CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 337 **Date: OCTOBER 29, 2004**

CHANGE REQUEST 3469

SUBJECT: Change in Hospital Type of Bill for Billing Diagnostic and Screening Mammographies

I. SUMMARY OF CHANGES: This instruction changes the type of bill (TOB) for billing diagnostic and screening mammographies.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/20/Mammography Services
R	18/20.2.1/Computer-Aided Detection (CAD) Add-On Codes
R	18/20.4/Billing Requirements – FI Claims
R	18/20.4.1.1/RHC/FQHC Claims With Dates of Service Prior to January 1, 2002
R	18/20.4.1.2/RHC/FQHC Claims With Dates of Service on or After January 1, 2002
R	18/20.4.2/FI Requirements for Nondigital Screening Mammographies
R	18/20.7/Mammograms Performed with New Technologies

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 337	Date: October 29, 2004	Change Request: 3469

SUBJECT: Change in Hospital Type of Bill for Billing Diagnostic and Screening Mammographies

I. GENERAL INFORMATION

A. Background: This instruction changes the hospital type of bill (TOB) for billing diagnostic and screening mammographies. Effective for claims with dates of service on or after April 1, 2005, diagnostic and screening mammography claims shall be billed utilizing the TOB 13X. These services should no longer be billed under TOB 14X. Appropriate TOBs for providers other than hospitals remain the same. They are 22x, 23x, and 85x.

B. Policy: Previously, diagnostic and screening mammographies furnished by hospitals were required to be billed under TOB 14X. This requirement is being changed to require billing of diagnostic and screening mammography claims under the TOB 13X.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3469.1	The standard system shall allow payment for diagnostic mammography claims furnished by hospitals (76090, 76091, G0204, G0206 and 76082) when submitted under TOB 13X.					X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3469.2	The standard system shall allow payment for screening mammography claims furnished by hospitals (76092, G0202 and 76083) when submitted under TOB 13X.					X				
3469.3	The standard system shall edit to assure that payment is not made for diagnostic mammography claims furnished by hospitals (76090, 76091, G0204, G0206 and 76082) when submitted under TOB 14X.					X				
3469.4	The standard system shall edit to assure that payment is not made for screening mammography claims furnished by hospitals (76092, G0202 and 76083) when submitted under TOB 14X.					X				
3469.5	The FIs shall instruct hospitals to use TOB 13X when submitting claims for diagnostic mammography (76090, 76091, G0204, G0206 and 76082)	X								
3469.6	The FIs shall instruct hospitals to use TOB 13X when submitting claims for screening mammography (76092, G0202 and 76083)	X								
3469.7	CWF shall modify the applicable screening mammography frequency edits to allow TOB 13X.								X	
3469.8	Requirements 3469.1 thru 3469.7 are effective for claims with dates of service on or after April 1, 2005.	X				X			X	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** William Ruiz 410-786-9283, wruiz@cms.hhs.gov **Post-Implementation Contact(s):** William Ruiz 410-786-9283, wruiz@cms.hhs.gov	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

20 - Mammography Services

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

A – Screening Mammography

Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiologic procedures for early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. Whether payment can be made is determined by a woman's age and statutory frequency parameter. See *Pub 100-02* Medicare Benefit Policy Manual, chapter 15, *section 280.3* for additional coverage information for a screening mammography.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39 and waives the Part B deductible. Coverage applies as follows:

Age Groups	**Screening Period**
Under age 35	No payment allowed for screening mammography.
35-39	Baseline (only one screening allowed for women in this age group)
Over age 39	Annual (11 full months have elapsed following the month of last screening

NOTE: Count months between mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2002, begin counting the next month (February 2002) until 11 months have elapsed. Payment can be made for another screening mammography in January 2003.

B - Diagnostic Mammography

A diagnostic mammography is a radiological mammogram and is a covered diagnostic test under the following conditions:

- A patient has distinct signs and symptoms for which a mammogram is indicated;
- A patient has a history of breast cancer; or
- A patient is asymptomatic, but based on the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

20.2.1 - Computer-Aided Detection (CAD) Add-On Codes

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

Screening Add-on Codes 76085 and 76083

Effective for services on or after January 1, 2002 through December 31, 2003, (or April 1, 2002 for hospitals subject to OPPS) a new CPT code 76085, CAD conversion of standard film images to digital images has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. The definition of 76085 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, mammography (list separately in addition to code for primary procedure)."

NOTE: For claims with dates of service April 1, 2003 – December 31, 2003, code G0202 may be billed in conjunction with 76085.

Carriers and FIs make payment under the Medicare physician fee schedule. There is no Part B deductible. However, coinsurance is applicable.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76083 under the 13X bill type. The 14X bill type will no longer be applicable. Appropriate TOBs for providers other than hospitals are 22x, 23x, and 85x.

Contractors must assure that claims containing code 76085 also contain HCPCS code 76092 or G0202. If not, FIs return claims to the provider with an explanation that payment for code 76085 cannot be made when billed alone. Carriers deny payment for 76085 when billed without 76092 or G0202.

NOTE: When screening CAD 76085 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76083, "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)," can be billed in conjunction with the primary service mammography code 76092 or G0202.

Contractors must assure that claims containing code 76083 also contain HCPCS code 76092 or G0202. FIs return claims containing code 76083 that do not also contain HCPCS code 76092 or G0202 with an explanation that payment for code 76083 cannot be made when billed alone. Carriers deny payment for 76083 when billed without 76092 or G0202.

NOTE: When screening CAD 76083 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Diagnostic Add-on Codes G0236 and *76082*

Effective for services on or after January 1, 2002 thru December 31, 2003, (or April 1, 2002 for hospital claims subject to OPPS*)*, HCPCS code G0236 was established for diagnostic mammography CAD that can be billed only on the same claim with the primary service of either 76090 or 76091. The definition of G0236 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation." The code must be listed separately in addition to code for the primary procedure.

NOTE*:* For claims with dates of service April 1, 2003 - December 31, 2003, code G0204 and G0206 may be billed in conjunction with G0236.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082 under the 13X bill type. The 14X bill type will no longer be applicable. Appropriate TOBs for providers other than hospitals are 22x, 23x, and 85x.

There are no frequency limitations on diagnostic tests or CAD-diagnostic tests.

Contractors must assure that claims containing code G0236 also contain HCPCS code 76090, 76091, G0204, or G0206. If not, FIs return claims to the provider with an explanation that payment for code G0236 cannot be made when billed alone. Carriers deny payment for G0236 when billed without 76090, 76091, G0204 or G0206.

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76082, "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; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76090, 76091, G0204, or G0206.

Contractors must assure that claims containing code 76082 also contain HCPCS codes 76090, 76091, G0204 or G0206. FIs return claims containing code 76082 that do not also contain HCPCS code 76090, 76091, G0204, or G0206 with an explanation that payment for code 76082 cannot be made when billed alone. Carriers deny payment for 76082 when billed without 76090, 76091, G0204, or G0206.

20.4 - Billing Requirements - FI Claims

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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 *13X,* 22X, 23X or 85X using revenue code 0403 and HCPCS code 76092.

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type 13X, 22X, 23X or 85X using revenue code 0401 and HCPCS code 76090 and 76091.

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

20.4.1.1 - RHC/FQHC Claims With Dates of Service Prior to January 1, 2002

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

A - Provider-Based RHC and FQHC

For claims with dates of service prior to January 1, 2002, provider-based RHCs and FQHCs bill the FI for the technical component and their carrier for the professional component of the screening *and diagnostic* mammography. Provider-based RHCs and FQHCs use the parent provider number and bill type (*13X,* 22X, 23X or 85X as appropriate) when billing the FI for this service. Payment is based on the payment method for the parent provider - the limitation.

B - Independent RHCs and Freestanding FQHCs

Independent RHCs and freestanding FQHCs bill their carrier for both the technical and professional components. Payment is made based on the limitation.

20.4.1.2 - RHC/FQHC Claims With Dates of Service on or After January 1, 2002

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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 parent provider. The provider of that service bills the FI under bill type *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 codes are 76085 and 76092. Payment is based on the payment method for the parent provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are 76090, 76091 and G0236*.

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

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 provider of the technical service bills their carrier on Form CMS-1500. Payment is based on the MPFS.

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

For claims with dates of service on or after January 1, 2002, 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 FI under bill type 71X or 73X for the professional component along with revenue code 0403 and HCPCS code 76085* or 76092. Payment is made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

*76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service January 1, 2004 and later.

RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography along with revenue code 0401 and HCPCS codes 76090 or 76091.

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. FIs should assure payment is not made for revenue code 0403 (screening mammography) or 0401(diagnostic mammography) unless the claim also contains a visit revenue code 0520 or 0521.

20.4.2 - FI Requirements for Nondigital Screening Mammographies

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

The FI will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code 76092;
- Presence of high risk diagnosis code indicator where appropriate;
- Date of last screening mammography; and
- Age of beneficiary.

FIs must accept revenue code 0403 for bill types *13X,* 22X, 23X, 71X, 73X, or 85X.

20.7 - Mammograms Performed With New Technologies

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

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 carrier claims and $10.20 for FI (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.

Mammography related CAD equipment does not require FDA certification.

Mammography utilizes a direct x-ray of the breast. By contrast, the CAD process uses laser beam to scan the mammography film from a film (analog) mammography, converts it into digital data for the computer, and analyzes the video display for areas suspicious for cancer. The CAD process used with digital mammography analyzes the data from the mammography on a video display for suspicious areas. The patient is not required to be present for the CAD process.

Only one screening mammogram, either 76092 or G0202, may be billed in a calendar year. Therefore, providers/suppliers must not submit claims reflecting both a film screening mammography (76092) and a digital screening mammography G0202. Also, they must not submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Contractors deny the claim when both a film and digital screening or diagnostic mammography is reported. However, a screening and diagnostic mammography can be billed together.

A - Payment Requirements for FI Claims With Dates of Service On or After April 1, 2001 Through December 31, 2001 (Through March 31, 2002 for Hospitals Subject to OPPS).

Providers bill the FI for the technical component of screening and diagnostic mammographies that utilize advanced technologies with one of six new HCPCS codes, G0202 - G0207. See payment methodology below for each of the codes during the period April 1, 2001 through December 31, 2001 (or March 31, 2002 for hospitals subject

to OPPS). Payments for codes G0202 through G0205 are based, in part, on the MPFS payment amounts. The amounts that are based on the MPFS that both carriers and FIs use in calculating the payments for these codes were furnished in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

HCPCS	Definition
G0202	Screening mammography producing direct digital image, bilateral, all views

Payment Method:

Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific technical component payment amount under the physician fee schedule for CPT code 76091, the code for bilateral diagnostic mammogram, during 2001.) Part B deductible does not apply. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

HCPCS	Definition
G0203	Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that is provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Part B deductible does not apply. Coinsurance is 20 percent of the charge.

HCPCS	Definition
G0204	Diagnostic mammography, direct digital image, bilateral, all views

Payment Method:

Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

HCPCS Definition

G0205 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

HCPCS Definition

G0206 Diagnostic mammography, direct digital image, unilateral, all views.

Payment Method:

Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, and one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

HCPCS Definition

G0207 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views.

Payment Method:

Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, and one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPPS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

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

Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

FI Payment

Code	Payment
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. Coinsurance is 20 percent of the lower amount; the Program pays 80 percent. Deductible does not apply.
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.
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.

Providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 under bill type *13X,* 22X, 23X, or 85X. The professional component is billed to the carrier on Form CMS-1500 (or electronic equivalent).

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

Providers 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.

Carrier Payment

All codes paid by the carrier are based on the Medicare Physician Fee Schedule (MPFS).

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

Contractors were furnished a mammography benefit pricing file to pay claims containing the above codes.