CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 916

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: APRIL 28, 2006

Change Request 5050

SUBJECT: Correct Reporting of Diagnosis Codes on Screening Mammography Claims

I. SUMMARY OF CHANGES: This instruction requires system maintainers to reprogram edits currently in place that edit for certain primary diagnosis codes on claims containing screening mammography services. In addition, this instruction updates Chapter 18 Section 20.4 for intermediary processed claims by removing 12X type of bill (TOB) from the list of applicable TOBs for diagnostic mammography, by adding HCPCS code G0202 to the list of valid codes for the billing of screening mammography, by and adding HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.

NEW/REVISED MATERIAL

EFFECTIVE DATE: October 1, 2006

IMPLEMENTATION DATE: October 2, 2006

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/20/20.2/HCPCS and Diagnosis Codes for Mammography Services
R	18/20/20.4/Billing Requirements - FI Claims

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 916	Date: April 28, 2006	Change Request 5050

SUBJECT: Correct Reporting of Diagnosis Codes on Screening Mammography Claims

I. GENERAL INFORMATION

A. Background: Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This instruction requires system maintainers to reprogram edits currently in place that require one of these primary diagnosis codes on a claim containing screening mammography services if other services are also on the claim. Such edits will continue to require one of these diagnosis codes on a claim that contains only screening mammography services.

In addition, this instruction updates Chapter 18, Section 20.4 for intermediary processed claims as follows:

- removes 12X type of bill (TOB) from the list of applicable TOBs for diagnostic mammography,
- adds HCPCS code G0202 to the list of valid codes for the billing of screening mammography, and
- adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.

B. Policy: Diagnosis code V76.11 or V76.12 must be reported as the principal diagnosis on a claim for screening mammography services. This requirement is changed to allow the reporting of any applicable diagnosis code as a primary diagnosis on claims containing other services in addition to a screening mammography. Providers continue reporting diagnosis code V76.11 or V76.12 as primary diagnosis codes on claims that contain only screening mammography services.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5050.1	Shared system maintainers shall reprogram any applicable edits currently in place that require the reporting of diagnosis codes V76.11 or V76.12 as primary on claims containing screening mammography services.					X	X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5050.1.1	Shared system maintainers shall reprogram such edits so that diagnosis codes V76.11 or V76.12 need not be reported as the primary diagnosis code if the claim contains services other than screening mammography services.					X	X			
5050.1.2	In reprogramming such edits, shared system maintainers shall ensure that the edits require that diagnosis code V76.11 or V76.12 is reported as the primary diagnosis on a claim containing only screening mammography services.					X	X			
5050.2	Contractors shall instruct providers to continue reporting diagnosis codes V76.11 or V76.12 as primary diagnosis codes on claims that contain only screening mammography services.	X		X						
5050.3	Contractors shall instruct providers to report diagnosis codes V76.11 or V76.12 as a secondary diagnosis on claims that contain other services in addition to a screening mammography.	X		X		X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5050.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMatters/Articles shortly after the CR is released. You will receive notification of the article release via the established "MLNMatters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** William Ruiz William.ruiz@cms.hhs.gov 410-786-9283 Tracey Hemphill tracey.hemphill@cms.hhs.gov 410-786-7169 **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev. 916, Issued: 04-28-06; Effective: 10-01-06; Implementation: 10-02-06)

The following HCPCS and TOS codes are used to bill for mammography services.

HCPCS Code	TOS	Definition
76082	4	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, diagnostic mammography (list separately in addition to code for primary procedure). **Effective January 1, 2004.**
76083	1	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). **Effective January 1, 2004.**
76085	1	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation screening mammography (list separately in addition to code for primary procedure). Use with CPT code 76092 **Code 76085 was effective January 1, 2002 for all claims submitted to a carrier or an FI, except hospital outpatient prospective payment (OPPS) claims, which are billed to the FI. For OPPS claims billed to the FI, this code is effective April 1, 2002. Deleted as of December 31, 2003.**
76090	1	Diagnostic mammography, unilateral.
76091	1	Diagnostic mammography, bilateral.
76092	1, B, C	Screening mammography, bilateral (two view film study of each breast).
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. **Code Effective April 1, 2001.**
G0203		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views; **Code Effective April 1, 2001 and terminated December 31, 2001, with the exception of hospitals subject to OPPS, who may bill this code through March 31, 2002.**

HCPCS Code	TOS	Definition
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; **Code Effective April 1, 2001.**
G0205		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views; **Code Effective April 1, 2001 and terminated December 31, 2001, with the exception of hospitals subject to OPPS, who may bill this code through March 31, 2002.**
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; **Code Effective April 1, 2001.**
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; **Code Effective April 1, 2001 and terminated December 31, 2001, with the exception of hospitals subject to OPPS, who may bill this code through March 31, 2002.**
G0236		Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). Use with CPT Codes 76090 or 76091. **Code G0236 was effective January 1, 2002 for all claims submitted to a carrier or an FI except hospital OPPS claims, which are billed to the FI. For OPPS claims billed to the FI, the code is effective April 1, 2002. Deleted as of December 31, 2003.**

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. Contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A. Diagnosis for Services On or After January 1, 1998

The BBA of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

V76.11 – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;

V76.12 - "Special screening for malignant neoplasm, other screening mammography."

Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9-CM code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

Providers report on Form CMS-1450 diagnosis *code V76.11 or V76.12* in FL 67, "Principal Diagnosis Code" *or in Loop 2300 of ANSI-X12 837 if the screening mammography is the only services reported on the claim. If the claim contains other services in addition to the screening mammography, diagnostic codes V76.11 or V76.12 are reported, as appropriate, in FL's 68-75, "Other Diagnostic Codes" or in Loop 2300 of ANSI-X12 837.* Carriers receive this diagnosis in field 21 *and field 24E with the appropriate pointer code* of Form CMS-1500 *or in Loop 2300 of ANSI- X12 837.*

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

B. Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - "Screening mammogram for high risk patient."

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as "Other Diagnoses codes" (Form CMS-1450, FL 68)

- V10.3 "Personal history - Malignant neoplasm female breast";
- V16.3 "Family history - Malignant neoplasm breast"; or
- V15.89 "Other specified personal history representing hazards to health."

The following chart indicates the ICD-9 diagnosis codes reported for each high-risk category:

High Risk Category	**Appropriate Diagnosis Code**
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

20.4 - Billing Requirements - FI Claims

(Rev. 916, Issued: 04-28-06; Effective: 10-01-06; Implementation: 10-02-06)

Except as provided in the following sections for RHCs and FQHCs, the following procedures apply to billing for screening mammographies.

The technical component portion of the screening mammography is billed on Form CMS-1450 under bill type 12X, 13X, 22X, 23X or 85X using revenue code 0403 and HCPCS *codes* 76092 *and G0202.*

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type 13X, 22X, 23X or 85X using revenue code 0401 and HCPCS *codes* 76090, 76091*, G0204, and G0206.*

Separate bills are required for claims with dates of service prior to January 1, 2002. Providers include on the bill only charges for the mammography screening. Separate bills are not required for claims with dates of service on or after January 1, 2002.

See separate instructions below for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).