CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1117	**Date: NOVEMBER 24, 2006**
	Change Request 5377

Subject: Reporting of Type of Bill (TOB) 12X for Billing of Diagnostic Mammographies

NOTE: The attached instruction was previously communicated as sensitive. This instruction is no longer sensitive and may be posted to the Intranet/Internet.

I. SUMMARY OF CHANGES: Transmittal 916, Change Request 5050 titled Correct Reporting of Diagnostic Codes on Screening Mammography Claims erroneously removed 12X TOB from the list of applicable TOBs for diagnostic mammography services. This instruction reinstates 12X TOB as an applicable TOB for diagnostic mammography services when provided to hospital inpatients under Part B.

New / Revised Material
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/20/20.4/Billing Requirements - FI Claims

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1117	Date: November 24, 2006	Change Request 5377

SUBJECT: Reporting of Type of Bill (TOB) 12X for Billing of Diagnostic Mammographies

NOTE: The attached instruction was previously communicated as sensitive. This instruction is no longer sensitive and may be posted to the Intranet/Internet.

Effective Date: **April 1, 2007**

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: Transmittal 916, Change Request 5050 titled "Correct Reporting of Diagnostic Codes on Screening Mammography Claims" erroneously removed 12X TOB from the list of applicable TOBs for diagnostic mammography services. This instruction reinstates 12X TOB as an applicable TOB for diagnostic mammography services when provided to hospital inpatients under Part B. Appropriate TOBs for diagnostic mammography services other than hospital inpatients remain the same. They are 13X, 22X, 23X, and 85X.

B. Policy: Diagnostic mammography services when provided to an inpatient of a hospital may be covered under Part B, if applicable conditions of coverage are met.

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5377.1	FIs shall instruct providers to report 12X TOB when submitting claims for diagnostic mammography services when provided to inpatients of a hospital.	X		X								
5377.2	FISS shall allow 12X TOB on hospital inpatient Part B claims containing diagnostic mammography services.							X				
5377.3	FIs shall instruct providers to continue reporting TOBs: 13X, 22X, 23X, and 85X when billing for diagnostic mammographies provided to other than hospital inpatients.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Bill Ruiz 410-786-9283 william.ruiz@cms.hhs.gov

Antoinette Johnson 410-786-9326 antoinette.johnson@cms.hhs.gov

Post-Implementation Contact(s):
Appropriate Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

20.4 - Billing Requirements - FI Claims

(Rev. 1117, Issued: 11-24-06; Effective: 04-01-07; Implementation: 04-02-07)

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 77057* (76092*).

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 77055* (76090*), 77056* (76091*), G0204 and G0206.

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 prior to January 1, 2007, providers report CPT codes 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, and 77057 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.