CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1624	**Date: OCOTBER 31, 2008**
	Change Request 6237

SUBJECT: Reporting National Provider Identifiers (NPI) on Claims for Out-of-Jurisdiction Purchased Mammography Preventive Screening and Diagnostic Services

I. SUMMARY OF CHANGES: This Change Request establishes an exception to the standard reporting of the NPI on certain Medicare fee-for-service claims for purchased mammography screening and diagnostic services. When a provider bills for a mammography screening or diagnostic services that has been purchased from a provider located in another contractor jurisdiction, the billing provider must, in addition to reporting its own NPI on paper or electronically-submitted Medicare claim (as the billing provider), also report its own NPI as the performing provider and annotate the claim with the name, address, and ZIP Code of the performing provider.

New / Revised Material
Effective Date: December 1, 2008
Implementation Date: December 1, 2008

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	18/20/20.5/Billing Requirements - Carrier/B MAC Claims

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1624	Date: October 31, 2008	Change Request: 6237

SUBJECT: Reporting National Provider Identifiers (NPI) on Claims for Out-of-Jurisdiction Purchased Mammography Preventive Screening and Diagnostic Services

Effective Date: December 1, 2008
Implementation Date: December 1, 2008

I. GENERAL INFORMATION

A. Background: This Transmittal establishes an exception to the standard reporting of the national provider identifier (NPI) on certain Medicare fee-for-service claims for purchased mammography screening and diagnostic services.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for health care providers. The NPI final rule, published on January 23, 2004, establishes the NPI as this standard. All entities covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-0045-F). Covered health care providers, suppliers and health plans (other than small plans) are required to use the NPI effective May 23, 2008. Specifically, every provider must report its NPI on a paper or electronically-submitted Medicare fee-for-service claim.

Certain Medicare-covered services may be forwarded by the billing provider to another provider for performance by such other provider. In such a circumstance, the forwarded service is "purchased" by the billing provider who must not only report its own NPI (as the billing provider) but also annotate the claim with the performing provider's NPI. However, when the performing provider is located in a contractor jurisdiction different from that of the billing provider, the contractor will not have a record of the performing provider's NPI. In this latter circumstance, the billing provider is permitted to annotate its own NPI as the performing provider's NPI in order for the claim to be adjudicated by Medicare. However, it should be noted that the billing provider has the responsibility to keep on record the performing provider's NPI in the clinical records for auditing purposes.

In reviewing the Medicare Program's business needs, it was determined that the foregoing described reporting convention had not previously been established for out-of-jurisdiction purchased mammography screening and diagnostic services. This Transmittal establishes this convention for such services.

B. Policy: When a provider bills for a mammography screening or diagnostic service that has been purchased from a provider located in another contractor jurisdiction, the billing provider must, in addition to reporting its own NPI on a paper or electronically-submitted Medicare claim (as the billing provider), also report its own NPI as the performing provider and annotate the claim with the name, address, and ZIP Code of the performing provider.

N.B.: In this Transmittal, the term "provider" shall be construed to also mean "physician or other supplier" if the context requires such alternative meaning.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6237.1	Carriers/AB MACs shall accept the billing provider's NPI in lieu of the performing provider's NPI if it is reported on a claim for out-of-jurisdiction purchased mammography screening or diagnostic service.	X			X						
6237.2	Carriers/AB MACs shall return as unprocessable a claim on out-of- jurisdiction purchased mammography screening or diagnostic service when submitted without a NPI or the name, address, and ZIP Code of the performing provider.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6237.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@cms.hhs.gov or dial Relay #711 and have agent dial 410-786-0843 and/or Eric Coulson at Eric.Coulson@cms.hhs.gov or (410) 786-3352.

Post-Implementation Contact(s): Your appropriate RO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

20.5 - Billing Requirements – Carrier/B MAC Claims

(Rev. 1624; Issued: 10-31-08; Effective/Implementation Date: 12-01-08)

Contractors use the weekly-updated file to verify that the billing facility is certified by the FDA to perform mammography services, and has the appropriate certification to perform the type of mammogram billed (film and/or digital). Carriers/B MACs match the FDA assigned, 6-digit mammography certification number on the claim to the FDA mammography certification number appearing on the file for the billing facility. Carriers/B MACs complete the following activities in processing mammography claims:

- If the claim does not contain the facility's 6-digit certification number, or if a 6-digit certification number is not reported in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF 02 segment, where 01=EW segment) of the ASC X12N 837 professional claim format, version 4010A1, for electronic claims, then carriers/B MACs return the claim as unprocessable.

- If the claim contains a 6-digit certification number that is reported in the proper field or segment (as specified in the previous bullet) but such number does not correspond to the number specified in the MQSA file for the facility, then carriers/B MACs deny the claim.

- When a film mammography HCPCS code is on a claim, the claim is checked for a "1" film indicator.

- If a film mammography HCPCS code comes in on a claim and the facility is certified for film mammography, the claim is paid if all other relevant Medicare criteria are met.

- If a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only, the claim is denied.

- When a digital mammography HCPCS code is on a claim, the claim is checked for "2" digital indicator.

- If a digital mammography HCPCS code is on a claim and the facility is certified for digital mammography, the claim is paid if all other relevant Medicare criteria are met.

- If a digital mammography HCPCS code is on a claim and the facility is certified for film mammography only, the claim is denied.

- Process the claim to the point of payment based on the information provided on the claim and in carrier claims history.

- Identify the claim as a screening mammography claim by the CPT-4 code listed in field 24D and the diagnosis code(s) listed in field 21 of Form CMS-1500.

- Assign physician specialty code 45 to facilities that are certified to perform only screening mammography.

- Ensure that entities that bill globally for screening mammography contain a blank in modifier position #1.

- Ensure that entities that bill for the technical component use only HCPCS modifier "-TC."

- Ensure that physicians who bill the professional component separately use HCPCS modifier "-26."

- Send the mammography modifier to CWF in the first modifier position on the claim. If more than one modifier is necessary, e.g., if the service was performed in a rural Health Manpower Shortage Area (HMSA) facility, instruct providers to bill the mammography modifier in modifier position 1 and the rural (or other) modifier in modifier position 2.

- Ensure all those who are qualified include the 6-digit FDA-assigned certification number of the screening center in field 32 of Form CMS-1500 and in the REF02 segment (where 01 = EW segment) of the 2400 loop for the ASC X12N 837 professional claim format, version 4010A1. Carriers/B MACs retain this number in their provider files.

- Waive Part B deductible and apply coinsurance for a screening mammography.

- Add diagnosis code V76.12 if a claim comes in for screening mammography without a diagnosis and the carrier file data shows this is appropriate. If there are other diagnoses on the claim, but not code V76.12, add it. (Do not change or overlay code V76.12 but ADD it). At a minimum, edit for age, frequency, and place of service (POS).

- After May 23, 2008, accept the screening mammography facility's NPI number in place of the attending/referring physician NPI number for self-referred mammography claims.

- *When a mammography claim is billed as a purchased service and the service is purchased from another billing jurisdiction, the provider must submit their own NPI with the name, address, and ZIP Code of the performing physician/supplier.*

- *Refer to Pub. 100-04, chapter 1, section 10.1.1.1., for claims processing instructions for payment jurisdiction on Form CMS-1500 and electronic form ANSI X12 837P.*

NOTE: Beginning October 1, 2003, carriers/B MACs are no longer permitted to add the ICD-9 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.

Carrier Provider Education

- Educate providers that when a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the "-GG" modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.

- Educate providers that they cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.

- Educate providers to submit their own NPI in place of an attending/referring physician NPI in cases where screening mammography services are self-referred.