Manual, Chapter 18, Section 10 as appropriate.

The CR will also update the Benefit Policy Manual, Publication 100-02, Chapter 15 to establish benefit policy guidance for COVID-19 vaccine coverage.

B. Policy: Pursuant to Section 3713 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), once the Food and Drug Administration has approved a COVID-19 vaccine, the vaccine, and its administration, will be added to the list of preventive vaccines that are covered under Medicare Part B without coinsurance or deductible. The CARES Act provision amended Section 1861(s)(10)(A) of the Social Security Act.

II. 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	
12634 - 04.1	Contractors shall update operational procedures, as necessary, to accommodate the following revisions to Chapter 18 of the Medicare Claims Processing	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Manual: - Modify existing preventive vaccine services language to add COVID-19 vaccines, COVID-19 vaccine administration, and resource hyperlinks; - Establish a subsection with background information related specifically to the COVID-19 vaccine benefit; - Modify instructions for roster billing and mass immunizer centralized billing to add the COVID-19 vaccines and COVID-19 mass immunizer roster billers; - Modify the mass immunizer centralized billing approval process to transfer and streamline the complete approval process to the designated Medicare Administrative Contractor; and - Revise dated information									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12634 - 04.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Charles Nixon, 410-786-9183 or charles.nixon@cms.hhs.gov , Bridgitte Davis-Hawkins, 410-786-4573 or bridgitte.davis-hawkins@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 11355, Issued:04-14-22)

1.2 – Table of Preventive and Screening Services

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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	***Not Rated**	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

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible

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**	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**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	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**	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	WAIVED
Diabetes Self-Management Training	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived

Services (DSMT)	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**	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**
	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**	WAIVED
	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
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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	**A**	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**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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**	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

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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

NOTE:

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.

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.

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	***Not Rated**	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	**A**	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 (KRAS mutations		WAIVED
	G0327	Colorectal cancer screening; blood-based biomarker Colon ca scrn;bld-bsd biomrk		WAIVED

Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	**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: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html		
	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
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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			**B**	
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use		WAIVED
	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use		WAIVED
	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED

	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	**B**	WAIVED

Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
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
Service	**CPT/ HCPCS**	**Long Descriptor**	**USPSTF Rating**	**Coins./ Deductible**
	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 Therapy for Obesity	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	**B**	WAIVED
	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		

Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	**B**	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		
COVID-19 Vaccine	*See link*	*https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies*		WAIVED

10 - Pneumococcal Pneumonia, Influenza Virus, Hepatitis B*, and Coronavirus Disease (COVID-19)* Vaccines *and Administration*

(Rev11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

For MACs *(Part* B), Part B of Medicare pays 100 percent of the Medicare allowed amount for pneumococcal, influenza, hepatitis B virus *COVID-19 vaccines* and their administration.

Part B deductible and coinsurance do not apply for pneumococcal, influenza, hepatitis virus *and/or COVID-19 vaccine.*

State laws governing who may administer preventive vaccinations and the coronavirus vaccines as well as how the vaccines are transported vary widely. Medicare contractors should instruct physicians, suppliers, and providers to become familiar with state regulations for all vaccines in the areas where they will be immunizing.

10.1 - Coverage Requirements

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Pneumococcal, influenza virus, hepatitis B, *and COVID-19* vaccine*s* and their administration are covered only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A.

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for additional coverage requirements for pneumococcal, hepatitis B, influenza virus*, and COVID-19 vaccinations.*

10.1.4 – COVID-19 Vaccine

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies.

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 - Billing Requirements

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

A. Edits Not Applicable to Claims for Pneumococcal, Influenza, 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*, 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 virus*, or COVID-19 virus 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 virus or *COVID-19 vaccine*. However, first claim development is performed if other services are submitted along with pneumococcal, influenza virus*, 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); and

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

Other billing entities that may submit institutional claims are:

Independent Renal Dialysis Facilities (RDFs).

All providers submit institutional claims for hepatitis B. Providers other than independent RHCs and freestanding FQHCs submit institutional claims for influenza virus*, COVID-19 vaccines* and pneumococcal

vaccinations. (See §10.2.2.2 of this chapter for special instructions for independent RHCs and freestanding FQHCs.)

Institutional providers, other than independent RHCs and freestanding FQHCs, 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.

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

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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

Note: COVID-19 vaccine and administration HCPCS are temporarily posted at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies.

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/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html

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/medicare/medicare-part-b-drug-average-sales-price/COVID-19-vaccines-and-monoclonal-antibodies.

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.

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

10.2.1.1 – Claims Received with Missing Data
(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

If a diagnosis code for a pneumococcus, hepatitis B, influenza virus*, or COVID-19 vaccination* is not reported on a claim, contractors may enter the diagnosis on the claim *and continue to process the claim for payment.*

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the MAC*s* (*Part* A or *Part* B) may correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is *Z23* and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine. Effective October 1, 2006, A/B MACs (B) should follow the instructions in Pub. 100-04, Chapter 1, Section

- (*MAC (Part B*) Data Element Requirements) for claims submitted without a HCPCS code.

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

- The provider's own NPI to be reported in the NPI field for the attending physician.

10.2.2 - Claims Submitted to MACs Using Institutional Formats
(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The applicable types of bill acceptable when billing for influenza virus, pneumococcal and *COVID-19* vaccines are 012x, 013x, 022x, 023x, 034x, 072x, 075x, 081x, 082x, and 085x. *Contractors shall refer to § 10.3.2 for applicable billing requirements for mass immunization.*

The following revenue codes are used for reporting vaccines and administration of the vaccines for all providers except RHCs and FQHCs. Independent and provider based RHCs and FQHCs follow §10.2.2.2 below when billing for influenza virus, pneumococcal, hepatitis B*, and COVID-19* vaccines.

Units and HCPCS codes are required with revenue code 0636:

Revenue Code	Description
0636	Pharmacy, Drugs requiring detailed coding (a)
0771	Preventive Care Services, Vaccine Administration

In addition, for the influenza virus vaccine, providers report condition code M1 when roster billing. See roster billing instructions in §10.3 of this chapter.

When vaccines are provided to inpatients of a hospital or SNF, they are covered under the vaccine benefit. However, the hospital bills on type of bill 012x using the discharge date of the hospital stay or the date benefits are exhausted. A SNF submits type of bill 022x for its Part A inpatients.

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.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Payment for Vaccines

Payment for these vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs)	012x, 013x	Reasonable cost
IHS Hospitals	012x, 013x,	95% of *the* AWP
IHS CAHs	085x	95% of *the* AWP
CAHs Method I and Method II	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	072x	95% of the AWP
Hospital-based Renal Dialysis Facilities	072x	Reasonable cost

Payment for Vaccine Administration

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

Facility	Type of Bill	Payment
Hospitals, other than IHS Hospitals 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	085x	MPFS
CAHs Method I and II	085x	Reasonable cost
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

Payment for the administration of hepatitis B vaccine is as follows:

Facility	**Type of Bill**	**Payment**
Hospitals other than IHS hospitals 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
CAHs Method I and II	085x	Reasonable cost
IHS CAHs	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

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

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Independent and provider-based RHCs and FQHCs do not include charges for influenza virus, pneumococcal *and COVID-19* vaccines on Form CMS-1450. Administration of these vaccines does not count as a visit when the only service involved is the administration of the vaccine. If there was another reason for the visit, the RHC/FQHC should bill for the visit without adding the cost of the influenza virus, pneumococcal *or COVID-19* vaccines to the charge for the visit on the bill. MACs (*Part* A*)* pay at the time of cost settlement and adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

Payment for the hepatitis B vaccine is included in the all-inclusive rate. However, RHCs/FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine. As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service are billed on the RHC/FQHC claims in addition to the encounter.

10.2.3 - Institutional Claims Submitted by Home Health Agencies and Hospices

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The following provides billing instructions for Home Health Agencies (HHAs) in various situations:

Where the sole purpose for an HHA visit is to administer a vaccine (influenza virus, pneumococcal, hepatitis B *or COVID-19*), Medicare will not pay for a skilled nursing visit by an HHA nurse under the HHA benefit. However, the vaccine and its administration are covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. Medicare does not allow HHAs to charge for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills

under bill type 034x and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is not allowed for the visit

If a vaccine (influenza virus, pneumococcal, hepatitis B, or *COVID-19*) is administered during the course of an otherwise covered home health visit (e.g., to perform wound care), the visit would be covered as normal but the HHA must not include the vaccine or its administration in their visit charge. In this case, the HHA is entitled to payment for the vaccine and its administration under the vaccine benefit. In this situation, the HHA bills under bill type 034x and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

NOTE: A separate bill is required for the visit

Where a beneficiary does **not** meet the eligibility criteria for home health coverage, a home health nurse may be paid for the vaccine (influenza virus, pneumococcal, hepatitis B *or COVID-19*) and its administration. No skilled nursing visit charge is billable. Administration of the services should include charges only for the supplies being used and the cost of the injection. Medicare does not pay for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 034x and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

If a beneficiary meets the eligibility criteria for coverage, but his or her spouse does not, and the spouse wants an injection the same time as a nursing visit, HHAs bill in accordance with the last bullet point above.

The following provides billing instructions for hospices:

Hospices can provide the influenza virus, pneumococcal, hepatitis B *and COVID-19* vaccines to those beneficiaries who request them, including those who have elected the hospice benefit. These services may be covered when furnished by the hospice.

For dates of service before October 1, 2016, services for vaccines and their administration provided by a hospice should be billed on a professional claim to the local MAC. Payment is made using the same methodology as if they were a supplier. Hospices that do not have a supplier number should contact their MAC to obtain one in order to bill for these benefits.

For dates of service on or after October 1, 2016, services for vaccines and their administration provided by a hospice may be billed on an institutional claim.

10.2.4 - Payment Procedures for Renal Dialysis Facilities (RDF)

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

MACs processing institutional claims pay for pneumococcal, influenza virus, hepatitis B and *COVID-19* vaccines for freestanding RDFs based on the lower of the actual charge or 95 percent of the average wholesale price and based on reasonable cost for provider- based RDFs. Deductible and coinsurance do not apply for pneumococcal, influenza virus, hepatitis B and *COVID-19* vaccines. MACs must contact their professional claims processing staff to obtain information in order to make payment for the administration of these vaccines.

10.2.4.1 - Hepatitis B Vaccine Furnished to ESRD Patients

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Hepatitis B vaccine and its administration (including staff time and supplies such as syringes) are paid to ESRD facilities in addition to, and separately from, the dialysis composite rate payment.

Payment for the hepatitis B vaccine for ESRD patients follows the same general principles that are applicable to any injectable drug or biological. Hospital-based facilities are paid for their direct and indirect costs on a reasonable cost basis, and independent facilities are paid the lower of the actual charge or 95 percent of the AWP. The allowance for *an* injectable is based on the cost of the injectable and any supplies used for administration, plus a maximum $2 for the labor involved, if the facility's staff administers the vaccine. In addition, the MAC (*Part* A) makes an appropriate allowance for facility overhead.

Where the vaccine is administered in a hospital outpatient department for home dialysis patients or for patients with chronic renal failure (but not yet on dialysis), payment is on a reasonable cost basis. Outpatient hospital vaccines for non-dialysis purposes are paid under hospital outpatient PPS rules.

10.2.5 - Claims Submitted to MACs (*Part* B)

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

Medicare does not require that the influenza virus*, pneumococcal or COVID-19* vaccine be administered under a physician's order or supervision. Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision. As a physician order is still required for claims for hepatitis B vaccinations, information on the ordering and/or referring physician must be entered on the claim.

A. Reporting Specialty Code/Place of Service (POS) to CWF
Specialty

MACs (*Part* B) use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)) for Public Health Service Clinics (PHCs).

MACs (*Part* B*)* use specialty code 73 (Mass Immunization Roster Billers) for *specialty code C1* centralized billers and specialty code *A5* for pharmacies (all other suppliers (drug stores, department stores)).

Entities and individuals other than PHCs and pharmacies use the CMS specialty code that best defines their provider type. A list of specialty codes can be found in Pub. 100-04, Chapter 26. The CMS specialty code 99 (Unknown Physician Specialty) is acceptable where no other code fits.

Place of Service (POS)

State or local PHCs use POS code 71 (State or Local Public Health Clinic). POS 71 is not used for individual offices/entities other than PHCs (e.g., a mobile unit that is non-PHC affiliated should use POS 99). Preprinted Form CMS-1500s (08-05) used for simplified roster billing should show POS 60 (Mass Immunization Center) regardless of the site where vaccines are given (e.g., a PHC or physician's office that roster claims should use POS 60). Individuals/entities administering influenza virus*,* pneumococcal*, and COVID-19* vaccinations in a mass immunization setting (including centralized billers), regardless of the site where vaccines are given, should use POS 60 for roster claims, paper claims, and electronically filed claims.

Normal POS codes should be used in other situations.

Providers use POS 99 (Other Unlisted Facility) if no other POS code applies.

10.2.5.1 - MAC (*Part* B) Indicators for the Common Working File (CWF)

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The MAC (*Part* B) record submitted to CWF must contain the following indicators:

Description	Payment Indicator	Payment	Deductible Indicator	Deductible	Type of Service
Pneumococcal	"1"	100 percent	"1"	Zero deductible	"V"
Influenza	"1"	100 percent	"1"	Zero deductible	"V"
Hepatitis B	"0"	80 percent	"0"	Deductible applies	"1"
COVID-19	*"1"*	*100 percent*	*"1"*	*Zero deductible*	*"V"*

A payment indicator of "1" represents 100 percent payment. A deductible indicator of "1" represents a zero deductible. A payment indicator of "0" represents 80 percent payment. A deductible indicator of "0" indicates that a deductible applies to the claim.

The record must also contain a "V" in the type of service field, which indicates that this is a pneumococcal*,* influenza virus*, or COVID-19* vaccine. MACs (*Part* B) use a "1" in the type of service field, which indicates medical care for a hepatitis B vaccine.

10.2.5.2 - MAC (*Part* B) Payment Requirements

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

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/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

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 - Simplified Roster Claims for Mass Immunizers

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass pneumococcal and influenza vaccination programs offered by PHCs and other individuals and entities that give the vaccine to a group of beneficiaries, e.g. at PHCs, shopping malls, grocery stores, senior citizen homes, and health fairs. *Effective December 11, 2020 roster billing is also available for billing COVID-19 vaccinations.*

Roster billing is not available for hepatitis B vaccinations.

If they agree to accept assignment for these claims, properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claim's filing procedure known as roster

billing to bill for influenza virus, *pneumococcal or COVID-19 vaccinations* for multiple beneficiaries. They may not collect any payment from the beneficiary.

Entities that submit claims on roster claims must accept assignment and may not collect any "donation" or other cost sharing of any kind from Medicare beneficiaries for pneumococcal, influenza virus, *or COVID-19* vaccinations. However, the entity may bill Medicare for the amount, which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

A. Provider Enrollment Criteria for Mass Immunizers

Those entities and individuals that desire to provide mass immunization services, but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type "Mass Immunization Roster Biller."

These individuals and entities must enroll by completing the Provider/Supplier Enrollment Application, Form CMS-855. Individuals and entities that enroll as this provider type may not bill Medicare for any services other than pneumococcal, influenza virus, *and/or COVID-19* vaccines and their administration. In addition, claims submitted by the provider type "Mass Immunization Roster Biller" are always reimbursed at the assigned payment rate.

B. Payment Floor for Roster Claims

Roster claims are considered paper claims and are not paid as quickly as electronic media claims (EMC). If available, offer electronic billing software free or at-cost to PHCs and other properly licensed individuals and entities. MACs (*Part* B*)* must ensure that the software is as user friendly as possible for the pneumococcal, influenza virus *and COVID-19 vaccination billing.*

10.3.1 - Roster Claims Submitted to MACs (*Part* B) for Mass Immunization

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

If the PHC or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 that contains standardized information about the entity and the benefit. See Pub. 100-04, Chapter 26, §10 for more information about the CMS-1500 claim form. Key information from the beneficiary roster list and the abbreviated claim form is used to process pneumococcal, influenza*, and COVID-19* vaccination claims.

Separate CMS-1500 claim forms, along with separate roster bills, must be submitted for influenza virus, pneumococcal, and *COVID-19* roster billing.

If other services are furnished to a beneficiary along with pneumococcal, influenza, or *COVID-19 vaccines*, individuals and entities must submit claims using normal billing procedures, e.g., submission of a separate claim for each beneficiary.

MACs (*Part* B) must create and count one claim per beneficiary from roster bills. They must split claims for each beneficiary if there are multiple beneficiaries included in a roster bill. Providers must show the unit cost for one service on the claim. The MACs (*Part* B) must replicate the claim for each beneficiary listed on the roster.

MACs (*Part* B) must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for pneumococcal, influenza*, and COVID-19 vaccines* and their administration. If PHCs or other individuals or entities inappropriately bill pneumococcal, influenza*, or COVID-19* vaccinations using the roster billing

method, MACs (Part B) *shall* return the claim as unprocessable with the appropriate rejection message. MACs (*Part* B) may not deny these claims.

Providers must retain roster bills with beneficiaries' signatures at their permanent location for a time period consistent with Medicare regulations.

A. Modified Form CMS-1500 for Cover Document

Entities submitting roster bills to MACs (*Part* B) must complete the following blocks on a single modified Form CMS-1500 claim form, which serves as the cover document for the roster for each facility where services are furnished. In order for MACs (*Part* B) to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility or physical location where services are furnished.

Item #	Instruction
Item 1:	An X in the Medicare block
Item 2:	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11:	(Insured's Policy Group or FECA Number): "NONE"
Item 20:	(Outside Lab?): An "X" in the NO block
Item 21:	(Diagnosis or Nature of Illness): Line A: Choose appropriate diagnosis code from §10.2.1 ICD Ind. Block: Enter ICD-10-CM code. Enter the indicator as a single digit between the vertical dotted lines.
Item 24B:	(Place of Service (POS)): Line 1: "60" Line 2: "60" NOTE: POS Code "60" must be used for roster billing.
Item 24D:	(Procedures, Services or Supplies): Line 1: Vaccine code Line 2: Vaccine Administration *code*
Item 24E:	(Diagnosis Pointer): Lines 1 and 2: "A"
Item 24F:	($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC pneumococcal or influenza virus vaccine claims only if your system is able to accept them.
Item 27:	(Accept Assignment): An "X" in the YES block.
Item 29:	(Amount Paid): "$0.00"
Item 31:	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.
Item 32:	Enter the name, address, and ZIP code of the location where the service was provided (including centralized billers).
Item32a:	Enter the NPI of the service facility.
Item 33:	(Physician's, Supplier's Billing Name): The entity must complete this item.
Item 33a:	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.

B. Format of Roster Claims

Qualifying individuals and entities must attach to the CMS-1500 claim form, a roster bill which contains the claims information regarding the supplier of the service and individual beneficiaries. While qualifying entities must use the modified Form CMS-1500 claim form without deviation, MACs (*Part* B) must work with these entities to develop a mutually suitable roster bill that contains the minimum data necessary to satisfy claims processing requirements for these claims. MACs (*Part* B) must key information from the beneficiary roster bill and abbreviated Form CMS-1500 claim form to process pneumococcal, influenza virus*, and COVID-19* vaccination claims.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;

  NOTE: Providers must include the individual date of service for each beneficiary's vaccination on the roster bill.
- Control number for MAC (*Part* B);
- Patient's Medicare beneficiary identifier number;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file".

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster bill if the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, the provider is not required to obtain the patient signature on the roster, but instead has the option of reporting signature on file in lieu of obtaining the patient's actual signature.

The pneumococcal roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the pneumococcal vaccination.

WARNING: Beneficiaries must be asked if they have received a pneumococcal vaccination.

- Rely on patients' memory to determine prior vaccination status.

MACs (Part B) shall use the data on the CMS-1500 claim form cover sheet and the roster bill to correct or add missing claims data and continue to process the claims for payment.

Contractors shall not return a claim as unprocessable if the following data fields on the CMS-1500 are not completed:

Item 1,
Item 2, or
Item 20.

The MAC (Part B) shall allow the roster claims to continue to process for payment. The MAC (Part B) shall complete the incomplete fields if the data is available on the attached roster bill.

The MAC (Part B) may fill in missing or incomplete information on the attached roster bill when the required data such as provider's name and NPI is missing but is included on the abbreviated CMS-1500 claim form. The MAC shall fill in the missing information and continue to process the claim for payment.

10.3.1.1 - Centralized Billing for Influenza, Pneumococcal *and COVID-19 Virus Vaccinations to MACs (Part* B*)*

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The CMS currently authorizes providers to centrally bill for influenza, pneumococcal, and *COVID-19 vaccination* claims. *That is to say, they bill all of the claims for those vaccinations to one MAC, rather than to each of the MACs that service the location where the services are rendered.*

Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

The contractor assigned to process the claims for centralized billing will be chosen at the discretion of The Centers for Medicare & Medicaid Services (CMS) based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. Currently the specialty contractor for centralized billing is Novitas (JH).

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different MACs processing claims. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the vaccinations are given and the MAC will verify this through the enrollment process.

As previously stated, centralized billers must send all claims for influenza, pneumococcal, *and COVID-19* vaccinations to a single MAC for payment, regardless of the jurisdiction 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.) Payment is made based on the payment locality where the service was provided. Centralized billing is only available for claims for the influenza, pneumococcal, *and COVID-19 vaccines* and their administration. The general coverage and coding rules still apply to these claims.

This section applies only to those individuals and entities that provide mass immunization services for influenza, pneumococcal, *and COVID-19* virus vaccinations that have been authorized by CMS to centrally bill. All other providers, including those individuals and entities that provide mass immunization services that are not authorized to centrally bill, must continue to submit claims to their regular MAC (*Part* B) per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to claims submitted to the designated processing MAC. However, all MACs (*Part* B) must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All MACs (*Part* B)."

A. Request for Approval

Centralized Billing for Influenza, Pneumococcal and COVID-19 Virus Vaccinations

A. ***Information for Providers Interested in Applying for Centralized Billing***

In order to qualify as a centralized biller, a provider must be operating in at least three payment localities for which there are three different MACs processing claims.

Individuals and corporations who wish to enroll as a CMS centralized biller must send their request in writing to Novitas, (the current specialty contractor) at the address at the end of this section.

Providers must include the following information in their application to become a centralized biller.

1. *Providers must indicate that they agree to the following:*

   a) *Centralized billers providing the vaccine and administration must be properly licensed in the States in which the vaccinations are given.*

   b) *Centralized biller must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza, pneumococcal and COVID-19 vaccinations, 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. This practice is unacceptable.*

   c) *Centralized billers must understand that beginning December 11, 2021 the payment rate for the administration of the COVID-19 vaccine is $40 and $30 for the other preventive vaccinations. These payment amounts are geographically adjusted by locality. Therefore, the centralized biller must be willing to accept that payments received may vary based on the geographic locality where the service was performed.*

   d) *Centralized billers must understand that the payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals.*

   e) *Centralized billers must agree to submit their claims in a CMS approved electronic media claims standard format. Paper claims will not be accepted.*

   f) *In addition to the elements required by regular roster billing, centralized billers must complete the service facility location in order for the MAC to be able to pay correctly by geographic locality. Centralized billers should contact the processing contractor for specific information.*

   g) *Centralized billers must obtain certain information for each beneficiary including name, Medicare Beneficiary Identifier, date of birth, sex, and signature. Novitas must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the correct MBI as Novitas will not be able to process incomplete or incorrect claims.*

   h) *Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary. Beneficiaries are sometimes confused when they receive an MSN from a MAC other than the MAC that normally processes their claims, which results in unnecessary beneficiary inquiries to the MAC. Therefore, centralized billers must notify every beneficiary receiving an influenza, pneumococcal or COVID-19 virus vaccination that the claim will be processed by Novitas. 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.*

   i) *Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. Novitas can provide this information.*

   j) *Though centralized billers may already have a National Provider Identifier (NPI) number, for purposes of centralized billing, they must also enroll with Novitas. This can be done by completing the Form CMS-855 (Provider Enrollment Application) that can be obtained from Novitas.*

   k) *If the request for centralized billing is approved, for influenza and pneumococcal, and COVID-19 vaccinations, that approval is ongoing. It is the responsibility of the approved centralized billers to contact Novitas to make updates to their provider enrollment data on file (i.e. clinic locations, name change, and change to ownership are a few examples) . Claims submitted without approval will be denied.*

l) *If a centralized biller is applying to provide COVID-19 vaccinations only, that approval will be ongoing. It is the responsibility of the approved centralized billers to contact Novitas to make updates to their provider enrollment data on file (i.e. clinic locations, name change, and change to ownership are a few examples). Claims submitted without approval will be denied.*

2. *Applicants for centralized billing should also include responses to the following:*

   a. *A list of the States in which vaccination clinics will be held;*
   b. *Contact information for a designated contact for the centralized billing program.*

Applications for centralized billing must be sent to the specialty MAC for centralized billing at:

Novitas Solutions, Inc.
Provider Enrollment Services
Attention: Centralized Billing Program
P.O. Box 3095
Mechanicsburg, PA 17055-1813

All applicants must meet the criteria for centralized billing at the time they apply for approval. Failure to provide a response to each statement will result in the request not being processed. Novitas will reach out to the applicant to attempt to complete any missing data. Should they be unable to resolve the matter via outreach efforts, Novitas shall return the application with details explaining why the submission could not be processed.

*B. **Review of Applications***

Novitas will review the information provided by applicants for completeness. Novitas will approve or deny the applicant's request for participation based on the information provided. Applicants who are approved shall continue to the next steps of enrollment through Novitas' provider enrollment department.

Novitas will send a letter of disapproval to applicants who are determined ineligible to participate in the Medicare centralized billing program. The letter will clearly explain why the request was denied.

Submitting a request for participation does not automatically provide approval to set up vaccination clinics, vaccinate beneficiaries, and bill Medicare for reimbursement. All new participants must complete the approval process, including submission of a CMS-855 Application for enrollment with Novitas and receive a final approval before they vaccinate Medicare beneficiaries and bill Medicare for reimbursement.

If a provider's request is approved for centralized billing for influenza, pneumococcal and COVID-19 vaccinations, the approval shall be ongoing. Approved providers will no longer be required to reapply on an annual basis. Centralized billers shall contact Novitas with any changes to their enrollment and/or that states in which they operate.

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/covid-19/enrollment-administering-covid-19-vaccine-shots

D. Electronic Submission of Claims on Roster Bills

All centralized billers must agree to submit their claims on roster bills in an electronic media claims format. The processing contractor must provide instructions on acceptable roster billing formats to the approved centralized billers. Paper claims will not be accepted.

E. Required Information on Roster Bills for Centralized Billing

In addition to the roster billing instructions found in §10.3.1 of this chapter, centralized billers must provide on the claim the ZIP code of where the service was rendered (to determine the payment locality for the claim), and the provider of service/supplier's billing name, address, ZIP code, and telephone number. In addition, the NPI of the billing provider or group must be appropriately reported.

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/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

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/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

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.

G. Common Working File Information

To identify these claims and to enable central office data collection on the project, special processing number 39 has been assigned. The number should be entered on the HUBC claim record to CWF in the field titled Demonstration Number.

H. Provider Education Instructions for the Designated Processing Part B MAC

The designated Part B MAC must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on influenza, pneumococcal, and *COVID-19 vaccine* coverage and billing instructions is available on the CMS Web site for providers.

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/covid-19/enrollment-administering-covid-19-vaccine-shots*** .

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.

10.3.2 - Claims Submitted to MACs (*Part* A) for Mass Immunizations of Influenza, Pneumococcal, *and/or COVID-19 Virus* Vaccinations

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

*T*o increase the number of beneficiaries who obtain needed preventive vaccinations, simplified roster billing procedures are also available to mass immunizers *that bill MACs (Part A)*. The simplified roster claims filing procedure has been expanded from availability for influenza and pneumococcal virus vaccinations to also include *COVID-19* virus vaccinations. A mass immunizer is defined as any entity that gives the influenza, pneumococcal, *or COVID-19 virus vaccinations* to a group of beneficiaries, e.g., at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required. (See §10.3.2.2 for an exception to this requirement for inpatient hospitals.)

The simplified roster billing claims filing procedure applies to providers other than RHCs and FQHCs that conduct mass immunizations. Since independent and provider based RHCs and FQHCs do not submit individual Form CMS-1450s for the influenza virus vaccine, they do not utilize the simplified billing process. Instead, payment is made for the vaccine at the time of cost settlement.

The simplified roster billing process involves use of the provider billing form (Form CMS-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form CMS-1450 that contains the variable claims information regarding the service provider and individual beneficiaries.

Qualifying individuals and entities must attach a roster, which contains the variable claims information regarding the supplier of the service and individual beneficiaries.

The roster must contain at a minimum the following information:

- Provider name and NPI;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient Medicare Beneficiary Identifier (MBI) number; and
- Beneficiary signature or stamped "signature on file."

In addition, for inpatient Part B services (12x and 22X) the following data elements are also needed:

- Admission date;
- Admission type;
- Admission diagnosis;
- Admission source code; and

- Patient status code.

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature for all institutional providers that roster bill from an inpatient or outpatient department provided the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature on the roster. However, the provider has the option of reporting "signature on file" in lieu of obtaining the patient's actual signature on the roster.

The pneumococcal vaccination roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering the pneumococcal vaccine.

Warning: Beneficiaries must be asked if they have been vaccinated with the pneumococcal vaccine.

- Rely on the patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate**.

For providers using the simplified billing procedure, the modified Form CMS-1450 shows the following preprinted information in the specific form locators (FLs). Information regarding the form locator numbers that correspond to the data element names below is found in Chapter 25:

- The words "See Attached Roster" (Patient Name);
- Patient Status code 01 (Patient Status);
- Condition code M1 (Condition Code) (See NOTE below);
- Condition code A6 (Condition Code);
- Revenue code 636 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 (Revenue Code), along with the appropriate "G" HCPCS code (HCPCS Code);
- "Medicare" (Payer, line A);
- The words "See Attached Roster" (Provider Number, line A); and

1. Diagnosis code

    - **ICD-10-CM** - Use Z23 for an encounter for immunization effective with the implementation of ICD-10.

- Influenza virus *and COVID-19 vaccines* require:

    - the provider’s own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2007.

Providers conducting mass immunizations are required to complete the following fields on the preprinted Form CMS-1450:

- Type of Bill;
- Total Charges;
- Provider Representative; and
- Date.

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in CWF for all mass immunization roster bills. However, if the provider knows that a particular group health plan covers the pneumococcal vaccine 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 influenza, pneumococcal or *COVID-19 vaccination claims*.

Contractors use the beneficiary roster list to generate claim records to process the pneumococcal virus vaccination claims by mass immunizers indicating condition code M1 to avoid MSP editing. Standard System Maintainers must develop the necessary software to generate records that will process through their system.

Providers that do not mass immunize must continue to bill for the influenza, pneumococcal and *COVID-19* virus *vaccinations* using the normal billing method, (e.g., submission of a Form CMS-1450 or electronic billing for each beneficiary).

10.3.2.1 - Simplified Billing for Influenza, Pneumococcal and *COVID-19 Virus Vaccination* Services by HHAs

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The following billing instructions apply to HHAs that roster bill for influenza, pneumococcal and/or COVID-19 virus vaccinations.

- When an HHA provides the influenza, pneumococcal *or COVID-19 vaccinations* in a mass immunization setting, it does not have the option to pick and choose whom to bill for this service. If it is using employees from the certified portion, and as a result will be reflecting these costs on the cost report, it must bill the MAC (HHH) on the Form CMS-1450.
- If the HHA is using employees from the noncertified portion of the agency (employees of another entity that are not certified as part of the HHA), and as a result, will not be reflecting these costs on the cost report, it must obtain a provider number and bill their MAC (*Part* B) on the Form CMS-1500.
- If employees from both certified and noncertified portions of the HHA furnish the vaccines at a single mass immunization site, they must prepare two separate rosters, (e.g., one for employees of the certified portion to be submitted to the MAC (HHH) and one roster for employees of the noncertified portion to be submitted to the MAC (Part B)).

10.3.2.2 - Hospital Inpatient Roster Billing

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

The following billing instructions apply to hospitals that roster bill for the influenza, pneumococcal *and/or COVID-19 vaccinations* provided to inpatients:

- Hospitals do not have to wait until patients are discharged to provide the vaccine. They may provide it anytime during the patient's stay;
- The roster should reflect the actual date of service;
- The requirement to provide the vaccine to five or more patients at the same time to meet the requirements for mass immunizers is waived when vaccines are provided to hospital inpatients. Therefore, the roster may contain fewer than five patients or fewer than five patients on the same day; and
    - The roster should contain information indicating that the vaccines were provided to inpatients to avoid questions regarding the number of patients or various dates.

10.3.2.3 - Electronic Roster Claims

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

As for all other Medicare-covered services, MACs (*Part* A) pay electronic claims more quickly than paper claims. For payment floor purposes, roster bills are paper bills and may not be paid as quickly as EMC. (See Chapter 1.) If available, MACs (*Part* A) must offer free, or at-cost, electronic billing software and ensure that the software is as user friendly as possible to roster bill for the influenza, pneumococcal *and COVID-19 vaccinations.*

10.4.1 – CWF Edits on MAC (*Part* A) Claims

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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, 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, 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, CWF rejects the second claim submitted 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,11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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, 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, 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, CWF will reject the second claim submitted.

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, or 90732; and the administration code G0008 or G0009.

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.

If CWF receives a claim with HCPCS codes 90670, 90671, 90677, 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.

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, CWF will reject the second claim submitted.

CWF will return a specific reject code for *these* edit*s*. 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, 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, 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, CWF will reject the second claim submitted.*

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 MAC (*Part* B) *Claims*

(Rev.11355; Issued:04-14-22; Effective:05-16-22; Implementation:05-16-22)

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, 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.