CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3961	**Date: February 2, 2018**
	Change Request 10435

SUBJECT: Editing Update for Mammography Services

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to modify existing editing to ensure claims containing mammography codes 77065, 77066, or 77067 are paid regardless of what the provider/supplier is certified by the Food and Drug Administration (FDA) to perform (film or digital). In addition, this CR updates sections 20.8.1 and 20.8.2 of Chapter 18 in Pub 100-04 by eliminating the differentiation between film and digital mammography on denial messages.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 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	18/20/20.8.1/MSN Messages
R	18/20/20.8.2/Remittance Advice Messages

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: 3961	Date: February 2, 2018	Change Request: 10435

SUBJECT: Editing Update for Mammography Services

EFFECTIVE DATE: January 1, 2018
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IMPLEMENTATION DATE: July 2, 2018

I. GENERAL INFORMATION

A. Background: CR 9752, *2017 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder*, implemented on January 3, 2017 lists film mammography codes 77055-77057 with an end date of December 31, 2016, replacing them with codes 77065, 77066, and 77067 effective January 1, 2017. For Part B, the Medicare Physician Fee Schedule (PFS) contains codes 77065, 77066, and 77067 with a status of "I", indicating that these codes are not payable under the PFS until January 1, 2018.

Consequently, providers/suppliers were instructed to report codes G0202, G0204, and G0206 on claims with dates of service January 1, 2017 thru December 31, 2017. CR 9752 also changed the description for codes G0202, G0204, and G0206 to eliminate the differentiation between film and digital mammography. This change implies that the mammography service being billed could be digital or film, allowing mammography providers/suppliers to report any of these codes regardless of what the provider/supplier is certified by the FDA to perform (film or digital).

Subsequently, due to existing logic in the Fiscal Intermediary Shared System (FISS) and in the Multi-Carrier System (MCS), claims submitted by providers/suppliers that are only certified to perform film mammograms with dates of service on or after January 1, 2017 are being rejected when billing for code G0202, G0204, or G0206.

The Centers for Medicare & Medicaid Services (CMS) issued technical guidance on March 23, 2017, implementing a workaround for A/B Medicare Administrative Contractors (MACs) to process claims for mammography containing codes G0202, G0204, or G0206 with dates of service January 1, 2017 thru December 31, 2017. CMS issued subsequent technical guidance instructing the A/B MACs to continue to apply the instructions while adding new mammography codes 77065, 77066, and 77067.

This CR provides instructions to modify system edits to pay claims containing code 77065, 77066, or 77067 regardless of what the provider/supplier is certified by the FDA to perform (film or digital).

B. Policy: There are no legislative or regulatory policies associated with this CR.

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	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10435.1	Effective for claims with dates of service on and after January 1, 2018, contractors shall modify editing to allow line-item claims containing code 77065, 77066, or 77067 regardless of what the provider/supplier is certified by the FDA to perform (film or digital).	X				X				
10435.2	Effective for claims with dates of service on and after January 1, 2018, contractors shall modify the MCS mammography certification editing to allow line-item claims containing code 77065, 77066, or 77067 regardless of what the provider/supplier is certified by the FDA to perform (film or digital).		X				X			
10435.3	Effective for claims with dates of service on and after January 1, 2018, contractors shall deny line-items on claims for mammography services when the facility is not certified to perform mammograms regardless of what the provider/supplier is certified by the FDA to perform (film or digital) using: MSN 16.2 - This service cannot be paid when provided in this location/facility. The Spanish version of this MSN message should read: Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad. CARC B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N570 - Missing/incomplete/invalid credentialing data. Group Code: CO NOTE: Contractors shall continue using current MSN messages.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
1	This Business Requirement modifies reason code 36428.

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

V. CONTACTS

Pre-Implementation Contact(s): Teira Canty, 410-786-1974 or teira.canty@cms.hhs.gov (For professional claims) , Bill Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov (For institutional claims)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

20.8.1 - MSN Messages

(Rev.3961, Issued: 02-02- 18, Effective: 01-01- 18, Implementation: 07-02-18)

B3-4601.4, A3-3660.10.I

The following messages are used on the MSN.

If the claim is denied because the beneficiary is under 35 years of age, use the following MSN:

MSN 18.3:

> Screening mammography is not covered for women under 35 years of age.

The Spanish version of this MSN message should read:

> Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.

If the claim is denied for a woman 35-39 because she has previously received this examination, use the following MSN:

MSN 18.6:

A screening mammography is covered only once for women age 35-39.

The Spanish version of this MSN message should read:

> Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.

If the claim is denied because the period of time between screenings for the woman based on age has not passed, use the following MSN:

MSN 18.4:

> This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

The Spanish version of this MSN message should read:

> Este servicio se denegó debido a que no han transcurrido 12 meses desde su último examen de este tipo.

If the claim is denied because the provider is not certified to perform *a mammography*, use the following MSN:

MSN 16.2:

> This service cannot be paid when provided in this location/facility.

The Spanish version of this MSN message should read:

> Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad.

In addition to the above denial messages, the A/B MAC (A) or (B) may add the following:

MSN 18.12:

> Screening mammograms are covered annually for women 40 years of age and older.

The Spanish version of this MSN message should read:

> El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.

For A/B MACs (B) only:

For claims submitted with invalid or missing certification number, use the following MSN:

MSN 9.2:

> This item or service was denied because information required to make payment was missing.

The Spanish version of this MSN message should read:

> Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.

20.8.2 - Remittance Advice Messages

(Rev.3961, Issued: 02-02- 18, Effective: 01-01- 18, Implementation: 07-02-18)

If the claim is denied because the beneficiary is under 35 years of age, 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: 6
RARC: M37
Group Code: CO

If the claim is denied for a woman 35-39 because she has previously received this examination, 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: 119
RARC: M89
Group Code: CO

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, 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: 119
RARC: M90
Group Code: CO

If the claim is denied because the provider that performed the screening is not certified to perform the type of mammography billed (film or digital) 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: B7
RARC: N570
Group Code: CO

For claims that were submitted without the facility's FDA-assigned certification number, 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 Two.

CARC: 16
RARC: MA128
Group Code: CO

For claims that were submitted with an invalid facility certification number, 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 Two.

CARC: 16
RARC: MA128
Group Code: CO