CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3844	**Date: August 18, 2017**
	Change Request 10181

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 21, 2017. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services

I. SUMMARY OF CHANGES: This transmittal provides for the replacement of HCPCS codes G0202, G0204, and G0206 with CPT codes 77067, 77066, and 77065, effective January 1, 2018. It also applies the waiver of deductible and coinsurance to 76706, 77067, prolonged preventive services, and anesthesia services furnished in conjunction with and in support of colorectal cancer screening services.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/Table of Contents
R	18/1.2 Table of Preventive and Screening Services
D	18/20.1.3 Using Certification Data in Claims Processing
R	18/20.2 HCPCS Codes for Mammography Services
R	18/20.2.1 Digital Breast Tomosynthesis
D	18/20.2.1.1 CAD Billing Charts
R	18/20.2.2 Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
D	18/20.2.3 Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages
R	18/20.3 Payment
R	18/20.3.1 Payment for Screening Mammography Services Provided On and After January 1, 2002
D	18/20.3.2 Payment for Screening Mammography Services Provided On and After January 1, 2002
D	18/20.3.2.1 Outpatient Hospital Mammography Payment Table
N	18/20.3.1.1 Outpatient Hospital Mammography Payment Table
D	18/20.3.2.2 Payment for Computer Add-On Diagnostic and Screening Mammograms for A/B MACs (A) and (B)
D	18/20.3.2.3 Critical Access Hospital Payment
N	18/20.3.1.2 Critical Access Hospital Payment
D	18/20.3.2.3.1 CAH Screening Mammography Payment Table
N	18/20.3.1.2.1 CAH Screening Mammography Payment Table
D	18/20.3.2.4 SNF Mammography Payment Table
N	18/20.3.1.3 SNF Mammography Payment
R	18/20.4 Billing Requirements - A/B MAC (A) Claims
R	18/20.4.1 Rural Health Clinics and Federally Qualified Health Centers
D	18/20.4.1.1 RHC/FQHC Claims With Dates of Service Prior to January 1, 2002
D	18/20.4.1.2 RHC/FQHC Claims With Dates of Service on or After January 1, 2002
R	18/20.4.2 A/B MAC (A) Requirements for Nondigital Screening Mammographies
R	18/20.4.2.1 A/B MAC (A) Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)
R	18/20.5.1 A/B MACs (B) and CWF Edits
D	18/20.5.1.1 A/B MACs (B) Claim Record for CWF

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/20.6 Instructions When an Interpretation Results in Additional Films
R	18/20.7 Mammograms Performed With New Technologies
R	18/60.1.1 Deductible and Coinsurance
N	18/240 Prolonged Preventive Services Codes

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: 3844	Date: August 18, 2017	Change Request: 10181

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SUBJECT: Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: Effective for claims with dates of service on or after January 1, 2018, HCPCS code G0202 "screening mammography, bilateral (2-view study of each breast), including computer-aided detection Computer-Aided Detection (CAD) when performed," G0204 "diagnostic mammography, including when performed; bilateral" and G0206 "diagnostic mammography, including CAD when performed; unilateral" are replaced with Current Procedural Terminology (CPT) codes 77067 "screening mammography, bilateral (2-view study of each breast), including CAD when performed," 77066 "diagnostic mammography, including (CAD) when performed; bilateral" and 77065 "diagnostic mammography, including CAD when performed; unilateral."

As part of the January 2017 HCPCS update, code G0389 was replaced by CPT code 76706. Type of Service (TOS) "5" was assigned to CPT code 76706, and the coinsurance and deductible were waived. Effective January 1, 2018, the TOS for 76706 will be changed to "4" as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and as a result, it waives any coinsurance that would otherwise apply under section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes anesthesia services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Final Rule, we modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services.

Effective for claims processed with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare.

B. Policy: Effective for claims with dates of service on or after January 1, 2018, HCPCS codes G0202, G0204, and G0206 are replaced with CPT codes 77067, 77066 and 77065. The deductible and coinsurance are waived for code 77067.

Effective for claims with dates of service on or after January 1, 2018, CPT code 76706 will have TOS "4" (including when billed with modifiers TC and 26), and the deductible and coinsurance continue to be waived.

The deductible and coinsurance will be waived for new CPT code 00812 beginning January 1, 2018 and for claims with new CPT code 00811 the deductible will be waived when submitted with the PT modifier.

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare Physician Fee Schedule, and both deductible and coinsurance do not apply.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10181.1	Effective for claims with dates of service on or after January 1, 2018, HCPCS screening mammography code G0202 is replaced with CPT code 77067. Contractors shall waive deductible and coinsurance for CPT code 77067. Contractors shall apply the same payment methodologies and editing as applicable (by TOB) for CPT code 77067 as they do for G0202. **NOTE:** The deletion of HCPCS code G0202 will be part of the 2018 annual HCPCS update. Code 77067 will be payable effective January 1, 2018.	X	X			X			X	IOCE, OPPS Pricer
10181.2	Effective for claims with dates of service on or after January 1, 2018, diagnostic mammography HCPCS codes G0204 and G0206 are replaced with CPT codes 77066 and 77065 respectively. Contractors shall apply the same payment methodologies and editing as applicable (by TOB) for CPT codes 77066, and 77065 as they do for G0204 and G0206. **NOTE:** The deletion of HCPCS codes G0204 and G0206 will be part of the 2018 annual HCPCS update. Codes 77066 and 77065 will be payable effective January 1, 2018.	X	X			X			X	IOCE, OPPS Pricer
10181.3	CWF shall calculate a next eligible date for screening mammography CPT code 77067 for a given beneficiary. The calculation shall include all applicable factors including: • Beneficiary Part B entitlement status • Beneficiary claims history • Utilization rules								X	MBD, NGD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The calculation for the next eligible date for screening mammography shall parallel claims processing.									
10181.3.1	CWF shall update the Rule Code and group together the following screening mammography HCPCS: 77057, 77067, 76092, G0202, and G0203 into one service 'MAMM' for Next Eligible Date. The next eligible date shall be displayed on all CWF provider query screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH , PRVN).					X			X	MBD, NGD
10181.3.2	When there is no 'next eligible date' the CWF provider query screens shall display an 8-position alpha code in the date field to indicate why there is no 'next eligible date.'								X	MBD, NGD
10181.3.3	Any change to beneficiary master data or claims data that would result in a change to any 'next eligible' date shall result in an update to the beneficiary's 'next eligible date.'								X	
10181.4	The Multi-Carrier System Desktop Tool (MCSDT) shall display code 77067 screening mammography in a format equivalent to the CWF HIMR screen.						X			
10181.5	Effective for dates of service on and after January 1, 2018, CWF shall waive coinsurance and deductible for CPT code 76706. NOTE: The type of service will be changed to "4" for 76706 as part of the annual 2018 HCPCS update.								X	
10181.6	Effective for claims with dates of service on or after January 1, 2018, contractors shall pay claim lines with new CPT code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy), and waive the deductible and coinsurance. **NOTE**: CPT code 00812 will be added as part of January1, 2018 HCPCS update.	X	X			X			X	IOCE
10181.7	Effective for claims with dates of service on or after January 1, 2018, contractors shall pay claim lines with new CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to	X	X			X			X	IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	duodenum; not otherwise specified), and waive the deductible when submitted with the PT modifier. **NOTE**: CPT code 00811 will be added as part of the January 1, 2018 HCPCS update.									
10181.8	Contractors shall not apply coinsurance and deductible to HCPCS codes G0513 and G0514 for prolonged preventive services. **NOTE**: G0513 and G0514 will be added as part of January1, 2018, HCPCS update.	X	X			X			X	IOCE
10181.8.1	Contractors shall pay for codes G0513 and G0514 based on the same payment methodology as the preventive service codes billed along with G0513 or G0514. Note: There are no special considerations based on type of bill.	X				X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10181.9	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Roberta Epps, 410-786-4503 or roberta.epps@cms.hhs.gov (diagnostic radiology) , Gail Addis, 410-786-4522 or Gail.Addis@cms.hhs.gov (policy contact) , William Ruiz, 410-786-9283 or William.Ruiz@cms.hhs.gov (institutional claims processing contact for Part A services) , Thomas Dorsey, 410-786-7434 or Thomas.Dorsey@cms.hhs.gov (practitioner claims processing contact for Part B services) , Teira Canty, 410-786-1974 or Teria.Canty@cms.hhs.gov (claims processing contact for mammography) , Jamie Hermanson, 410-789-2064 or Jamie.Hermansen@cms.hhs.gov (anesthesia services with colorectal cancer screening services) , Emily Yoder, 410-786-1804 or emily.Yoder@cms.hhs.gov (prolonged preventive services) , Patrick Sartini, 410-786-9252 or patrick.sartini@cms.hhs.gov (diagnostic radiology)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

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1.2 – Table of Preventive and Screening Services

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished prior to January 1, 2017	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	**B**	WAIVED
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) services furnished on or after January 1, 2017	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	**B**	WAIVED
Cardiovascular Disease Screening	80061	Lipid panel	**A**	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	**B**	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	**B**	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	**B**	WAIVED
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	**A**	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	**A**	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	**A**	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	**A**	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	**A**	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	**A**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	**A**	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	**A**	WAIVED
Screening Mammography	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	**B**	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	**B**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	77063	Screening digital breast tomosynthesis, bilateral		WAIVED
	77067	*Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed*		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	**B**	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	77083	Radiographic absorptiometry (e.g., photo densitometry, radiogrammetry), 1 or more sites		WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
NOTE: *Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.* *Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.*				
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	**A**	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**A**	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	**D**	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	**I**	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	**B**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use		WAIVED
	90654	Influenza virus vaccine, split virus, preservative free, for intradermal use, for adults ages 18-64		WAIVED
	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	90672	Influenza virus vaccine, live, quadrivalent, for intranasal use		WAIVED
	90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use		WAIVED
	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use		WAIVED
	90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6- 35 months of age, for intramuscular use		WAIVED

	90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	**B**	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
Hepatitis B Vaccine	90739	Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use	**A**	WAIVED
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use		WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of Hepatitis B vaccine	**A**	WAIVED
Hepatitis C Virus Screening	G0472	Screening for Hepatitis C antibody	**B**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple- step method, HIV-1 or HIV-2, screening	**A**	WAIVED
	G0433	Infectious agent antigen detection by enzyme- linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking Cessation for services furnished prior to October 1, 2016	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Smoking Cessation for services furnished on or after October 1, 2016	99406	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	**A**	WAIVED

Service	CPT/ HCPCS	Long Descriptor	USPSTF Rating	Coins./ Deductible
	99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED
Intensive Behavioral Therapy for Obesity	G0447	Face-to-Face Behavioral Counseling for Obesity, 15 minutes	**B**	WAIVED
	G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s)		
Lung Cancer Screening	G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	**B**	WAIVED
	G0297	Low dose CT scan (LDCT) for lung cancer screening		

20.2 - HCPCS Codes for Mammography Services

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

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

HCPCS Code	Definition
77065 (G0206*)*	*Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral*
77066 (G0204*)*	*Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral*
77067 (G0202*)*	*Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed*
*77063***	*Screening Breast Tomosynthesis; bilateral (list separately in addition to code for primary procedure).*
G0279**	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to code for *primary procedure*)

****NOTE:** For claims with dates of service January 1, 2017 through December 31, 2017 providers report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018 providers report CPT codes 77067, 77066, and 77065 respectively.*

****NOTE:** HCPCS codes 77063 and G0279 are effective for claims with dates of service on or after January 1, 2015.

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. A/B MACs (A) and (B) 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 ensure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

ICD-9-CM

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

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

ICD-10-CM

Z12.31 - Encounter for screening mammogram for malignant neoplasm of breast.

Beginning October 1, 2003, A/B MACs (B) are not permitted to plug the 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.

In general, providers report diagnosis codes in accordance with the instructions in the appropriate ASC X12 837 claim technical report 3 (institutional or professional) and the paper claim form instructions found in chapters 25 (institutional) and 26 (professional).

In addition, for institutional claims, providers report diagnosis code V76.11 or V76.12 (ICD-9-CM) or Z12.31 (if ICD-10-CM is applicable) in "Principal Diagnosis Code" if the screening mammography is the only service reported on the claim. If the claim contains other services in addition to the screening mammography, these diagnostic codes V76.11 or V76.12 (ICD-9-CM) or Z12.31 (ICD-10-CM) are reported, as appropriate, in "Other Diagnostic Codes." **NOTE:** Information regarding the form locator number that corresponds to the principal and other diagnosis codes is found in chapter 25.

A/B MACs (B) receive this diagnosis in field 21 and field 24E with the appropriate pointer code of Form CMS-1500 or in Loop 2300 of ASC- X12 837 professional claim format.

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

20.2.1 -*Digital Breast Tomosynthesis*

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

A. Screening Breast Tomosynthesis

Effective for claims with dates of service January 1, 2017 through December 31, 2017, HCPCS code 77063, "Screening Digital Breast Tomosynthesis, bilateral, must be billed in conjunction with the primary service mammogram code G0202. Effective for claims with dates of service January 1, 2018 and later HCPCS code 77063, "Screening Digital Breast Tomosynthesis, bilateral, must be billed in conjunction with the primary service mammogram code 77067.

A/B MACs (A) and (B) must assure that claims containing code 77063 also contain HCPCS code 77067 (G0202*). A/B MACs (A) return claims containing code 77063 that do not also contain HCPCS code 77067* (G0202*)with an explanation that payment for code 77063 cannot be made when billed alone. A/B MACs (B) deny payment for 77063 when billed without 77067* (G0202*).*

***NOTE:** When screening digital breast tomosynthesis, code 77063, is billed in conjunction with a screening mammography, code 77067* (G0202*), and the screening mammography 77067* (G0202*) fails the age and frequency edits in CWF, both services will be rejected by CWF.*

B. Diagnostic Breast Tomosynthesis

Effective with claims with dates of service January 1, 2017 through December 31, 2017 HCPCS code G0279, "Diagnostic digital breast tomosynthesis, unilateral or bilateral", must be billed in conjunction with the primary service mammogram code G0204 or G0206. Effective with claims with dates of service January 1, 2018 and later, HCPCS code G0279, "Diagnostic digital breast tomosynthesis, unilateral or bilateral", must be billed in conjunction with the primary service mammogram code 77065 or 77066.Effective for claims with dates of service January 1, 2017 through December 31, 2017 A/B MACs (A) and (B) must assure that claims containing code G0279 also contain HCPCS code G0204 or G0206. A/B MACs (A) or (B) deny claims containing code G0279 that do not also contain HCPCS code G0202 or G0206 with an explanation that payment for code G0279 cannot be made when billed alone. Effective for claims with dates of service January 1, 2018 and later A/B MACs (A) and (B) must assure that claims containing code G0279 also contain HCPCS code 77065 or 77066. A/B MACs (A) or (B) deny claims containing code G0279 that do not also contain HCPCS code 77065 or 77066 with an explanation that payment for code G0279 cannot be made when billed alone.

Claims for diagnostic breast tomosynthesis, HCPCS code G0279, submitted with a revenue code other than 0401, 096X, 097X, or 098X will be return to providers.

Claims for diagnostic breast tomosynthesis, HCPCS code G0279, submitted with a TOB other than 12X, 13X, 22X, 23X, or 85X will be return to providers.

20.2.2 - *Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages*

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

When denying claim lines for HCPCS code 77063 that are not submitted with the diagnosis code V76.11 or V76.12, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

CARC: 167
RARC: N386
MSN: 14.9

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying claim lines for HCPCS code G0279 that are not submitted with HCPCS 77066 or 77065

20.3 - Payment

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

There is no Part B deductible *or coinsurance* for screening mammographies. The anti-markup payment limitation on physician billing for diagnostic tests does not apply to these services. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is the physician's interpretation of the results of the examination);
- Technical component (all other services); or
- Both professional and technical components (global). However, global billing is not permitted for services furnished in provider outpatient departments, except for CAHs electing the optional method of payment for mammography services furnished on or after January 1, 2002.

20.3.1 - *Payment for Screening Mammography Services Provided On and After January 1, 2002*

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

The payment limitation methodology does not apply to claims with dates of service on or after January 1, 2002.

A/B MAC (A) Claims

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammography under the Medicare physician fee schedule (MPFS) when furnished in hospitals, skilled nursing facilities (SNFs), and CAHs not electing the optional method of payment for outpatient services. However, payment under the physician fee schedule is not applicable to hospitals subject to the Outpatient Prospective Payment System (OPPS) until April 1, 2002.

The payment for code 77067 is equal to the lower of:*

- *The actual charge or*
- *Locality specific technical component payment amount under the MPFS.*

Part B deductible and coinsurance does not apply. This is a final payment.

A/B MACs (A) use the benefit-pricing file provided by CMS to pay mammography codes.

Payment for the add-on code 76085 is made under the Medicare Physician Fee Schedule. Deductible does not apply, however, coinsurance is applicable.

***For claims with dates of service prior to January 1, 2007, providers report CPT code 76092. For claims with dates of service January 1, 2007 and later, providers report CPT code 77057.*

A/B MACs (B) Claims

Physicians and suppliers are paid by the A/B MACs (B) for all mammography tests (including screening mammography) under the MPFS. Separate prices for the technical component, the professional component and the global service are included on the MPFS.

The Medicare allowed charge is the lower of:

- *The actual charge, or*
- *The MPFS amount for the service billed.*

The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Part B deductible is waived and does not apply to screening mammography.

As with other MPFS services, the nonparticipating provider reduction and the limiting charge provisions apply to all mammography tests (including screening mammography).

20.3.1.1 - Outpatient Hospital Mammography Payment Table

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment for screening mammography in the Hospital Outpatient Setting (Revenue code 403) is the lesser of charge, or TC of MPFS for code 77067 (G0202*). Neither deductible nor a coinsurance applies.*

Payment for diagnostic mammography, bilateral in the Hospital Outpatient Setting (Revenue code 401) is the lesser of charge, or TC of MPFS for code 77066 (G0204*).*

Payment for diagnostic mammography, unilateral in the Hospital Outpatient Setting (Revenue code 401) is the lesser of charge, or TC of MPFS for code 77065 (G0206*). Deductible and coinsurance apply.*

Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, §644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

20.3.1.2 - Critical Access Hospital Payment

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment to a CAH for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. Any deductible or coinsurance collected is deducted from the payment.

A. Under the Optional (All Inclusive) Method

Section 403(d) of the BBRA amended §1834(g) of the Act to permit a CAH to elect an optional method of payment for outpatient services. This option is effective for cost reporting periods beginning on or after October 1, 2001. A CAH may elect to be paid for outpatient services by reasonable costs for facility services and §202 of BIPA allows an amount equal to 115 percent of the allowed amount for professional component. (Costs related to professional services are excluded from the cost payment.)

CAHs electing the optional method of reimbursement bill the A/B MAC (A) with type of bill 85X, revenue code 0403 and HCPCS code 77067 (G0202*). They also include the professional component on a separate line, with revenue code 96X, 97X, or 98X and HCPCS code 77067* (G0202*).*

B. Under the Standard Method

CAHs reimbursed on the standard method of payment bill the technical component of a screening mammography to the A/B MAC (A) on type of bill 85X, revenue code 0403 and HCPCS code 77067 (G0202*).*

Professional services are billed to the A/B MAC (B) and paid based on the fee schedule by the A/B MAC (B).

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammographies under the Medicare physician fee schedule (MPFS) in CAHs not electing the optional method of payment for outpatient services.

20.3.1.2.1 - CAH Screening Mammography Payment Table

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment for Screening Mammography in the Critical Access Hospital Outpatient Setting

Method 1 (Standard)

	TOB	***Rev Code***	***HCPCS***	***Payment***
Services on or after January 1 2002				
Technical Component *Deductible does not apply.* *Coinsurance based on charge.*	*85X*	*403*	*77067** *(G0202)**	*A/B MAC (A) payment is 80% of the lower of the charge or the fee schedule amount.*
Professional Component *Deductible does not apply.* *Coinsurance based on lower of MPFS or charge.*			*77067** *(G0202)**	*A/B MACs (B) payment is 80% of the lower of the charge or MPFS amount for the technical component. The new A3 states payment for 76092 is lower of charge or locality specific TECHNICAL component amount under MPFS.*

Method 2 (Optional Method) - Option available with cost reporting periods starting on or after October 1, 2001 and dates of service on or after July 1, 2001.

	TOB	***Rev Code***	***HCPCS***	***Payment***
Services on or after January 1 2002				
Technical Component *Deductible does not apply.* *Coinsurance based on charge.*	*85X*	*403*	*77067** *(G0202)**	*A/B MAC (A) payment is 80% of the lower of the charge or the fee schedule amount.*
Professional Component *Deductible does not apply.* *Coinsurance based on lower of*	*85X*	*96X, 97X, or 98X*	*77067** *(G0202*)*	*A/B MAC (A) pays 115% of 80% (that is 92%) of the lower of the*

	TOB	Rev Code	HCPCS	Payment
MPFS or charge.				*charge or the MPFS amount.*

20.3.1.3 - SNF Mammography Payment

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Payment for screening mammography in a SNF is equal to the lower of:

charge, or TC of MPFS for code 77067. No deductible,

coinsurance applies.

Payment for diagnostic mammography, bilateral in a SNF is equal to the lower of: charge, or TC of MPFS for code 77066 (G0204*). Deductible and coinsurance apply. Payment for diagnostic mammography, unilateral in a SNF is equal to the lower of: charge, or TC of MPFS for code 77065* (G0206*). Deductible and coinsurance apply.*

20.4 - Billing Requirements - A/B MAC (A) Claims

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

A/B MACs use the weekly-updated MQSA 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). (See §20.1.) A/B MACs (A) use the provider number submitted on the claim to identify the facility and use the MQSA data file to verify the facility's certification(s). A/B MAC (A) complete the following activities in processing mammography claims:

- If the provider number on the claim does not correspond with a certified mammography facility on the MQSA file, then A/B MACs (A) 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.

NOTE: The Common Working File (CWF) no longer receives the mammography file for editing purposes.

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, 14X**, 22X, 23X or 85X using revenue code 0403 and HCPCS code *77067** (*G0202**).

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type 12X, 13X, 14X**, 22X, 23X or 85X using revenue code 0401 and HCPCS code *77065** (*G0206**),* *77066*(G0204)*.

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

* For claims with dates of service January 1, 20*17 through December 31, 2017*, providers report CPT codes *G0202*, *G0204*, and *G0206*. For claims with dates of service January 1, *2018* and later, providers report CPT codes *77067, 77066*, *and 77065* respectively.

** For claims with dates of service April 1, 2005 and later, hospitals bill for all mammography services under the 13X type of bill or for dates of service April 1, 2007 and later, 12X or 13X as appropriate. The

14X type of bill is no longer applicable. Appropriate bill types for providers other than hospitals are 22X, 23X, and 85X.

In cases where screening mammography services are self-referred and as a result an attending physician NPI is not available, the provider shall duplicate their facility NPI in the attending physician identifier field on the claim.

20.4.1 - Rural Health Clinics and Federally Qualified Health Centers

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

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 A/B MAC (A) 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 code is 77067, (G0202)*). 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 77065 (G0206*), 77066* (G0204*), .*

***G0236 is a deleted code after December 31, 2003. Use 76082* for claims with dates of service January 1, 2004 through December 31, 2006, and code 77051 for claims with dates of service January 1, 2007 and later.*

****** For claims with dates of service January 1, 2017 through December 31, 2017, report CPT codes G0206, G0204, and G0202. For claims with dates of service January 1, 2018 and later, report CPT codes 77065, 77066, and 77067respectively.*

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 A/B MACs (B) on Form CMS-1500. Payment is based on the MPFS.

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

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. A/B MACs (A) 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 A/B MAC (A) 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 A/B MAC (A) 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.

20.4.2 - A/B MAC (A) Requirements for Nondigital Screening Mammographies

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

The A/B MAC (A) will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code *77067** (*G0206**);
- Presence of high risk diagnosis code indicator where appropriate;
- Date of last screening mammography; and
- Age of beneficiary.

The A/B MACs (A) must accept revenue code 0403 for bill types 13X, 22X, 23X, 71X, 73X, or 85X.

***** For claims with dates of service January 1, 2017 *thru December 31, 2017* providers report HCPCS code *G0206.* For claims with dates of service January 1, *2018* and later, providers report CPT code *77067*.

20.4.2.1 - A/B MAC (A) Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

The CWF records are annotated with the date of the first (technical) screening mammography claim received. The record is updated based on the next covered (technical) claim received. A/B MACs (A) and (B) assume the claim is the first received for the beneficiary where records do not contain a date of last screening and process accordingly.

The A/B MACs (A) include revenue code, HCPCS code, units, and covered charges in the CWF record fields with the same name. They report the payment amount for revenue code 0403 in the CWF field named "Rate" and the billed charges in the field named "Charges" of the CWF record. In addition, A/B MACs (A) report special override code 1 in the field named "Special Action" of the CWF record to avoid application of the Part B deductible.
The A/B MACs (A) include in the financial data portion of the PS&R record, revenue code, HCPCS code, units, charges, and rate (fee schedule amount).

The PS&R system will include screening mammographies on a separate report from cost-based payments. See the PS&R guidelines for specific information.

20.5.1 - A/B MACs (B) Claim Record for CWF

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

B3-4601.3.B

A/B MACs (B) complete the type of service field in the CWF Part B claim record with a “B” if the patient is a high risk screening mammography patient or a “C” if she is a low risk screening mammography patient for services prior to January 1, 1998.

For services on or after January 1, 1998, the type of service field on CWF must have a value of “1” for medical care (screening) or a “4” for diagnostic radiology (diagnostic). Fill in POS. Fill in deductible indicator field with a “1”; not subject to deductible if screening mammography. Submit the claim to the CWF host. Trailer 17 of the Part B Basic Reply record will give the date of the last screening mammography.

The CWF edits for age and frequency for screening mammography. There are no frequency limitations on diagnostic tests.

20.6 - Instructions When an Interpretation Results in Additional Films

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. When a radiologist's interpretation results in additional films, Medicare will pay for both the screening and diagnostic mammogram.

A/B MACs (B) Claims

For A/B MACs (B) claims, providers submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier "-GG" to the diagnostic mammography. A modifier "-GG" is appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse both the screening mammography and the diagnostic mammography.

A/B MAC (A) Claims

A/B MACs (A) require the diagnostic claim be prepared reflecting the diagnostic revenue code (0401) along with HCPCS code *77065*(G0206*), 77066*(G0204*),* or *G0279* and modifier "-GG" "Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day." Reporting of this modifier is needed for data collection purposes. Regular billing instructions remain in place for a screening mammography that does not fit this situation.

Both A/B MACs (A) and (B) systems must accept the GH and GG modifiers where appropriate.

***** For claims with dates of service prior to January 1, 20*17 thru December 31, 2017,* providers report CPT codes *G0206* and *G0204*. For claims with dates of service January 1, 20*18* and later, providers report CPT codes *77065* and *77066* respectively.

20.7 - Mammograms Performed With New Technologies

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled Modernization of Screening Mammography Benefit, provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, to December 31, 2001 (to March 31, 2002 for hospitals subject to OPPS). Under this provision, payment for technologies that directly take digital images would equal 150 percent of the amount that would otherwise be paid for a bilateral diagnostic mammography. For technologies that convert standard film images to digital form, payment will be derived from the statutory screening mammography limit plus an additional payment of $15.00 for A/B MACs (B) claims and $10.20 for A/B MAC (A) (technical component only) claims.

Payment restrictions for digital screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality Standards Act. However, CAD codes billed in conjunction with digital mammographies or film mammographies are not subject to FDA certification requirements.

Payment Requirements for Claims with Dates of Service on or After January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

A/B MAC (A) Payment

Code	Payment
*77067** *(*G0202**)*	Payment will be equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS when performed in a hospital outpatient department, CAH, or SNF. Deductible *and coinsurance do* not apply.
*77066** *(*G0204**)*	Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF and coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies. **NOTE:** Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.
*77065** *(*G0206**)*	Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies. **NOTE:** Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

Institutional providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 *(or electronic equivalent)* under bill type 13X, 22X, 23X, or 85X.

Institutional providers bill for digital screening mammographies on Form CMS-1450, utilizing revenue code 0403 and HCPCS G0202 or G0203.

*Institutional p*roviders bill for digital diagnostic mammographies on Form CMS-1450, utilizing revenue code 0401 and HCPCS G0204, G0205, G0206 or G0207.

NOTE: Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

CAHs electing the optional method of payment for outpatient services are paid according to §20.3.2.3 of this chapter.

A/B MACs (B) Payment

All codes paid by the A/B MACs (B) are based on the Medicare Physician Fee Schedule (MPFS).

Code	**Payment**
*77067**	Payment is the lesser of the provider's charge or the MPFS amount provided
*(*G0202**)*	for this code in the pricing file.
	Part B deductible does not apply, however, coinsurance applies.
*77066**	Payment is the lesser of the provider's charge or the MPFS amount provided
*(*G0204**)*	for this code in the pricing file.
	Deductible and coinsurance apply.
*77065**	Payment is the lesser of the provider's charge or the MPFS amount provided
*(*G0206**)*	for this code in the pricing file.
	Deductible and coinsurance apply.

The professional component is billed to the A/B MACs (B) on Form CMS-1500 (or electronic equivalent).
A/B MACs (A) and (B) were furnished a mammography benefit pricing file to pay claims containing the above codes.

60.1.1 – Deductible and Coinsurance

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

There is no deductible and no coinsurance or copayment for the FOBTs (HCPCS G0107, G0328), flexible sigmoidoscopies (G0104), colonoscopies on individuals at high risk (HCPCS G0105), or colonoscopies on individuals not meeting criteria of high risk (HCPCS G0121).

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.

Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.

Prior to January 1, 2007 deductible and coinsurance apply to other colorectal procedures (HCPCS G0106 and G0120). After January 1, 2007, the deductible is waived for those tests. Coinsurance applies.

Effective for claims with dates of service on and after October 9, 2014, deductible and coinsurance do not apply to the Cologuard™ multitarget sDNA screening test (HCPCS G0464).

NOTE: A 25% coinsurance applies for all colorectal cancer screening colonoscopies (HCPCS G0105 and G0121) performed in ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25% coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25% coinsurance also applies for colorectal cancer screening sigmoidoscopies (HCPCS G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (HCPCS G0104) are payable in ASCs, and a 25% coinsurance applies. The 25% coinsurance for colorectal cancer screening sigmoidoscopies was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

240 - Prolonged Preventive Services Codes

(Rev. 3844, Issued: 08-18-17, Effective: 01-01-18, Implementation: 01-02-18)

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services (PPS) may be reported as an add-on to a covered preventive service that is payable from the Medicare Physician Fee Schedule. PPS codes are treated as a preventive service and both coinsurance and deductible do not apply when billed with a covered preventive service which is part of a particular subset of procedure codes listed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html

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