CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 827

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 1, 2006

Change Request 4243

SUBJECT: Use of 12X Type of Bill (TOB) for Billing Screening Mammography, Screening Pelvic Examinations, and Screening Pap Smears

I. SUMMARY OF CHANGES: This instruction requires 12X type of bill to be used in place of 13X type for the billing of screening mammography, screening pelvic examinations, and screening pap smears when provided to hospital inpatients under Part B.

NEW/REVISED MATERIAL

EFFECTIVE DATE: July 01, 2006

IMPLEMENTATION DATE: July 03, 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	18/20/20.4/Billing Requirements - FI Claims
R	18/20/20.4.1.2/RHC/FQHC Claims With Dates of Service on or After January 1, 2002
R	18/30/30.7/Type of Bill and Revenue Codes for Form CMS-1450
R	18/40/40.6/Revenue Code and HCPCS Codes for Billing

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: 827	Date: February 1, 2006	Change Request 4243

SUBJECT: Use of 12X Type of Bill (TOB) for Billing Screening Mammography, Screening Pelvic Examinations, and Screening Pap Smears

I. GENERAL INFORMATION

A. Background: Currently, 12X TOB is not a valid TOB for the billing of screening mammography, screening pelvic examinations, and screening pap smears when provided to hospital inpatients under Part B. Providers are currently billing for these services using TOB 13X. This instruction requires 12X TOB to be used in place of 13X TOB for the billing of screening mammography, screening pelvic examinations, and screening pap smears when provided to hospital inpatients under Part B. Appropriate TOBs for services other than hospital inpatients remain the same. They are 13X, 22X, 23X, and 85X for screening mammography, 13X, 14X, 22X, 23X and 85X for screening pap smears and 13X, 22X, 23X, and 85X for screening pelvic examinations.

B. Policy: Screening mammography services, screening pelvic examinations, and screening pap smears when provided to an inpatient of a hospital may be covered under Part B, even though the patient has Part A coverage for the hospital stay, if applicable conditions of coverage are met and the applicable frequency limitations have not been exceeded by the patient.

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	
4243.1	FIs shall instruct providers to use 12X TOB instead of 13X when submitting claims for screening mammographies when provided to hospital inpatients.	X				X			X	
4243.2	FIs shall instruct providers to use 12X TOB instead of 13X when submitting claims for screening pap smears when provided to hospital inpatients.	X				X			X	
4243.3	FIs shall instruct providers to use 12X TOB	X				X				

	instead of 13Xwhen submitting claims for screening pelvic examinations when provided to hospital inpatients.									
4243.4	FISS and CWF shall modify any editing that currently takes place on claims containing 12X TOB submitted during an inpatient stay (11X TOB) to allow the 12X TOB if the claim contains anyone of these screening services.					X			X	
4243.5	Billing of screening mammographies, screening pelvic examinations, and screening pap smears when provided to other than hospital inpatients under Part B remain unchanged. Therefore, providers continue to report appropriate TOBs as follows: 13X, 14X, 22X, 23X, and 85X.	X				X				
4243.6	FIs shall instruct providers to continue reporting appropriate TOB as follows: 13X, 14X, 22X, 23X, and 85X. Billing of screening mammographies, screening pelvic examinations, and screening pap smears when provided to other than hospital inpatients under Part B remain unchanged.	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	
4243.5	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include 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	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	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*: July 1, 2006 **Implementation Date:** July 3, 2006 **Pre-Implementation Contact(s):** Bill Ruiz 410-786-9283 William.Ruiz@cms.hhs.gov **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.**

20.4 - Billing Requirements - FI Claims

(Rev. 827, Issued: 02-01-06; Effective Date: 07-01-06; Implementation Date: 07-03-06)

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 code 76092.

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type *12X,* 13X, 22X, 23X or 85X using revenue code 0401 and HCPCS code 76090 and 76091.

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).

20.4.1.2 - RHC/FQHC Claims With Dates of Service on or After January 1, 2002

(Rev. 827, Issued: 02-01-06; Effective Date: 07-01-06; Implementation Date: 07-03-06)

A. Provider-Based RHC & FQHC - Technical Component

The technical component of a screening or diagnostic mammography for provider-based RHCs/FQHCs is typically furnished by the base provider. The provider of that service bills the FI under bill type *12X,* 13X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code for a screening mammography is 0403, and the appropriate HCPCS codes are 76085 and 76092. Payment is based on the payment method for the base provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are 76090, 76091 and G0236*.

*G0236 is a deleted code after December 31, 2003. Use 76082 for claims with dates of service January 1, 2004 and later.

B. Independent RHCs and Freestanding FQHCs - Technical Component

The technical component of a screening or diagnostic mammography is outside the scope of the RHC/FQHC benefit. The practitioner that renders the technical service bills their carrier on Form CMS-1500. Payment is based on the MPFS.

C. Provider-Based RHC & FQHC, Independent RHCs and Freestanding FQHCs - Professional Component

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 0403 and HCPCS code 76085* or 76092. Payment is made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

*76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service on or after January 1, 2004 but before April 1, 2005.

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography along with revenue code 0401 and HCPCS codes 76090 or 76091.

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. FIs should assure payment is not made for revenue code 0403 (screening mammography) or 0401(diagnostic mammography). The claim must also contain a visit revenue code 0520 or 0521. Payment is made for the professional component under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0403.

For claims with dates of service on or after April 1, 2005, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component. Payment is made for the professional component under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the professional component. Use revenue code 0520 or 0521 as appropriate.

For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography. Use revenue code 0520 or 0521 as appropriate. No HCPCS coding is required for the diagnostic mammography.

30.7 - Type of Bill and Revenue Codes for Form CMS-1450

(Rev. 827, Issued: 02-01-06; Effective Date: 07-01-06; Implementation Date: 07-03-06)

The applicable bill types for screening Pap smears are *12X,* 13X, 14X, 22X, 23X, and 85X. Use revenue code 0311 (laboratory, pathology, cytology). Report the screening pap smear as a diagnostic clinical laboratory service using one of the HCPCS codes shown in §30.5.B.

In addition, CAHs electing method II report *professional* services under revenue codes 096X, 097X, or 098X.

Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens.

40.6 - Revenue Code and HCPCS Codes for Billing

(Rev. 827, Issued: 02-01-06; Effective Date: 07-01-06; Implementation Date: 07-03-06)

A. Billing to the Carrier

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

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

B. Billing to the FI

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

The professional component of a screening pelvic examination furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 052X.

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on ANSI X12N 837 P or hardcopy Form CMS-1500.

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