



Related MLN Matters Article #: MM5050

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Correct Reporting of Diagnosis Codes on Screening Mammography Claims

Key Words

MM5050, CR5050, R916CP, Diagnosis, Mammography, V76.11, V76.12, G0204, G0206, G0202, CR5377, MM5377, R117CP

Provider Types Affected

All providers billing Medicare Carriers and Fiscal Intermediaries (FIs) for screening mammography claims

Key Points

- The effective date of the instruction is October 1, 2006.
- The implementation date is October 2, 2006.
- MLN article MM5050 and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:
 - Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.
 - Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.
- In addition, CR5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:
 - It removes 12X type of bill (TOB) from the list of applicable TOBs for diagnostic mammography;
 - It adds Healthcare Common Procedure Coding System (HCPCS) code G0202 to the list of valid codes for the billing of screening mammography; and
 - It adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.
- The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

- Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. CR5050 adjusts that requirement.

TOB 12X Reinstated

- MM5050 erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services supplied to Medicare inpatients and billable under Medicare Part B.
- CR5377 announced that effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACS as an appropriate bill type for such services.
- Effective April 1, 2007, hospitals should use TOB 12X to bill Medicare for diagnostic mammography services provided to hospital inpatients, where those services are being billed to Medicare Part B. As appropriate, hospitals should continue to use TOBs 13X, 22X, 23X, or 85X when billing for diagnostic mammographies provided to Medicare patients who are other than hospital inpatients.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5050.pdf> on the CMS website.

Providers may find the official instructions issued regarding this change at

<http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf> on the CMS website. The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR5050.

Providers may view the instruction (CR5377) that reversed the removal of TOB 12x, by visiting

<http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf> on the CMS website. The related MLN Matters article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf> on the CMS website.

If providers have questions, they may contact their Medicare FI or carrier at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.