



Physician Services Version

KEY CONCEPTS OUTLINE

Module 12: Medicare Coverage of Preventive Services

I. Preventive Evaluation and Management Services

A. Initial Preventive Physical Exam ("IPPE")

1. An IPPE is a specialized preventive physical examination designed to screen Medicare beneficiaries for a variety of diseases. The goals of the IPPE are health promotion and disease detection. IPPEs are sometimes referred to as "Welcome to Medicare" physical exams. <January 2015 CMS Flyer on "ABCs of IPPE">
2. Limitations on Coverage
 - a. Frequency Limit
 - (i) Medicare allows only one IPPE for each beneficiary. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(C)>
 - b. Timing Limitation
 - (i) An IPPE is only covered if the beneficiary receives the IPPE within twelve months after the effective date of his/her first Medicare Part B coverage. <42 CFR § 410.16(b), 410.16(a); Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(C)>
 - c. The Qualified Practitioner Limitations
 - (i) Only IPPEs furnished by one of the following types of practitioners are covered:
 - (a) Physician (MD or DO),

- (b) Physician Assistant,
- (c) Nurse practitioner, or
- (d) Clinical Nurse Specialist. <42 CFR § 410.16(b), 410.16(a); Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(B)>

d. Scope of Services Limitation

- (i) To be covered, the IPPE must include: <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1>:
 - (a) Review of the beneficiary's medical and social history, including past medical and surgical history, current medications, family history, history of alcohol, tobacco and illicit drug use, diet, and physical activities;
 - (b) A review of the beneficiary's potential risk factors for depression or other mood disorders based on the use of standardized screening tests;
 - (c) A review of the beneficiary's functional ability and level of safety, including hearing impairment, activities of daily living, falls risk, and home safety;
 - (d) An examination which includes measurement of the beneficiary's height, weight, body mass index, blood pressure; visual acuity screen, and other factors based on the beneficiary's medical and social history and the clinical standards;
 - (e) End of life planning, upon consent of the individual, where verbal or written information may be obtained and used to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions; and
 - (f) Education, counseling, a written plan for obtaining appropriate preventive services, and referrals, if appropriate, based on the results of the IPPE evaluation. <42 CFR § 410.16(b), 410.16(a)>

3. Billing Issues

- a. Specific HCPCS codes have been developed for billing for IPPEs and related services:

- (i) G0402 – used to bill for the IPPE itself, including the face-to-face visit and related services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
 - (a) If a medically necessary E/M service is provided at the same visit as the IPPE, an E/M code with the -25 modifier may also be billed, indicating that the E/M service was a significant, separately identifiable service from the IPPE. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(G)>
- b. A referral for a screening electrocardiogram (EKG) may be made. When the screening EKG is performed as a result of the IPPE, specific HCPCS Level II codes are to be used. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
 - (i) G0403 – used to bill for a 12 lead EKG furnished in connection with an IPPE when the test (technical component) and interpretation (professional component) were both furnished by the billing entity.
 - (ii) G0404 – used to bill for a 12 lead EKG furnished in connection with an IPPE when only the test (technical component) was furnished by the billing entity.
 - (iii) G0405 – used to bill for a 12 lead EKG furnished in connection with an IPPE when only the interpretation (professional component) was furnished by the billing entity. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
- c. Prolonged Preventive Services <MLN Matters Article, MM10181>
 - (i) Effective January 1, 2018, Medicare established payment for prolonged preventive services when billed in addition to an applicable preventive service payable under the Medicare Physician Fee Schedule
 - (ii) Both deductible and coinsurance are waived
 - (iii) HCPCS Coding
 - (a) G0513 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)

- (b) G0514 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)

- (iv) Effective January 1, 2019, both prolonged preventive services, G0513 and G0514 are payable as telehealth services <83 Fed. Reg. 60031>

d. Screening for Abdominal Aortic Aneurysm (AAA)

- (i) Referral from an IPPE is no longer required. The 2014 Medicare Physician Fee Schedule Final Rule established a policy change. Effective January 27, 2014, Medicare beneficiaries eligible to receive ultrasound screening for abdominal aortic aneurysms (AAA screening) can be referred for this one-time benefit at any time.

- (a) Policy change removed the IPPE related referral.

- (ii) Provided on or after January 1, 2017

- (a) 76706 – used to bill for a screening ultrasound for abdominal aortic aneurysm

- (iii) Provided on or before December 31, 2016

- (a) G0389 – used to bill for an ultrasound screening for abdominal aortic aneurysm

- (iv) Payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

- (a) receives a referral for such an ultrasound screening from the beneficiary's attending physician, physician assistant, nurse practitioner or clinical nurse specialist;
 - (b) receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services;
 - (c) has not been previously furnished such an ultrasound screening under the Medicare Program; and
 - (d) is included in at least one of the following risk categories:
 - (1) has a family history of abdominal aortic aneurysm;

- (2) is a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime; or
- (3) is a beneficiary who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determination process.

4. Coinsurance and Deductible Applicability

- a. The Part B coinsurance and deductible are applied to the IPPE services as follows:
 - (i) IPPE (G0402) – Effective January 1, 2011, the coinsurance is waived. <MLN Matters SE1023>
 - (a) The deductible for the IPPE was waived starting January 1, 2009.
 - (ii) EKG codes (G0403, G0404, G0405) – The deductible and the coinsurance apply. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1(D)>
 - (iii) AAA screening (76706) – Starting January 1, 2011, both the deductible and coinsurance are waived. <One Time Notification Manual, Transmittal 864>
 - (a) Prior to January 1, 2011, G0389 was exempt only from the deductible. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A>

5. ABN/Limitation on Liability Issues

- a. The ABN requirements applicable to IPPE services are as follows:
 - (i) IPPEs Furnished During the Twelve-Month Eligibility Period
 - (a) Beneficiary Receives More Than One IPPE
 - (1) No ABN is required to hold the beneficiary liable for additional IPPEs furnished during the twelve-month eligibility period. <Medicare Claims Processing Manual, Chapter 18 § 80.8>
 - (ii) IPPEs Furnished After the Twelve-Month Eligibility Period

- (a) An ABN should be issued to hold beneficiaries liable when they are receiving any IPPE outside the twelve-month eligibility period. <Medicare Claims Processing Manual, Chapter 18 § 80.8>

B. Annual Wellness Visit (AWV)

1. The AWV is a preventive physical exam which includes personal prevention plan services (PPPS). <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.2>

2. Limitations on Coverage

- a. Frequency Limit

- (i) Initial AWVs are a once in a lifetime benefit. Unlimited subsequent AWVs are allowed after sufficient time has passed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.2>

- b. Timing Limitation

- (i) Medicare will pay for an initial AWV if a beneficiary is more than 12 months past the effective date of his/her Medicare Part B coverage and has not received either an IPPE or an AWV within the preceding 12 months. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2>
 - (a) Beneficiaries in their first 12 months of Part B coverage will only be eligible for an IPPE. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2>
 - (ii) Subsequent AWVs will be allowed after more than 12 months have passed from the initial AWV or a previous subsequent AWV. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2; Medicare Claims Processing Manual, Chapter 18 § 140.6>

- c. The Qualified Practitioner Limitations

- (i) AWVs provided by the following types of practitioners are covered:
 - (a) Physician (MD or DO),
 - (b) Physician Assistant,
 - (c) Nurse practitioner,

- (d) Clinical Nurse Specialist
- (e) Other types of medical professionals include a health educator, registered dietitian, nutrition professional or other licensed practitioner or a team of such medical professionals who are working under the direct supervision of a physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.B>

d. Scope of Services Limitation

- (i) To be covered, the initial AWW must include: <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.(2)>
 - (a) Establishment of, or update to, the individual's medical/family history,
 - (b) Measurement of height, weight, body mass index (BMI) or waist circumference, and blood pressure and other routine measurements as deemed appropriate,
 - (c) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;
 - (d) Detection of any cognitive impairment the individual may have,
 - (e) Review of an individual's potential risk factors for depression,
 - (f) Review of the individual's functional ability and level of safety,
 - (g) Establishment of a written screening schedule checklist for the individual for the next 5 to 10 years, as appropriate,
 - (h) Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits, and
 - (i) Provision of personalized health advice to the individual and referral, as appropriate, to health education or preventive counseling services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.(2)>
- (ii) To be covered, the subsequent AWW must include:

- (a) Update to the individual's medical /family history,
- (b) Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- (c) Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual,
- (d) Detection of any cognitive impairment that the individual may have,
- (e) Update to the individual's written screening schedule as developed at the first AWW providing PPPS,
- (f) Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWW providing PPPS, and
- (g) Appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.

3. Billing Issues

- a. Specific HCPCS codes were developed to describe AWW services effective January 1, 2011:
 - (i) G0438 – Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
 - (ii) G0439 – Annual wellness visit, includes PPPS, subsequent visit
<Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.F.(2)>

C. Vaccinations Covered Under Medicare Part B

1. In Home Administration

- a. Medicare will reimburse for in-home administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 in the patient's home.
- b. HCPCS M0201- Administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home
 - (i) Reported once per individual home per date of service

2. Influenza

- a. Medicare Part B covers the seasonal flu shot.
- b. Medicare covers additional flu shots if medically necessary.
 - (i) Patients can get flu shots twice in a calendar year during 2 different flu seasons, and we'll pay for both shots.
 - (ii) Payment limits are established annually
 - (a) August 1st to July 31st of the following year.
- c. Your patients pay nothing if you accept assignment. There's no copayment, coinsurance, or deductible.
- d. Coverage Requirements
- e. Coding and Billing
 - (i) Vaccine Products billed with appropriate CPT/HCPCS code
 - (a) Product codes can be found at:
[www.cms.gov/medicare/payment/part-b-drugs/\\$vaccine-pricing](https://www.cms.gov/medicare/payment/part-b-drugs/$vaccine-pricing)
 - (ii) Administration
 - (a) G0008
 - (1) Locally adjusted payment rates

3. Pneumonia

a. Covered Annually

- (i) For coverage of subsequent vaccine -11 full months have passed following the month in which the last pneumococcal vaccine was administered.
- (ii) Adults age ≥ 65 years who have not previously received pneumococcal conjugate vaccine (PCV) or whose previous vaccination history is unknown.
- (iii) Adults aged 19–64 years with certain underlying medical conditions or other risk factors who have not previously received PCV or whose previous vaccination history is unknown <Medicare Benefit Policy Manual, Chapter 15, § 50.4.4.2>

b. Coding and Billing

(i) CPT codes

(a) Vaccine Product

- (1) 90670 — Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
- (2) 90671 — Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
- (3) 90677 — Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
- (4) 90684 — Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use
- (5) 90732 — Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

(b) Administration

- (1) G0009 — Administration of pneumococcal vaccine

4. Hepatitis B

- a. Medicare Part B provides coverage for hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B.
- b. High- risk groups currently identified include:
 - (i) ESRD patients;
 - (ii) Hemophiliacs who receive Factor VIII or IX concentrates;
 - (iii) Clients of institutions for the mentally retarded;
 - (iv) Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
 - (v) Homosexual men;
 - (vi) Illicit injectable drug users; and
 - (vii) Persons diagnosed with diabetes mellitus
- c. Intermediate-risk groups include:
 - (i) Staff in institutions for the mentally retarded; and
 - (ii) Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work
- d. Exceptions to the Risk Groups:
 - (i) Individuals are not considered to be of high or intermediate risk, if there is laboratory evidence positive for antibodies to hepatitis B
- e. Vaccine may be administered upon the order of a physician, home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, and persons recognized under the incident to physicians' services provision of law
- f. Coding and Billing
 - (i) Vaccine Product CPT Codes
 - (a) 90739 — Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use

- (b) 90740 — Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
- (c) 90743 — Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use
- (d) 90744 — Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
- (e) 90746 — Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
- (f) 90747 — Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use
- (g) 90759 — Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use <Medicare Preventive Services MLN>

(ii) Administration

- (a) G0010 — Administration of hepatitis B vaccine

5. COVID-19 Vaccine

- a. Medicare coverage is provided for COVID-19 vaccines, additional doses, and booster doses.
 - (i) Includes bivalent and updated vaccines.
- b. Can be provided without a physician order or supervision.
- c. Providers and practitioners can participate in the CDC COVID 19 vaccination program.
 - (i) Administer the vaccine with no out-of-pocket cost to your patients for the vaccine or administration of the vaccine.
 - (ii) Vaccinate everyone, including the uninsured, regardless of coverage or network status.
- d. Providers and Practitioners cannot:
 - (i) Balance bill for COVID-19 vaccinations;

- (ii) Charge your patients for an office visit or other fee if COVID-19 vaccination is the only medical service given; or
- (iii) Require additional medical or other services during the visit as a condition for getting a COVID-19 vaccination.

e. Billing and Coding

(i) Administration – CPT 90480

(ii) Vaccine Product

- (a) Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose
- (b) 91304 — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use
- (c) 91318 — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- (d) 91319 — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- (e) 91320 — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- (f) 91321 — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use
- (g) 91322 — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use

6. Monkey Pox Vaccine

- a. Effective July 26, 2022, the Monkey Pox vaccine and administration are covered under Medicare.
- b. The vaccine product is provided by the federal government.
 - (a) The no-charge product code will be addressed/adjusted during claims processing; therefore, product HCPCS codes are to be reported on the claim.
 - (b) Patient cost-sharing is only applicable to the administration codes.
- c. Reporting Vaccine Product
 - (i) Monkey Pox and smallpox – CPT code 90611
 - (ii) Vaccinia (smallpox) virus product – CPT code 90622
- d. Administration is reported with CPT codes 90471 or 90472.

II. Medicare Part D Vaccines

- A. Medicare Part D plans provide coverage for all vaccines that are:
 - 1. Commercially available
 - 2. Reasonable and necessary to prevent illness
 - 3. Not covered by Medicare Part B
- B. Medicare Part D drug plans cover vaccine administration costs as part of each vaccine's negotiated price, including:
 - 1. Dispensing fee (if applicable)
 - 2. Sales tax (if applicable)
 - 3. Vaccine administration fee
 - 4. Vaccine ingredient cost
- C. Beginning CY 2023, patients with Medicare drug plans will pay nothing out-of-pocket for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

- D. The Inflation Reduction Act of 2022, Part 5, Section 11401 requires these vaccines to be free to patients and makes Part D vaccine cost-sharing consistent with coverage under Part B where the patient has no coinsurance or deductible.

III. Medicare Diabetes Prevention Program Expanded Model (MDPP)

A. Overview

1. A program consisting of an evidence-based set of services aimed to help prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. < Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet>
2. The MDPP is a once in a lifetime benefit.
3. Clinical Goals of the MDPP Expanded Model
 - a. Attendance at core sessions and core maintenance sessions, or
 - b. Weight loss.
 - c. Long-term dietary change.
 - d. Adherence to long-term health behavior changes.

B. Supplier Enrollment <MDPP Provider Enrollment Fact Sheet; Fact Sheet Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule>

1. Supplier enrollment begins January 1, 2018, and will continue on a rolling basis.
2. To enroll as an MDPP supplier an entity must satisfy the following criteria and meet all other Medicare enrollment requirements:
 - a. At the time of enrollment has full CDC DPRP recognition.

- b. Obtain and maintain an active and valid TIN and NPI at the organizational level.
 - c. Pass the application screening at a high categorical risk level § 424.518(c).
 - d. All coaches who will be furnishing MDPP services on the entity's behalf must obtain and maintain active and valid NPIs.
 - e. Submit a roster of all coaches who will be furnishing MDPP services on the entity's behalf. The roster must include:
 - (i) Coaches' first and last names,
 - (ii) SSN, and
 - (iii) NPI.
3. Utilize the MDPP-specific application, CMS-20134
- C. Technology furnished to beneficiary by MDPP Supplier <42 CFR §424.210(b); 42 CFR §424.210(c)>
- 1. Items, in aggregate, may not exceed \$1000.00 exceeding retail value for any one beneficiary.
 - 2. The items must meet the following:
 - a. Be of the minimum technology required to meet/advance a clinical goal;
 - b. Must not be advertised or promoted as an incentive of the MDPP program; and
 - c. The cost of the technology cannot be shifted to another Federal program or the Medicare MDPP beneficiary.
 - 3. For technology items exceeding \$100.00 in retail value:
 - a. Must remain the property of the MDPP supplier;
 - b. Be retrieved from the MDPP beneficiary at the end of the engagement incentive period;
 - c. The MDPP supplier must document all retrieval attempts, including the ultimate date of retrieval.
 - (i) Documented diligent, good faith attempts to retrieve items of technology – considered to meet the requirements of retrieval.

D. Effective April 1, 2018, MDPP Services were made available to eligible Medicare beneficiaries.

1. Eligible beneficiaries are those who:

- a. Are enrolled in Medicare Part B;
- b. Have a body mass index (BMI) of at least 25, or at least 23 if self-identified as Asian
- c. Meet 1 of the following 3 blood test requirements within the 12 months of the first core session:
 - (i) A hemoglobin A1c test with a value between 5.7 and 6.4%, or
 - (ii) A fasting plasma glucose of 110-125 mg/dL, or
 - (iii) A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- d. Have no previous diagnosis of type 1 or type 2 diabetes (other than gestational diabetes) and
- e. Do not have end-stage renal disease (ESRD)

E. Beginning January 1, 2022 – the program was transitioned to a 12-month program.

- 1. Structured sessions utilizing a “coach” and presenting a Center of Disease Control curriculum to provide training for changes in diet and physical activity while providing weight loss strategies and attendance goals.
 - a. Two components:
 - (i) Core Sessions
 - (a) MDPP suppliers must offer a minimum of 16 sessions, offered at least a week apart, during the first 6 months;
 - (b) Available to eligible beneficiaries regardless of weight loss and attendance; and
 - (c) MDPP suppliers must use a CDC-approved curriculum to guide sessions.
 - (ii) Core Maintenance Sessions

- (a) Months 7-12;
 - (b) Sessions are available to eligible beneficiaries regardless of weight loss and attendance; and
 - (c) MDPP suppliers must use a CDC-approved curriculum to guide sessions.
 - (d) Suppliers must offer a minimum of six-monthly sessions during the second six months.
- b. Given that MDPP is a once in a lifetime benefit, the program must be portable and make up sessions available.
- (i) Beneficiaries can change MDPP suppliers.
 - (ii) Example: Dual cities, beneficiary relocation, and freedom of choice
- c. Make up Sessions must be available
- (i) Can be in person or virtual
 - (a) In-person
 - (1) Must use same curriculum as session missed
 - (2) Maximum of one per week;
 - (3) Maximum of one per day of regularly scheduled sessions
 - (b) Virtual
 - (1) Same requirements as in-person make-up sessions;
 - (2) Only by beneficiary request;
 - (3) Compliant with Diabetes Prevention Recognition Program (DPRP) virtual standards;
 - (4) Maximum of 4 during the core services period, of which no more than 2 are core maintenance sessions;
 - (5) Maximum of 3 that are ongoing maintenance sessions; and
 - (6) Weight loss measurements taken cannot be used for payment or eligibility.

- (7) All sessions, except the first session, may be provided as a virtual make up session.
- (8) Modifier -VM should be appended to the appropriate HCPCS code to indicate the make-up session was provided via a virtual setting. <82 Federal Register, 53287>
 - a. VM - Medicare diabetes prevention program (MDPP) virtual make-up session

2. MDPP Payment Structure and HCPCS Coding

a. Core Sessions and Core Maintenance Sessions < 2025 Medicare FFS Billing and Payment Fact Sheet >

(i) Attendance – Fee-for-Service Payments

- (1) HCPCS G9886 - Behavioral counseling for diabetes prevention, in-person, group, 60 minutes
 - a. Beneficiary attended a core session in person, group, 60 minutes
 - i. Medicare Reimbursement CY 2025- \$26.00
- (2) HCPCS G9887 - Behavioral counseling for diabetes prevention, distance learning, 60 minutes
 - a. The beneficiary attended a core session via distance learning, 60 minutes.
 - i. Medicare Reimbursement CY 2025 - \$26.00

(ii) Performance Payments

- (1) HCPCS G9880- The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP expanded model (EM). his is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session
 - a. Billable once

i. Medicare Reimbursement CY 2025 - \$149.00

- (2) HCPCS G9881 - The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP expanded model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session

a. Billable once

i. Medicare Reimbursement CY 2025 - \$26

- (3) HCPCS G9888 - Maintenance 5% WL from baseline weight in months 7-12

(iii) Bridge Payment

- (a) Medicare removed the bridge payment as of January 1, 2025.
Provides are no longer paid for bridge payment services

- (1) Bridge payment: a one-time payment for the first Medicare diabetes prevention program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP expanded model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP expanded model. a supplier may only receive one bridge payment per MDPP beneficiary

a. Billable once per supplier

i. Medicare Reimbursement for CY 2024 - \$25.00

(iv) Frequency of Medicare Payments

- (a) Medicare pays up to 22 visits billed with codes G9886 and G9887, combined, in a 12-month period:

- (1) Months 1-6: one in-person/distance learning visit every week (up to 16)
- (2) Months 7-12: one in-person/distance learning visit every month (up to 6)

- (3) Months 7-12, once participant achieves 5% WL, supplier may submit Maintenance of 5% WL claim with attendance claim (G9888 + G9886/G9887).
- (4) Medicare will pay for Maintenance 5% WL up to 6 times in months 7-12. < See: OTN Transmittal 12770>

Version 08/01/2025
Check for Updates

Version 08/01/2025
Check for Updates

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12546	Date: March 14, 2024
	Change Request 13548

SUBJECT: Update Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1 Concerning Healthcare Common Procedure Coding System (HCPCS) Billing Codes and Chapter 12, Section 30.6.2 Concerning Advance Beneficiary Notice of Non-coverage (ABN) Requirements

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the HCPCS code billing section 30.6.1.1 and the Advance Beneficiary Notice of Non-coverage (ABN) section 30.6.2 in Chapter 12 of Pub. 100-04, Medicare Claims Processing Manual concerning the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) services. These updates clarify the billing code requirements for the IPPE and the AWV and provide additional ABN guidance.

EFFECTIVE DATE: May 15, 2024

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

IMPLEMENTATION DATE: May 15, 2024

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	12/30/30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
R	12/30/30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service

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: 12546	Date: March 14, 2024	Change Request: 13548
-------------	--------------------	----------------------	-----------------------

SUBJECT: Update Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1 Concerning Healthcare Common Procedure Coding System (HCPCS) Billing Codes and Chapter 12, Section 30.6.2 Concerning Advance Beneficiary Notice of Non-coverage (ABN) Requirements

EFFECTIVE DATE: May 15, 2024

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

IMPLEMENTATION DATE: May 15, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the HCPCS code billing section 30.6.1.1 and the Advance Beneficiary Notice of Non-coverage (ABN) section 30.6.2 in Chapter 12 of Pub. 100-04, Medicare Claims Processing Manual concerning the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) services. These updates clarify the billing code requirements for the IPPE and the AWV and provide additional ABN guidance.

Medicare established preventive service billing HCPCS codes G0402 - Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment, G0438 - Annual Wellness Visit; includes a personalized prevention plan of service (PPS), initial visit, and G0439 - Annual Wellness Visit; includes a personalized prevention plan of service (PPS), subsequent visit. These codes must be used for these services for Medicare beneficiaries. CPT codes 99381-99397 for comprehensive preventive medicine evaluation and management services should not be used to bill for Medicare services covered by HCPCS codes G0402, G0438 and G0439.

A physician is not required to give a Medicare beneficiary written advance notice of noncoverage of the part of the visit that constitutes a routine preventive visit not covered by Medicare such as comprehensive preventive Medicine evaluation and management services in the CPT code range 99381-99397. However, in accordance with Pub.100-04, Chapter 50, section 50.2.1, physicians are strongly encouraged to provide an ABN to beneficiaries when providing and billing for a preventive medicine service (CPT codes 99381-99397). The physician is responsible for notifying the patient in advance of his/her liability for the charges for services that are not medically necessary to treat an illness or injury.

B. Policy: No new policy is established by this Change Request.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
13548.1	Contractors shall be aware of the updates to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12,	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	section 30.6.1.1									
13548.2	Contractors shall be aware of the updates to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 30.6.2	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
13548.3	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	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

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

Version 08/01/2025
Check for Updates

30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

(Rev. 12546; Issued: 03-14-24; Effective: 05-15-24; Implementation: 05-15-24)

F. HCPCS Codes Used to Bill the IPPE or AWV

1. HCPCS Codes Used to Bill the IPPE

For IPPE and EKG services provided prior to January 1, 2009, the physician or qualified NPP shall bill HCPCS code G0344 for the IPPE performed face-to-face, and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the IPPE, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. HCPCS codes G0344, G0366, G0367 and G0368 will not be billable codes effective on or after January 1, 2009.

Effective for a beneficiary who has the IPPE on or after January 1, 2009, and within his/her 12-month enrollment period of Medicare Part B, the IPPE and screening EKG services are billable with the appropriate HCPCS G code(s).

The physician or qualified NPP shall bill HCPCS code G0402 for the IPPE performed face-to-face with the patient.

The physician or entity shall bill HCPCS code G0403 for performing the complete screening EKG that includes the tracing, interpretation and report.

The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0404.

The physician or entity that performs the screening EKG interpretation and report only, (without the EKG tracing) shall bill HCPCS code G0405.

2. HCPCS Codes Used to Bill the AWV

For the first AWV provided on or after January 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per beneficiary per lifetime allowable Medicare Part B benefit. *Do not bill for AWV services using CPT codes 99381-99397.*

All subsequent AWVs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). In the event that a beneficiary selects a new health professional to complete a subsequent AWV, the new health professional will continue to bill the subsequent AWV with HCPCS G0439. *Do not bill for AWV services using CPT codes 99381-99397.*

NOTE: For an IPPE or AWV performed during the global period of surgery, refer to chapter 12, §30.6.6 of this chapter for reporting instructions.

30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service

(Rev. 12546; Issued: 03-14-24; Effective: 05-15-24; Implementation: 05-15-24)

See Chapter 18 for payment for covered preventive services.

When a physician furnishes a Medicare beneficiary a covered visit at the same place and on the same occasion as a noncovered preventive medicine service (CPT codes 99381-99397), consider the covered visit to be provided in lieu of a part of the preventive medicine service of equal value to the visit. A preventive medicine service (CPT codes 99381-99397) is a noncovered service. The physician may charge the beneficiary, as a charge for the noncovered remainder of the service, the amount by which the physician's current established charge for the preventive medicine service exceeds his/her current established charge for the covered visit. Pay for the covered visit based on the lesser of the fee schedule amount or the physician's actual charge for the visit. The physician is not required to give the beneficiary written advance notice of noncoverage (ABN) of the part of the visit that constitutes a routine preventive visit. *However, in accordance with Pub.100-04, Chapter 50, section 50.2.1, physicians are strongly encouraged to provide an ABN to beneficiaries when providing and billing for a preventive medicine service (CPT codes 99381-99397). Also, the* physician is responsible for notifying the patient in advance of his/her liability for the charges for services that are not medically necessary to treat the illness or injury.

There could be covered and noncovered procedures performed during this encounter (e.g., screening x-ray, EKG, lab tests.). These are considered individually. Those procedures which are for screening for asymptomatic conditions are considered noncovered and, therefore, no payment is made. Those procedures ordered to diagnose or monitor a symptom, medical condition, or treatment are evaluated for medical necessity and, if covered, are paid.

Version 08/01/2024
Check for Updates

Pneumococcal Shot & Administration

HCPCS Codes

G0009 — Administration of pneumococcal vaccine

M0201 — Administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home

What's Changed?

No FY 2025
quarter 3
changes

CPT Codes

90670 — Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use

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

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

90684 — Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use

90732 — Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

ICD-10 Codes

Z23

Note: Additional ICD-10 codes may apply. Find individual change requests and specific ICD-10-CM service codes we cover on [CMS ICD-10](https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10) (<https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10>). Find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>) for more information.

Medicare Covers

Patients with Medicare Part B

Frequency

Visit CDC's [Pneumococcal Vaccine Timing for Adults](https://www.cdc.gov/pneumococcal/downloads/vaccine-timing-adults-jobaid.pdf) (<https://www.cdc.gov/pneumococcal/downloads/vaccine-timing-adults-jobaid.pdf>).

See FAQ on [how to check eligibility \(#FAQ\)](#).

Patient Pays

No copayment, coinsurance, or deductible

Other Notes

- Most Medicare providers may [bill and get paid](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf#page=30) (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf#page=30>) for pneumococcal shot services.
- We return eligibility transactions with the specific pneumococcal vaccine, date of service, and NPI to let providers know if the patient already got either or both vaccines and from which provider.
- If the patient isn't certain about their shot history and you can't get medical record verification, provide the shot. The patient is liable for added shot costs if they exceed the benefit maximum or if service timing is sooner than allowed.
- We make an [additional payment](https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment) (<https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment>) for in-home pneumococcal shot administration under certain circumstances.

CPT only copyright 2024 American Medical Association. All Rights Reserved.

How do I determine the last date a patient got a preventive service so I know if they're eligible to get the next service, and it won't deny due to frequency edits?

Learn how to [check eligibility](https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) (<https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf>). You may access eligibility information through the CMS [HIPAA Eligibility Transaction System](https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system/how-to-get-connected) (HETS) either directly or through your:

- Eligibility services provider
- Medicare Administrative Contractor (MAC) provider web portal

Contact your eligibility services provider or find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>).

My patients don't follow up on routine preventive care. How can I help them remember when they're due for their next preventive service?

We offer a [Preventive Services Checklist](https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf) (<https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf>) so they can track their preventive services.

When can CMS add new Medicare preventive services?

We may add preventive services coverage through the National Coverage Determination (NCD) process if the service is:

- Reasonable and necessary for preventing or detecting illness or disability in early stages
- U.S. Preventive Services Task Force (USPSTF)-recommended with grade A or B
- Appropriate for people entitled to Medicare Part A benefits or enrolled under Medicare Part B

We may also add preventive services through statutory and regulatory authority.

[USPSTF Published Recommendations](https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) (https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) has more preventive services information.

What's a primary care setting?

We define a primary care setting as a place where clinicians deliver integrated, accessible health care services and are responsible for:

- Addressing most patient health care needs
- Developing a sustained patient partnership
- Practicing in the family and community context

Under this direction, we don't consider these facilities as primary care settings:

- Emergency departments
- Inpatient hospital settings
- Ambulatory surgical centers
- Independent diagnostic testing facilities
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Hospices

Can I bill the office and outpatient evaluation and management (E/M) visit complexity add-on HCPCS code G2211 with Medicare Part B preventive services?

Starting January 1, 2025, you can report HCPCS code G2211 and E/M services (CPT codes 99202–99205 and 99211–99215) billed with modifier 25 only when performed on the same day as:

- Annual wellness visit (HCPCS codes G0438 and G0439)
- Vaccine administration
- Any Part B preventive service provided in the office or outpatient setting, except glaucoma screenings

We believe that building trust in the longitudinal relationship with your patients is significant when making decisions about their Part B preventive services. We recognize that when preventive services are the primary reason for a visit, you may still address complex medical needs and provide ongoing care coordination. [MLN Matters article MM13473](https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-code-g2211) (<https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-code-g2211>) has more information on HCPCS code G2211.

Resources

- [CMS Preventive Services](https://www.cms.gov/medicare/coverage/preventive-services-coverage) (<https://www.cms.gov/medicare/coverage/preventive-services-coverage>)
- [National Training Program Resources](https://cmsnationaltrainingprogram.cms.gov/resources) (<https://cmsnationaltrainingprogram.cms.gov/resources>)

Disclaimers

CPT codes, descriptions and other data only are copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer) (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer>).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Version 08/01/2025
Check for Updates

COVID-19 Vaccine & Administration

Find the current list of COVID-19 billing codes, payment allowances, and effective dates at [Vaccine Pricing](https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing) (<https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing>).

HCPCS Code

M0201 — Administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home

What's Changed?

No FY 2025
quarter 3
changes

CPT Codes

- 90480** — Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose
- 91304** — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use
- 91318** — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- 91319** — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- 91320** — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- 91321** — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use
- 91322** — Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use

Z23

Note: Additional ICD-10 codes may apply. Find individual change requests and specific ICD-10-CM service codes we cover on [CMS ICD-10](https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10) (<https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10>). Find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>) for more information.

Medicare Covers

Patients with Medicare Part B

Frequency

Review the [FDA emergency use authorization](https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#vaccines) (<https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#vaccines>) (EUA) criteria for each vaccine.

See FAQ on [how to check eligibility](#) (#FAQ).

Patient Pays

No copayment, coinsurance, or deductible

Other Notes

- The Medicare payment rate for administering the COVID-19 vaccine is different than the payment rate for administering other Part B preventive vaccines, like the flu, hepatitis B, and pneumococcal vaccines. View the [COVID-19 Vaccine Toolkit](https://www.cms.gov/covidvax-provider) (<https://www.cms.gov/covidvax-provider>) for more information about payment, billing, and coding for COVID-19 vaccines.
- Effective January 1 of the year following the year in which the EUA declaration for COVID-19 drugs and biologicals ends, we set the payment rate for administering COVID-19 vaccines to align with the payment rate for administering other Part B preventive vaccines.
- Patients can get the COVID-19 vaccine, including additional doses and booster doses, without a physician's order or supervision.
- For hospice patients under Part B only, you must include the GW modifier on COVID-19 vaccine administration claims if either of these apply:
 - The vaccine isn't related to your patient's terminal condition
 - The attending physician administered the vaccine
- We make an [additional payment](https://www.cms.gov/medicare/payment/covid-19-vaccine-toolkit/medicare-covid-19-vaccine-shot-payment#Home) (<https://www.cms.gov/medicare/payment/covid-19-vaccine-toolkit/medicare-covid-19-vaccine-shot-payment#Home>) for in-home COVID-19 vaccine administration under certain circumstances.

Version 08/01/2025
Check for Updates

How do I determine the last date a patient got a preventive service so I know if they're eligible to get the next service, and it won't deny due to frequency edits?

Learn how to [check eligibility](https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) (<https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf>). You may access eligibility information through the CMS [HIPAA Eligibility Transaction System](https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system/how-to-get-connected) (HETS) either directly or through your:

- Eligibility services provider
- Medicare Administrative Contractor (MAC) provider web portal

Contact your eligibility services provider or find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>).

My patients don't follow up on routine preventive care. How can I help them remember when they're due for their next preventive service?

We offer a [Preventive Services Checklist](https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf) (<https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf>) so they can track their preventive services.

When can CMS add new Medicare preventive services?

We may add preventive services coverage through the National Coverage Determination (NCD) process if the service is:

- Reasonable and necessary for preventing or detecting illness or disability in early stages
- U.S. Preventive Services Task Force (USPSTF)-recommended with grade A or B
- Appropriate for people entitled to Medicare Part A benefits or enrolled under Medicare Part B

We may also add preventive services through statutory and regulatory authority.

[USPSTF Published Recommendations](https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) (https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) has more preventive services information.

What's a primary care setting?

We define a primary care setting as a place where clinicians deliver integrated, accessible health care services and are responsible for:

- Addressing most patient health care needs
- Developing a sustained patient partnership
- Practicing in the family and community context

Under this direction, we don't consider these facilities as primary care settings:

- Emergency departments
- Inpatient hospital settings
- Ambulatory surgical centers
- Independent diagnostic testing facilities
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Hospices

Can I bill the office and outpatient evaluation and management (E/M) visit complexity add-on HCPCS code G2211 with Medicare Part B preventive services?

Starting January 1, 2025, you can report HCPCS code G2211 and E/M services (CPT codes 99202–99205 and 99211–99215) billed with modifier 25 only when performed on the same day as:

- Annual wellness visit (HCPCS codes G0438 and G0439)
- Vaccine administration
- Any Part B preventive service provided in the office or outpatient setting, except glaucoma screenings

We believe that building trust in the longitudinal relationship with your patients is significant when making decisions about their Part B preventive services. We recognize that when preventive services are the primary reason for a visit, you may still address complex medical needs and provide ongoing care coordination. [MLN Matters article MM13473](https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-code-g2211) (<https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-code-g2211>) has more information on HCPCS code G2211.

Resources

- [CMS Preventive Services](https://www.cms.gov/medicare/coverage/preventive-services-coverage) (<https://www.cms.gov/medicare/coverage/preventive-services-coverage>)
- [National Training Program Resources](https://cmsnationaltrainingprogram.cms.gov/resources) (<https://cmsnationaltrainingprogram.cms.gov/resources>)

Flu Shot & Administration

Find the current flu season's list of billing codes, payment allowances, and effective dates at [Vaccine Pricing](https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing) (<https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing>).

HCPCS Codes

G0008 — Administration of influenza virus vaccine

M0201 — Administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home

Q2039 — Influenza virus vaccine, not otherwise specified

What's Changed?

No FY 2025
quarter 3
changes

CPT Codes

90653 — Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use

90656 — Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use

90657 — Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use

90658 — Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use

90660 — Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use

90661 — Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use

90662 — Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

90673 — Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

Z23

Note: Additional ICD-10 codes may apply. Find individual change requests and specific ICD-10-CM service codes we cover on [CMS ICD-10 \(https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10\)](https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10). Find your [MAC's website \(https://www.cms.gov/MAC-info\)](https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Patients with Medicare Part B

Frequency

- Once per flu season
- We cover additional flu shots if medically necessary

See FAQ on [how to check eligibility \(#FAQ\)](#).

Patient Pays

No copayment, coinsurance, or deductible

Other Notes

- Most Medicare providers may [bill and get paid \(https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf#page=30\)](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf#page=30) for flu shot services
- [CMS Flu Shot \(https://www.cms.gov/flu-provider\)](https://www.cms.gov/flu-provider) and [CDC Clinical Guidance for Seasonal Influenza Vaccine Safety \(https://www.cdc.gov/flu/hcp/vax-summary/vaccine-safety.html\)](https://www.cdc.gov/flu/hcp/vax-summary/vaccine-safety.html) have more information
- We make an [additional payment \(https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment\)](https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment) for in-home flu shot administration under certain circumstances

How do I determine the last date a patient got a preventive service so I know if they're eligible to get the next service, and it won't deny due to frequency edits?

Learn how to [check eligibility](https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) (<https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf>). You may access eligibility information through the CMS [HIPAA Eligibility Transaction System](https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system/how-to-get-connected) (HETS) either directly or through your:

- Eligibility services provider
- Medicare Administrative Contractor (MAC) provider web portal

Contact your eligibility services provider or find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>).

My patients don't follow up on routine preventive care. How can I help them remember when they're due for their next preventive service?

We offer a [Preventive Services Checklist](https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf) (<https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf>) so they can track their preventive services.

When can CMS add new Medicare preventive services?

We may add preventive services coverage through the National Coverage Determination (NCD) process if the service is:

- Reasonable and necessary for preventing or detecting illness or disability in early stages
- U.S. Preventive Services Task Force (USPSTF)-recommended with grade A or B
- Appropriate for people entitled to Medicare Part A benefits or enrolled under Medicare Part B

We may also add preventive services through statutory and regulatory authority.

[USPSTF Published Recommendations](https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) (https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) has more preventive services information.

What's a primary care setting?

We define a primary care setting as a place where clinicians deliver integrated, accessible health care services and are responsible for:

- Addressing most patient health care needs
- Developing a sustained patient partnership
- Practicing in the family and community context

Under this direction, we don't consider these facilities as primary care settings:

- Emergency departments
- Inpatient hospital settings
- Ambulatory surgical centers
- Independent diagnostic testing facilities
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Hospices

Can I bill the office and outpatient evaluation and management (E/M) visit complexity add-on HCPCS code G2211 with Medicare Part B preventive services?

Starting January 1, 2025, you can report HCPCS code G2211 and E/M services (CPT codes 99202–99205 and 99211–99215) billed with modifier 25 only when performed on the same day as:

- Annual wellness visit (HCPCS codes G0438 and G0439)
- Vaccine administration
- Any Part B preventive service provided in the office or outpatient setting, except glaucoma screenings

We believe that building trust in the longitudinal relationship with your patients is significant when making decisions about their Part B preventive services. We recognize that when preventive services are the primary reason for a visit, you may still address complex medical needs and provide ongoing care coordination. [MLN Matters article MM13473](https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-hcpcs-code-g2211) (<https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-hcpcs-code-g2211>) has more information on HCPCS code G2211.

Resources

- [CMS Preventive Services](https://www.cms.gov/medicare/coverage/preventive-services-coverage) (<https://www.cms.gov/medicare/coverage/preventive-services-coverage>)
- [National Training Program Resources](https://cmsnationaltrainingprogram.cms.gov/resources) (<https://cmsnationaltrainingprogram.cms.gov/resources>)

Disclaimers

CPT codes, descriptions and other data only are copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer) (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer>).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Version 08/01/2025
Check for Updates

Hepatitis B Shot & Administration

HCPCS Codes

G0010 — Administration of hepatitis B vaccine

M0201 — Administration of pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home

What's Changed?

No FY 2025
quarter 3
changes

CPT Codes

90739 — Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use

90740 — Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use

90743 — Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use

90744 — Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use

90746 — Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use

90747 — Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use

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

ICD-10 Codes

Z23

Note: Additional ICD-10 codes may apply. Find individual change requests and specific ICD-10-CM service codes we cover on [CMS ICD-10](https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10) (<https://www.cms.gov/medicare/coverage/determination-process/basics/icd-10>). Find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>) for more information.

Medicare Covers

Patients with Medicare Part B at [intermediate or high risk](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=48) (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=48>) for contracting hepatitis B, including patients who haven't completed a hepatitis B shot series or whose shot history is unknown.

Note: Patients currently positive for hepatitis B antibodies aren't eligible for this benefit.

Frequency

Depending on vaccine or condition, 2, 3, or 4 doses

See FAQ on [how to check eligibility](#) (#FAQ).

Patient Pays

No copayment, coinsurance, or deductible

Other Notes

- We make an [additional payment](https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment) (<https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment>) for in-home hepatitis B shot administration under certain circumstances
- A physician's order isn't required for administering a hepatitis B shot

CPT only copyright 2024 American Medical Association. All Rights Reserved.

How do I determine the last date a patient got a preventive service so I know if they're eligible to get the next service, and it won't deny due to frequency edits?

Learn how to [check eligibility](https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) (<https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf>). You may access eligibility information through the CMS [HIPAA Eligibility Transaction System](https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system/how-to-get-connected) (HETS) either directly or through your:

- Eligibility services provider
- Medicare Administrative Contractor (MAC) provider web portal

Contact your eligibility services provider or find your [MAC's website](https://www.cms.gov/MAC-info) (<https://www.cms.gov/MAC-info>).

My patients don't follow up on routine preventive care. How can I help them remember when they're due for their next preventive service?

We offer a [Preventive Services Checklist](https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf) (<https://www.medicare.gov/publications/11420-are-you-up-to-date-on-your-medicare-preventive-services.pdf>) so they can track their preventive services.

When can CMS add new Medicare preventive services?

We may add preventive services coverage through the National Coverage Determination (NCD) process if the service is:

- Reasonable and necessary for preventing or detecting illness or disability in early stages
- U.S. Preventive Services Task Force (USPSTF)-recommended with grade A or B
- Appropriate for people entitled to Medicare Part A benefits or enrolled under Medicare Part B

We may also add preventive services through statutory and regulatory authority.

[USPSTF Published Recommendations](https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) (https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P) has more preventive services information.

What's a primary care setting?

We define a primary care setting as a place where clinicians deliver integrated, accessible health care services and are responsible for:

- Addressing most patient health care needs
- Developing a sustained patient partnership
- Practicing in the family and community context

Under this direction, we don't consider these facilities as primary care settings:

- Emergency departments
- Inpatient hospital settings
- Ambulatory surgical centers
- Independent diagnostic testing facilities
- Skilled nursing facilities
- Inpatient rehabilitation facilities
- Hospices

Can I bill the office and outpatient evaluation and management (E/M) visit complexity add-on HCPCS code G2211 with Medicare Part B preventive services?

Starting January 1, 2025, you can report HCPCS code G2211 and E/M services (CPT codes 99202–99205 and 99211–99215) billed with modifier 25 only when performed on the same day as:

- Annual wellness visit (HCPCS codes G0438 and G0439)
- Vaccine administration
- Any Part B preventive service provided in the office or outpatient setting, except glaucoma screenings

We believe that building trust in the longitudinal relationship with your patients is significant when making decisions about their Part B preventive services. We recognize that when preventive services are the primary reason for a visit, you may still address complex medical needs and provide ongoing care coordination. [MLN Matters article MM13473](https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-code-g2211) (<https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-on-code-g2211>) has more information on HCPCS code G2211.

Resources

- [CMS Preventive Services](https://www.cms.gov/medicare/coverage/preventive-services-coverage) (<https://www.cms.gov/medicare/coverage/preventive-services-coverage>)
- [National Training Program Resources](https://cmsnationaltrainingprogram.cms.gov/resources) (<https://cmsnationaltrainingprogram.cms.gov/resources>)

Disclaimers

CPT codes, descriptions and other data only are copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer) (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer>).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Version 08/01/2025
Check for Updates



Medicare Part D Vaccines



What's Changed?

- Clarified policy on new vaccines and Part D plan formularies (page 2)
- Clarified general policy on billing Part D vaccines (page 3)

Substantive content changes are in dark red.

If you're a health care provider who administers certain vaccines to patients with Medicare prescription drug (Part D) plans, it's important to understand that their Part D plans generally pay for the vaccines and administration.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

Part B Vaccines

Medicare Part B covers vaccines and vaccine administration for:

- [Flu](#)
- [Pneumonia](#)
- [Hepatitis B](#) (for people at high and intermediate risk)
- [COVID-19](#)
- Certain reasonable and necessary vaccines to **treat** an injury or exposure to a disease

Part D Vaccines

Part D plans cover all commercially available vaccines when they're reasonable and necessary to **prevent** illness, **except those covered by Part B**.

Part D plans may not immediately add newly approved vaccines to their formularies. If a new vaccine isn't on the Part D plan's formulary, the enrollee or the enrollee's representative, prescribing physician, or other prescriber acting on behalf of the enrollee can request vaccine coverage through the [formulary exception](#) process.

Part D Vaccine Administration

Part D plans cover [vaccine administration costs](#) as part of each vaccine's negotiated price, including:

- Dispensing fee (if applicable)
- Vaccine administration fee
- Vaccine ingredient cost

Examples

The shingles, respiratory syncytial virus (RSV), and tetanus-diphtheria-whooping cough vaccines are Part D vaccines.

Treat (Part B) vs. Prevent (Part D)

If a patient gets a tetanus vaccination because of an accidental puncture wound, it's a Part B-covered vaccine. However, if the patient gets a tetanus booster shot, unrelated to injury or illness, it's a Part D-covered vaccine.

Bill Part D vaccines, including their associated administration costs, [on 1 claim](#) when the same provider is both dispensing and administering the vaccine. This applies to both in-network and out-of-network providers.

Part D plans may pay **either** a single vaccine administration fee for all vaccines **or** multiple administration fees based on:

- Product administration complexity
- Provider type
- Vaccine type

Contact your patient's [Part D plan](#) to learn about specific vaccine administration fees.

Patient Cost-Sharing

Patients with Part D plans pay nothing out of pocket for [adult vaccines recommended by the Advisory Committee on Immunization Practices](#) (ACIP) even if they get the Part D vaccine from an out-of-network provider. Part D vaccine cost-sharing is consistent with coverage under Part B where the patient has no coinsurance or deductible.

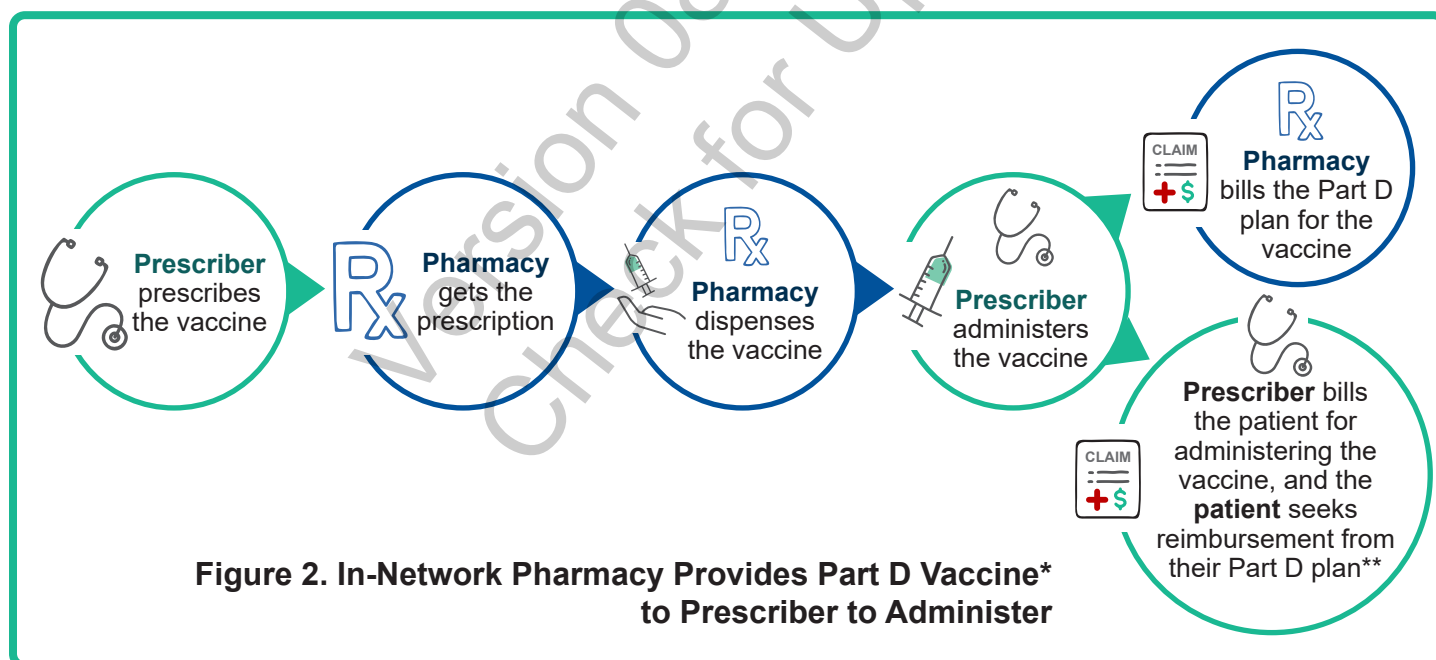
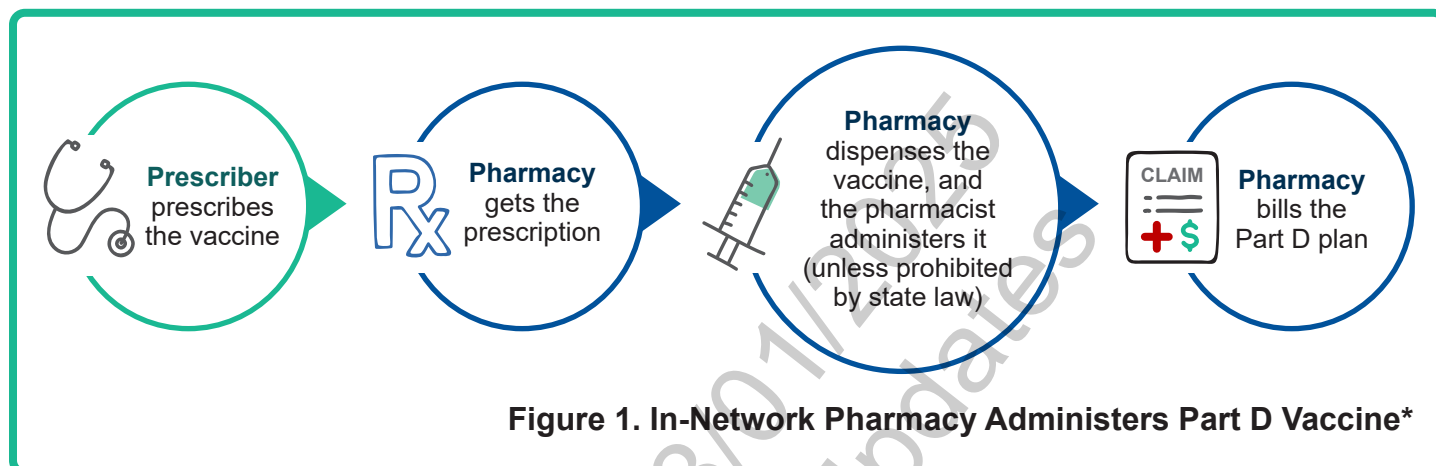
If an out-of-network provider administers the vaccine, the patient may have to pay a vaccine administration fee at the time of service, but they can get reimbursed in full for this fee from their Part D plan.



Patient Access to Part D Vaccines

Part D In-Network Pharmacy Options

If you aren't able to bill the Part D plan directly, work with your patient and their [Part D plan](#) for payment. Figures 1 and 2 show how in-network pharmacies can dispense, administer, and bill for Part D vaccines.



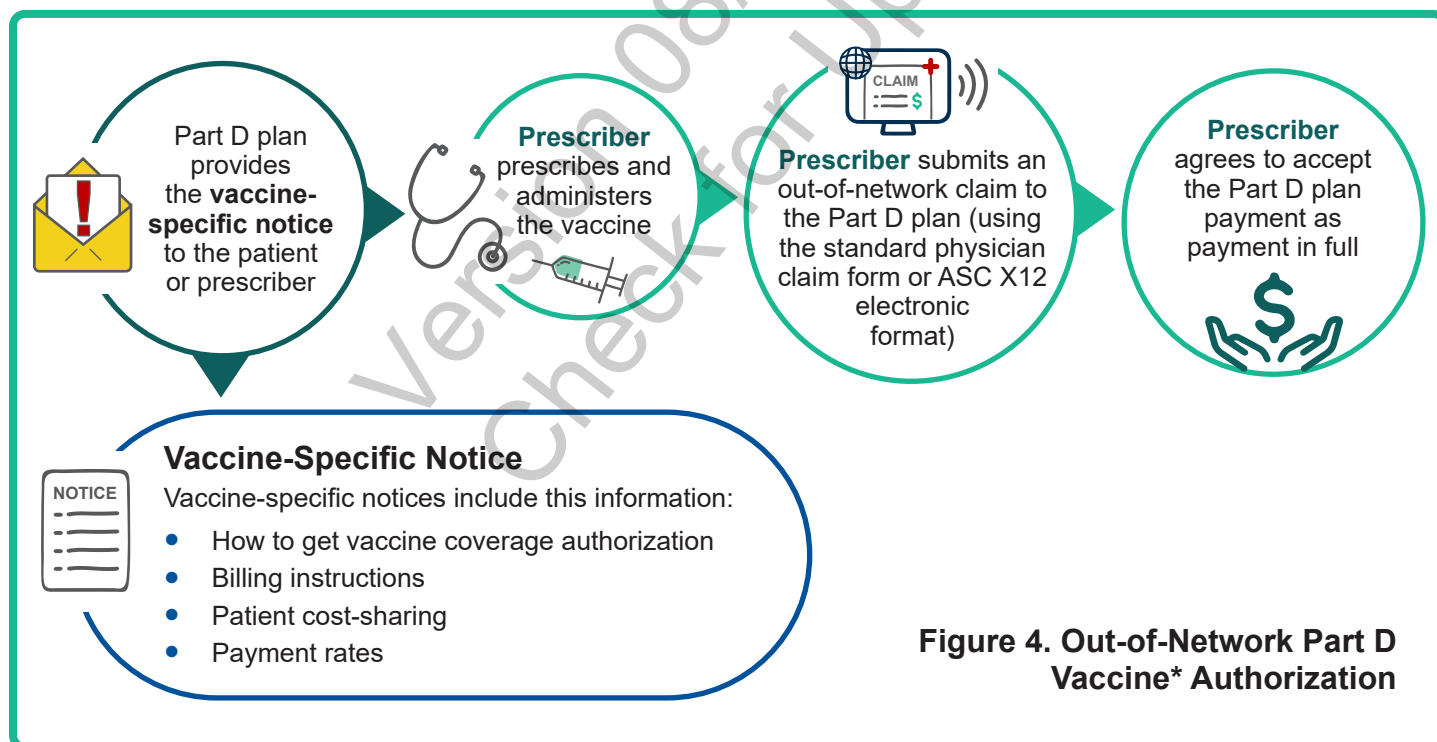
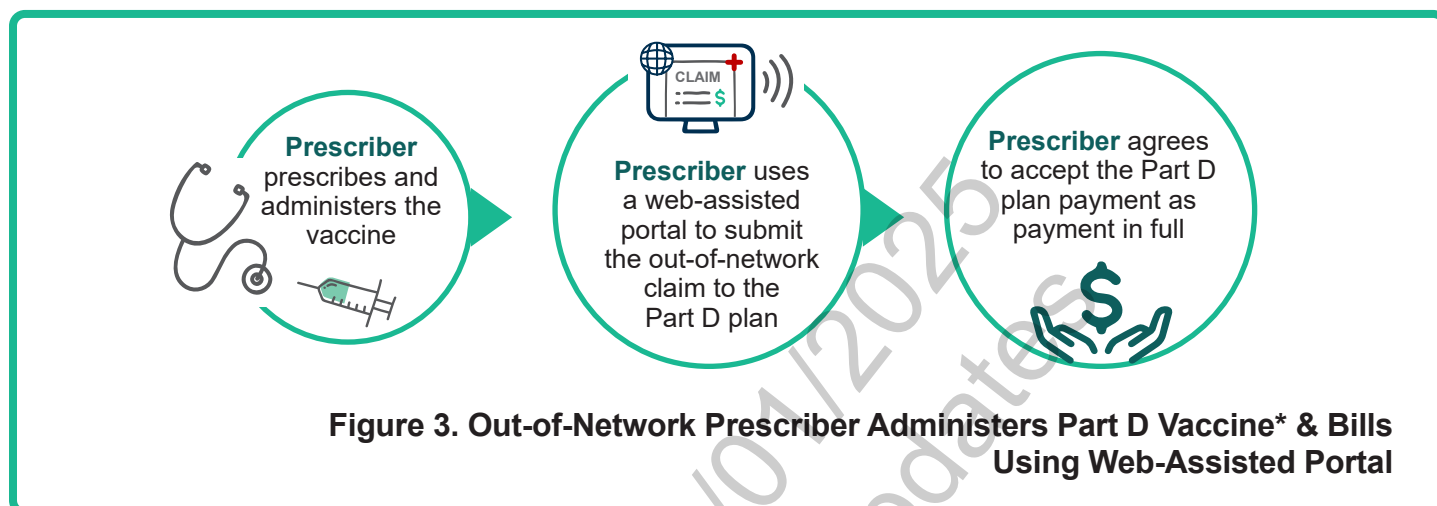
*Most prescribed vaccines are [ACIP-recommended](#). If you prescribe a vaccine that isn't ACIP-recommended, the Part D plan may charge the patient coinsurance or a copayment.

**Vaccine administration in prescribers' offices is considered out of network because Part D sponsors' networks are defined as pharmacy networks only.

Part D Out-of-Network Prescriber Options

In out-of-network situations, the prescriber may assist patients in submitting their vaccine claims. The prescriber doesn't become a network provider.

Figures 3 and 4 show how out-of-network prescribers can administer and bill Part D vaccines.



*Most prescribed vaccines are [ACIP-recommended](#). If you prescribe a vaccine that isn't ACIP-recommended, the Part D plan may charge the patient coinsurance or a copayment.

Resources

- [Medicare COVID-19 Vaccine Shot Payment](#)
- [Medicare Part D Patient Information](#)
- [Prescription Drug Coverage – General Information](#)
- [Sections 60.2–60.3.4 of Medicare Prescription Drug Benefit Manual, Chapter 5](#)
- [Section 10.14 of Medicare Prescription Drug Benefit Manual, Chapter 6](#)

Version 08/01/2025
Check for Updates

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](#).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).



Medicare Part D Vaccines



What's Changed?

- Clarified policy on new vaccines and Part D plan formularies (page 2)
- Clarified general policy on billing Part D vaccines (page 3)

Substantive content changes are in dark red.

If you're a health care provider who administers certain vaccines to patients with Medicare prescription drug (Part D) plans, it's important to understand that their Part D plans generally pay for the vaccines and administration.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

Part B Vaccines

Medicare Part B covers vaccines and vaccine administration for:

- [Flu](#)
- [Pneumonia](#)
- [Hepatitis B](#) (for people at high and intermediate risk)
- [COVID-19](#)
- Certain reasonable and necessary vaccines to **treat** an injury or exposure to a disease

Part D Vaccines

Part D plans cover all commercially available vaccines when they're reasonable and necessary to **prevent** illness, **except those covered by Part B**.

Part D plans may not immediately add newly approved vaccines to their formularies. If a new vaccine isn't on the Part D plan's formulary, the enrollee or the enrollee's representative, prescribing physician, or other prescriber acting on behalf of the enrollee can request vaccine coverage through the [formulary exception](#) process.

Part D Vaccine Administration

Part D plans cover [vaccine administration costs](#) as part of each vaccine's negotiated price, including:

- Dispensing fee (if applicable)
- Vaccine administration fee
- Vaccine ingredient cost

Examples

The shingles, respiratory syncytial virus (RSV), and tetanus-diphtheria-whooping cough vaccines are Part D vaccines.

Treat (Part B) vs. Prevent (Part D)

If a patient gets a tetanus vaccination because of an accidental puncture wound, it's a Part B-covered vaccine. However, if the patient gets a tetanus booster shot, unrelated to injury or illness, it's a Part D-covered vaccine.

Bill Part D vaccines, including their associated administration costs, [on 1 claim](#) when the same provider is both dispensing and administering the vaccine. This applies to both in-network and out-of-network providers.

Part D plans may pay **either** a single vaccine administration fee for all vaccines **or** multiple administration fees based on:

- Product administration complexity
- Provider type
- Vaccine type

Contact your patient's [Part D plan](#) to learn about specific vaccine administration fees.

Patient Cost-Sharing

Patients with Part D plans pay nothing out of pocket for [adult vaccines recommended by the Advisory Committee on Immunization Practices](#) (ACIP) even if they get the Part D vaccine from an out-of-network provider. Part D vaccine cost-sharing is consistent with coverage under Part B where the patient has no coinsurance or deductible.

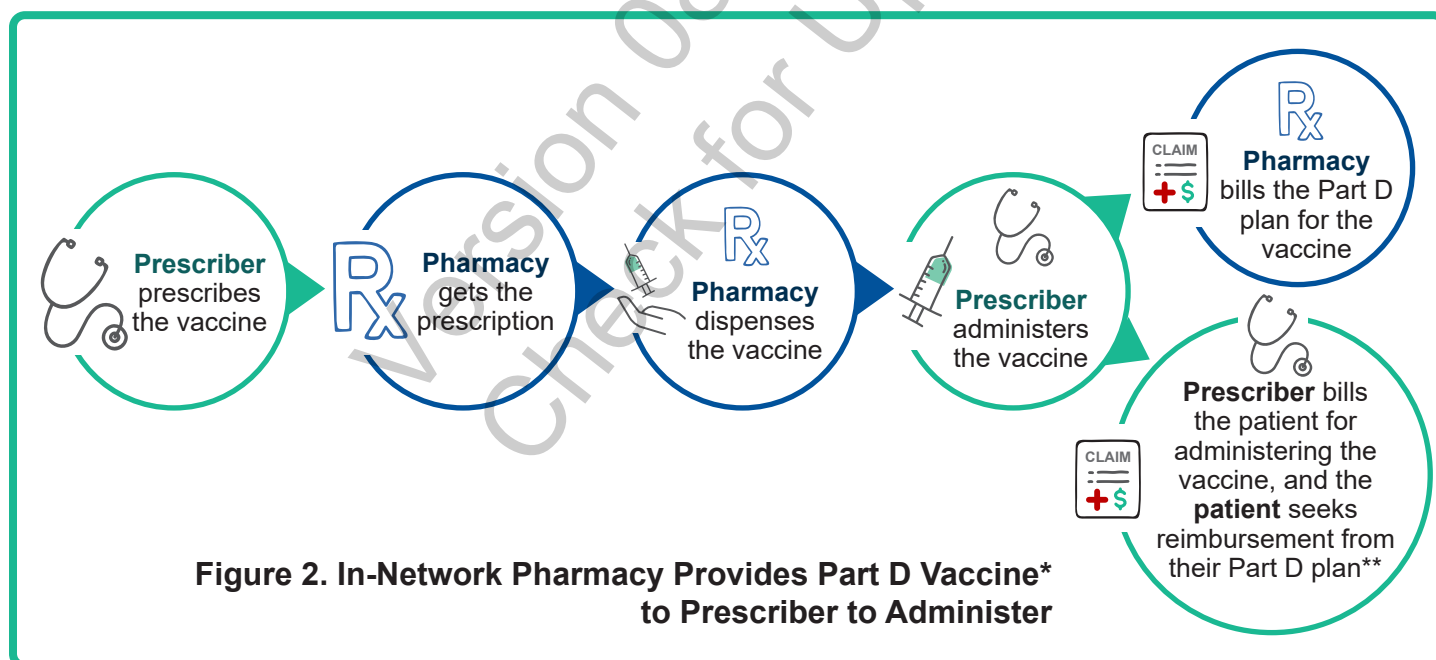
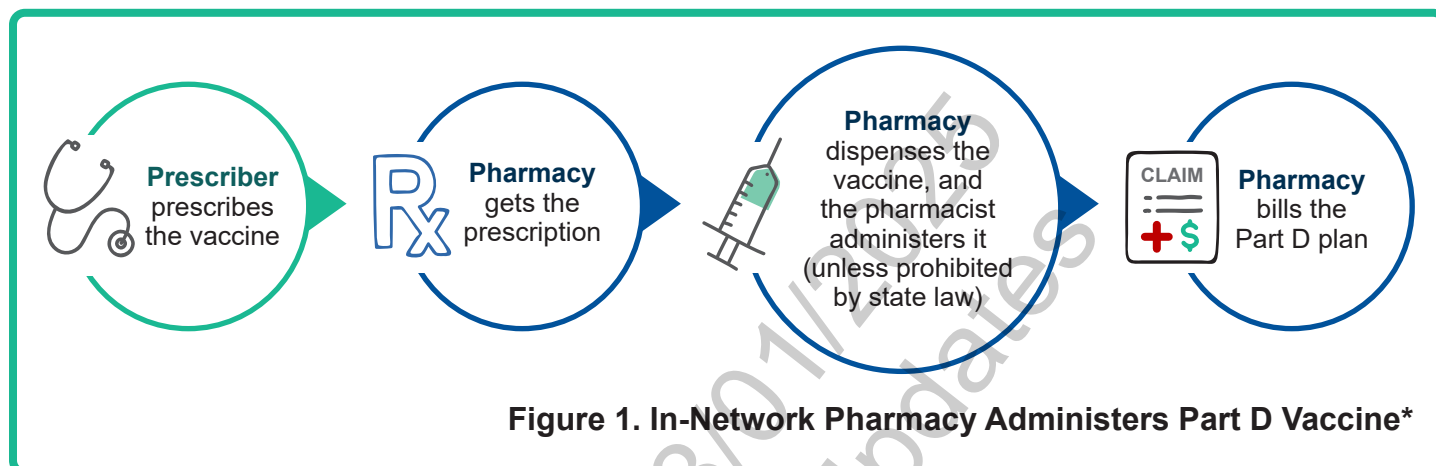
If an out-of-network provider administers the vaccine, the patient may have to pay a vaccine administration fee at the time of service, but they can get reimbursed in full for this fee from their Part D plan.



Patient Access to Part D Vaccines

Part D In-Network Pharmacy Options

If you aren't able to bill the Part D plan directly, work with your patient and their [Part D plan](#) for payment. Figures 1 and 2 show how in-network pharmacies can dispense, administer, and bill for Part D vaccines.



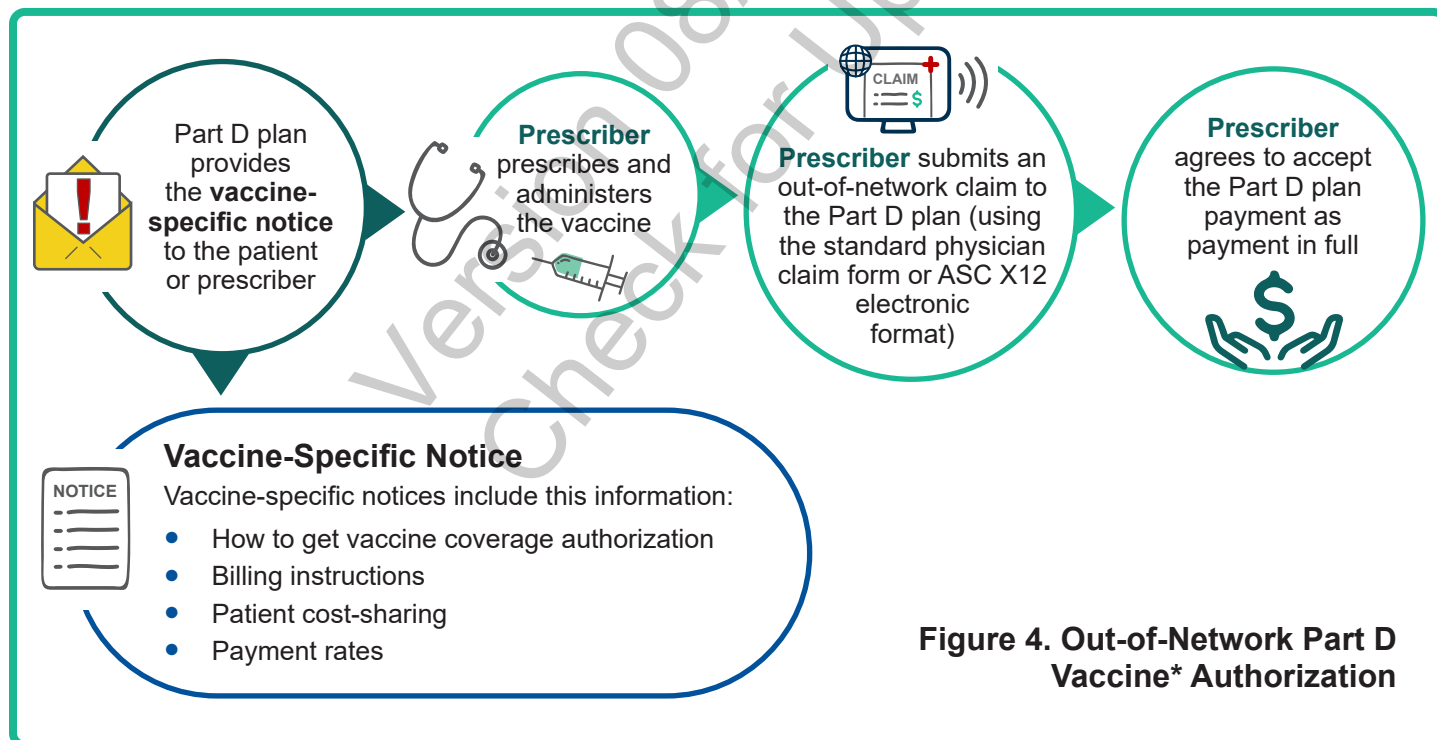
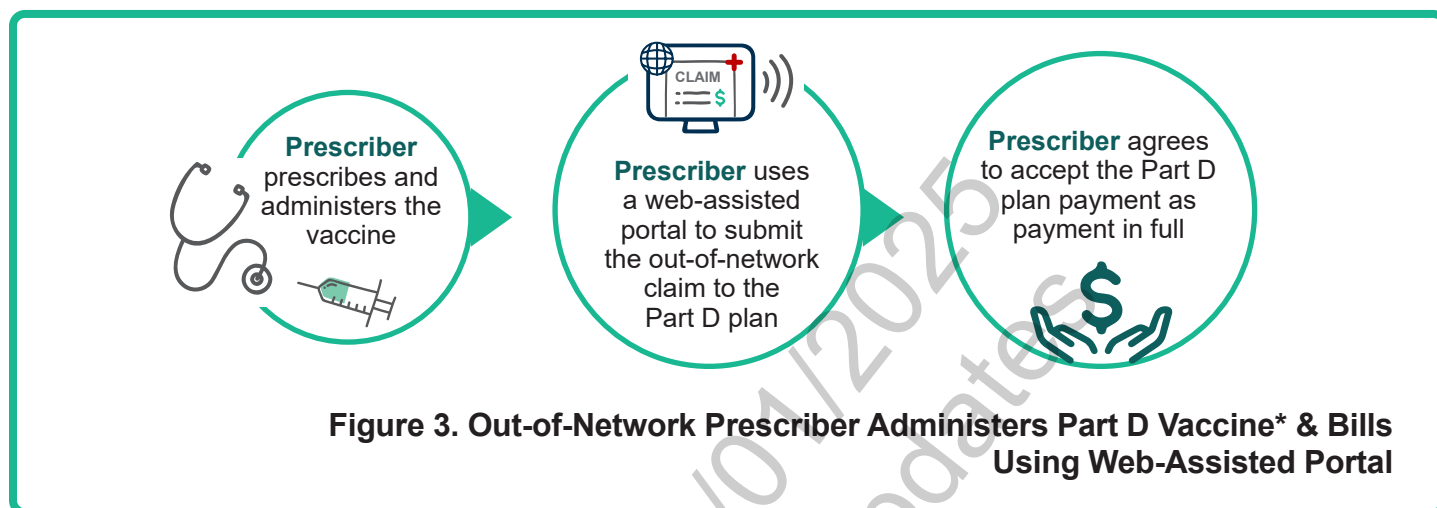
*Most prescribed vaccines are [ACIP-recommended](#). If you prescribe a vaccine that isn't ACIP-recommended, the Part D plan may charge the patient coinsurance or a copayment.

**Vaccine administration in prescribers' offices is considered out of network because Part D sponsors' networks are defined as pharmacy networks only.

Part D Out-of-Network Prescriber Options

In out-of-network situations, the prescriber may assist patients in submitting their vaccine claims. The prescriber doesn't become a network provider.

Figures 3 and 4 show how out-of-network prescribers can administer and bill Part D vaccines.



*Most prescribed vaccines are [ACIP-recommended](#). If you prescribe a vaccine that isn't ACIP-recommended, the Part D plan may charge the patient coinsurance or a copayment.

Resources

- [Medicare COVID-19 Vaccine Shot Payment](#)
- [Medicare Part D Patient Information](#)
- [Prescription Drug Coverage – General Information](#)
- [Sections 60.2–60.3.4 of Medicare Prescription Drug Benefit Manual, Chapter 5](#)
- [Section 10.14 of Medicare Prescription Drug Benefit Manual, Chapter 6](#)

Version 08/01/2025
Check for Updates

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](#).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).