CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1387	**Date: DECEMBER 7, 2007**
	Change Request 5577

Subject: Mammography: Change Certification-Based Action from Return to Provider (RTP)/Return as Unprocessable to Reject/Denial

I. SUMMARY OF CHANGES: This Change Request instructs contractors to deny claims if the appropriate FDA certification status is not listed on the Mammography Quality Standard Act (MQSA) file instead of returning the claim to the provider/returning the claim as unprocessable. The transmittal also revises section headings included in Chapter 18, section 20 of the Internet Only Manual.

New / Revised Material
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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/Mammography Services (Screening and Diagnostic)
R	18/20.1/Certification of Mammography Facilities
R	18/20.1.1/Services Under Arrangements
R	18/20.1.2/FDA Certification Data
R	18/20.4/Billing Requirements - FI/A MAC Claims
R	18.20.5/Billing Requirements -Carrier/B MAC Claims
R	18/20.8.2/Remittance Advice Messages

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1387	Date: December 7, 2007	Change Request: 5577

SUBJECT: Mammography: Change Certification-Based Action from Return to Provider (RTP)/Return as Unprocessable to Reject/Denial

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: Medicare pays for film mammography and digital mammography at different rates and pays for a service only if the provider or supplier is certified by the Food and Drug Administration (FDA) to perform the type of mammogram for which payment is sought. Medicare determines the certification of each mammography facility based on data supplied by the FDA. Weekly, the FDA sends an updated Mammography Quality Standard Act (MQSA) file to the Centers for Medicare and Medicaid Services (CMS). This file contains information to indicate whether a mammography facility is certified to perform film or digital mammography. CMS, in turn, furnishes this file to its claimsprocessing contractors on a weekly basis. In accordance with Change Request (CR) 4303, contractors must upload the most recent MQSA file weekly to ensure proper and timely payment of claims submitted by facilities certified by the FDA to perform the screening and diagnostic mammography services. (See CR 4303, Transmittal 828, issued on February 2, 2006.)

Contractors use the updated MQSA file to validate the information submitted on the claim by the mammography facility during the claims adjudication process. In accordance with chapter 18, §20.1.2, of Pub. 100-04, contractors use the data on this file to confirm that the facility listed on the claim is, in fact, certified to perform the service billed. Intermediaries/Part A activities of Medicare Administrative Contractors (A MACs) identify the facility using the provider number submitted on the claim and use the certification data contained on the MQSA file to verify that the facility is certified by the FDA to perform mammography services. Carriers/Part B activities of Medicare Administrative Contractors (B MACs) match the mammography certification number submitted on the claim to the 6-digit FDA-assigned certification number appearing on the file for the billing facility. In addition, both intermediaries/A MACs and carriers/B MACs look for the film indicator (designated by "1") or the digital indicator (designated by "2") on the MQSA file to verify the type of mammography (film and/or digital) that the facility is certified to perform. Currently, intermediaries/A MACs return to provider (RTP) and carriers/B MACs return as unprocessable claims for mammography services under the following circumstances:

- A film mammography Healthcare Common Procedure Coding System (HCPCS) code is submitted on a claim and the facility is certified for digital mammography only;

- A film mammography HCPCS code is submitted on a claim and there is no certification number on the claim (carriers/B MACs only);

- A digital mammography HCPCS codes is submitted on a claim and the facility is certified for film mammography only;

- A digital mammography HCPCS code is submitted on a claim and there is no certification number on the claim (carriers/B MACs only).

(See Pub.100-04, §20.2 for a list of the mammography service HCPCS codes.)

This CR instructs Carriers/B MACs to deny and Intermediaries/A MACs to reject every claim for a screening or diagnostic mammography service when the appropriate FDA certification status is not listed on the MQSA file, instead of returning the claim to the provider/returning the claim as unprocessable to the supplier. A denial of the claim will ensure that the facility has a right of appeal for an inappropriate denial based on the status of its FDA certification. Carriers/B MACs will continue to return the claim as unprocessable if the facility's FDA-assigned certification number is missing from the claim.

B. Policy: Contractors must deny a claim for a mammography service if the nature of the billed HCPCS code (i.e., film or digital) does not correspond to the FDA certification status listed on the MQSA file for the billing mammography facility. Carriers/B MACs shall continue to use the MQSA file to verify the facility's FDA-assigned 6-digit certification number submitted on the claim. If the claim does not contain the facility's certification number, then carriers/B MACs shall return the claim as unprocessable to the supplier.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5577.1	Carriers/B MACs shall verify whether a claim for mammography services submitted by a supplier, i.e., by an independent facility, contains an FDA-assigned 6-digit certification number.	X			X			X			
5577.1.1	Carriers/B MACs shall verify that the facility's FDA-assigned 6-digit certification number is reported in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF 02 segment, where 01 = EW segment) of the ASC X12N 837 professional claim format, version 4010A1, for electronic claims.	X			X			X			
5577.1.2	If the claim does not contain a 6-digit number or if a 6-digit number is not reported in the field or segment specified in 5577.1.1, then carriers/B MACs shall	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	return the claim as unprocessable.										
5577.1.3	If the claim contains a 6-digit number that is reported in the proper field or segment (as specified in 5577.1.1) but such number does not correspond to the number specified in the MQSA file for the facility, then Carriers /B MACs shall deny the claim.	X			X			X			
5577.1.4	Carriers/B MACs shall use the following Remittance Advice (RA) reason code and remark code to return as unprocessable claims for mammography services submitted without the facility's FDA-assigned certification number: **Reason Code 16:** Claim/service lacks information which is needed for adjudication. **Remark Code MA128**: Missing/incomplete/ invalid FDA approval number.	X			X			X			
5577.2	Contractors shall verify that the billing facility is eligible to bill for the type of mammography service submitted on the claim (i.e., digital or film mammography) using certification data from the FDA-created, CMS-supplied MQSA file, supplied weekly, per CR 4303, Transmittal 828.	X		X	X		X	X			
5577.2.1	Carriers/B MACs shall deny the claim if the facility's certification number submitted on the claim in item 32 of the Form CMS-1500, for paper claims, or in the 2400 loop (REF 02 segment, where 01 = EW segment) of the ASC X12N 837 professional format, version 4010A1, for electronic claims, does not match the certification number on the MQSA file.	X			X			X			
5577.2.1.1	Carriers/B MACs shall use the following MSN message for claims denied due to an invalid facility certification number: **MSN Message 9.4:** This item or service was denied because information required to make payment was incorrect.	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Spanish translation: Este servicio fue denegado debido a que información requerida para hacer el pago fue incorrecta.										
5577.2.1.2	Carriers/B MACs shall use the following RA reason code and remark code for claims denied due to an invalid facility certification number: **Reason Code 125:** Payment adjusted due to a submission/billing error (s). **Remark Code MA128:** Missing/incomplete/ invalid FDA approval number.	X			X			X			
5577.2.2	Intermediaries/A MACs shall verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file. If the provider number on the claim does not correspond to a certified facility on the MQSA file, then intermediaries/A MACs shall reject the claim.	X		X			X				
5577.2.2.1	Intermediaries/A MACs shall use the following MSN message to reject claims submitted by providers not listed as certified facilities on the MQSA file: **MSN Message 16.2:** This service cannot be paid when provided in this location/facility. Spanish translation: Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad.	X		X			X				
5577.2.2.2	Intermediaries/A MACs shall use the following Remittance Advice (RA) reason code to reject claims submitted by providers not listed as certified facilities on the MQSA file: **Reason Code B7:** This provider was not certified/eligible to be paid for this procedure/service on this date of service.	X		X			X				
5577.3	Carriers/B MACs shall deny the claim if the HCPCS code on the claim (for film or digital mammography) does not match the type of certification indicated on the	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MQSA file.										
5577.3.1	Intermediaries/A MACs shall reject the claim if the HCPCS code on the claim (for film or digital mammography) does not match the type of certification indicated on the MQSA file.	X		X			X				
5577.3.1.1	Carriers/B MACs shall deny a claim if a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only.	X			X			X			
5577.3.1.2	Intermediaries/A MACs shall reject a claim if a film mammography HCPCS code is on a claim and the facility is certified for digital mammography only.	X		X			X				
5577.3.1.3	Carriers/B MACs shall use the following MSN message for claims denied because the facility is not certified to perform a film mammogram: **MSN 16.2:** This service cannot be paid when provided in this location/facility. Spanish translation: Este service no se puede pagar cuando es suministrado en este sitio/facilidad.	X			X			X			
5577.3.1.4	Intermediaries/A MACs shall use the following MSN message for claims rejected because the facility is not certified to perform a film mammogram: **MSN 16.2:** This service cannot be paid when provided in this location/facility. Spanish translation: Este service no se puede pagar cuando es suministrado en este sitio/facilidad.	X		X			X				
5577.3.1.5	Contractors shall use the following RA reason code and remark code for claims submitted by a facility not certified to perform a film mammogram: For Carriers/B MACs: **Reason Code 171:** Payment is denied when performed/billed by this type of provider in this type of facility.	X		X	X		X	X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Remark Code N110: This facility is not certified for film mammography. For Intermediaries/A MACs: **Reason Code B7**: This provider was not certified/eligible to be paid for this procedure/service on this date of service.										
5577.3.2	Carriers/B MACs shall deny a claim if a digital mammography HCPCS code is on a claim and the facility is certified for film mammography only.	X			X			X			
5577.3.2.1	Intermediaries/A MACs shall reject a claim if a digital mammography HCPCS code is on a claim and the facility is certified for film mammography only.	X		X			X				
5577.3.2.2	Carriers/B MACs shall use the following MSN message for claims denied because the facility is not certified to perform a digital mammogram: **MSN 16.2:** This service cannot be paid when provided in this location/facility. Spanish translation: Este service no se puede pagar cuando es suministrado en este sitio/facilidad.	X			X			X			
5577.3.2.3	Intermediaries/A MACs shall use the following MSN message for claims rejected because the facility is not certified to perform a digital mammogram: **MSN 16.2:** This service cannot be paid when provided in this location/facility. Spanish translation: Este service no se puede pagar cuando es suministrado en este sitio/facilidad.	X		X			X				
5577.3.2.4	Carriers/B MACs shall use the following RA reason code and remark code for claims denied because the facility is not certified to perform a digital mammogram:	X			X			X			

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Reason Code 171: Payment is denied when performed/billed by this type of provider in this type of facility. **Remark Code N92:** This facility is not certified for digital mammography.										
5577.3.2.5	Intermediaries/A MACs shall use the following RA reason code and remark code for claims rejected because the facility is not certified to perform a digital mammogram: **Reason Code B7**: This provider was not certified/eligible to be paid for this procedure/service on this date of service.	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5577.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 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 shall be included in your next regularly	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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.										

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:
5577.2	Contractors shall upload and use the FDA-created, CMS-supplied MQSA file, supplied weekly, to validate the billing facility's certification to perform mammography services, in accordance with CR 4303.
5577.2	Contractors shall refer to Pub. 100-04, Chapter 18, §20.2 for a list of the mammography service HCPCS codes that are applicable to the business requirements specified in this instruction.
5577.1.4, 5577.2.1.2	Coding changes included in CR 5806 are needed to implement these requirements.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Carriers/B MACs: Tracey Hemphill at Tracey.Hemphill@cms.hhs.gov for FIs/A MACs: William Ruiz at William.Ruiz@cms.hhs.gov

Post-Implementation Contact(s): Carriers/B MACs: Tracey Hemphill at Tracey.Hemphill@cms.hhs.gov for FIs/A MACs: William Ruiz at William.Ruiz@cms.hhs.gov

VI. FUNDING

A. For *Fiscal Intermediaries and Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MACs),* use the following statement:

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 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.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 1387, 12-07-07)

20 - Mammography Services *(Screening and Diagnostic)*

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

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 (pay for only one screening mammography performed on a woman between her 35th and 40th birthday)
Over age 39	Annual (11 full months have elapsed following the month of last screening

NOTE: Count months between screening mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2005, begin counting the next month (February 2005) until 11 months have elapsed. Payment can be made for another screening mammography in January 2006.

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.
- 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 will pay based on the MPFS in lieu of OPPS or the lower of the actual change.

20.1 - *Certification of Mammography Facilities*

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

The *Mammography Quality Standards Act (MQSA)* provides specific standards regarding those qualified to perform screening and diagnostic mammograms and how they should be certified. The *MQSA* requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate. The FDA, Center for Devices and Radiological Health, is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).

The FDA provides CMS with a listing of all providers that have been issued certificates to perform mammography services and CMS notifies contractors accordingly. Contractors are also notified of situations where a provider's certificate has expired, or has been suspended or revoked. The information provided includes the provider's name, address, 6-position certification number, effective/expiration dates and the letter "T" to designate the facility as terminated.

Medicare will reimburse *only* FDA-certified mammography centers *for mammography services*. *Carriers/Part B of Medicare Administrative Contractors (B MACs)* must inform physicians and suppliers at least annually, through their provider/supplier publications, of those facilities centers, *that* are certified. Carriers*/B MACs* encourage physicians to inform their patients about centers that are certified.

Mammography facilities that perform screening mammographies are **not** to release screening mammography x-rays for interpretation to physicians who are not approved under the facility's certification number unless the patient has requested a transfer of the *mammography* from one facility to another for a second opinion, or unless the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed **only** by physicians who are associated with the certified mammography facility. Carriers*/B MACs* are not required to maintain a list of these associations unless there is a specific reason for doing so and only on a case-by-case basis.

When adjudicating a screening mammography claim, contractors refer to the table of certified facilities provided by the FDA *through CMS* and confirm that the facility listed on the claim is in fact certified to perform the service. When the contractor determines that the facility that performed the mammography service has not been issued a certificate by the FDA or the certificate is suspended or revoked, the claim will be denied utilizing the denial language in §20.8.1 of this chapter, related to certified facilities.

20.1.1 - *Services* Under Arrangements

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

When mammography services are obtained for patients under arrangements with another facility, the provider arranging the service must ensure that the facility performing the services has been issued *an* MQSA certificate by *the* FDA.

20.1.2 - *FDA Certification Data*

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

The FDA furnishes data to CMS on a weekly basis, which specify the certification of facilities under the MQSA. This data are contained in a "MQSA file."

Prior to April 1, 2003, the MQSA file showed all facilities that are certified to perform film screening and diagnostic mammograms. After April 1, 2003, the file shows a new Record Type with two indicators, "1" for film and "2" for digital to determine which mammograms the facility is certified to perform.

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. The new digital mammography codes have a higher payment rate. In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, *CMS relies upon the FDA certification data contained in the MQSA file.* The FDA sends an updated file via *the* CMS Mainframe Telecommunications System (CMSTS), formerly Network Data Mover, on a weekly basis.

Effective July 1, 2006, the *MQSA* file shows:

- Name of Facility,
- Certification number of the facility,
- Film certification obtained (Record-type =1) or digital certification obtained (Record-type = 2),
- Effective and Expiration dates of each certification,
- Letter "T" to designate the facility as terminated,

Some mammography facilities are certified to perform both film and digital mammography. In this case, the facility's name and FDA certification number shows up on this file twice. One line will indicate film certification with effective date/expiration date while the other line will indicate digital certification with effective date/expiration date.

NOTE: The FDA does not issue printed certification which indicates film or/and digital. Refer to the MQSA file for proof of types of mammography the facility is certified to perform.

If the *MQSA* file *appears to be in* error, contact your regional office mammography coordinator. The coordinators will contact the FDA to research the *apparent* error.

20.4 - Billing Requirements – FI*/A MAC* Claims

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

Contractors 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.) FIs/A MACs 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). FIs/A MACs 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 intermediaries/A MACs 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 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.

20.5 - *Billing* Requirements – Carrier/*B MAC Claims*

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

Contractors use the weekly-updated 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). Carriers/B MACs match the FDA assigned, 6-digit mammography certification number on the claim to the FDA mammography certification number appearing on the file for the billing facility. Carriers/B MACs complete the following activities in processing mammography claims:

- *If the claim does not contain the facility's 6-digit certification number, or if a 6-digit certification number is not reported in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF 02 segment, where 01=EW segment) of the ASC X12N 837 professional claim format, version 4010A1, for electronic claims, then carriers/B MACs return the claim as unprocessable.*

- *If the claim contains a 6-digit certification number that is reported in the proper field or segment (as specified in the previous bullet) but such number does not correspond to the number specified in the MQSA file for the facility, then Carriers/B MACs 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.*

- Process the claim to the point of payment based on the information provided on the claim and in carrier claims history.

- Identify the claim as a screening mammography claim by the CPT-4 code listed in field 24D and the diagnosis code(s) listed in field 21 of Form CMS-1500.

- *Assign* physician specialty code 45 to facilities *that* are certified to perform only screening mammography.

- Ensure that entities that bill globally for screening mammography contain a blank in modifier position #1.

- Ensure that entities that bill for the technical component use only HCPCS modifier "-TC."

- Ensure that physicians who bill the professional component separately use HCPCS modifier "-26."

- Send the mammography modifier to CWF in the first modifier position on the claim. If more than one modifier is necessary, e.g., if the service was performed in a rural Health Manpower Shortage Area (HMSA) facility, instruct providers to bill the mammography modifier in modifier position 1 and the rural (or other) modifier in modifier position 2.

- Ensure all those who are qualified include the 6-digit FDA-assigned certification number of the screening center in field 32 of Form CMS-1500 and *in the REF02 segment (where 01 = EW segment) of the 2400 loop for the ASC X12N 837 professional claim format, version 4010A1*. Carriers*/B MACs* retain this number in their provider files.

- Waive Part B deductible and apply coinsurance for a screening mammography.

- Add diagnosis code V76.12 if a claim comes in for screening mammography without a diagnosis and the carrier file data shows this is appropriate. If there are other diagnoses on the claim, but not code V76.12, add it. (Do not change or overlay code V76.12 but ADD it). At a minimum, edit for age, frequency, and place of service (POS).

NOTE: Beginning October 1, 2003, carriers*/B MACs* are no longer permitted to add the ICD-9 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.

Carrier Provider Education

- Educate providers that when a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the "-GG" modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.

- Educate providers that they cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.

20.8.2 - Remittance Advice Messages

(Rev.1387, Issued: 12-07-07, Effective: 04-01-08, Implementation: 04-07-08)

If the claim is denied because the beneficiary is under 35 years of age, contractors must use existing *ASC* X12N 835 claim adjustment reason code/message 6, "The procedure/revenue code is inconsistent with the patient's age" along with the remark code M37 (at the line item level), "Service is not covered when the patient is under age 35."

If the claim is denied for a woman 35-39 because she has previously received this examination, contractors must use existing *ASC* X12N 835 claim adjustment reason code/message 119, "Benefit maximum for this time period or occurrence has been reached" along with the remark code M89 (at the line item level), "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, contractors must use existing *ASC* X12N 835 claim adjustment reason code/message 119, "Benefit maximum for this time period or occurrence has been reached" along with remark code M90 (at the line item level), "Not covered more than once in a 12-month period."

For Intermediaries/A MACs only:

If the claim is denied because the provider that performed the screening is not certified *to perform the type of mammography billed (film and/or digital)* use existing *ASC* X12N 835 claim adjustment reason code/message B7, "This provider was not certified/eligible to be paid for this procedure/service on this date of service."

For Carriers*/B MACs* only:

For claims submitted by a facility not certified to perform film mammography, use existing reason *code 171,* "*Payment is denied when performed/billed by this type of provider in this type of facility*." along with remark code N110, "This facility is not certified for film mammography."

For claims submitted by a facility not certified to perform digital mammograms, use existing reason code *171*, "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty" along with remark code N92,"This facility is not certified for digital mammography."

For claims that were submitted *without the facility's FDA-assigned certification* number, use existing reason code 16, "Claim/service lacks information which is needed for adjudication" along with remark code MA128 "Missing/incomplete/invalid FDA *approval* number."

For claims that were submitted with an invalid facility certification number, use existing reason code 125, "Payment adjusted due to a submission/billing error(s) along with remark code MA128 "Missing/incomplete/invalid FDA approval number."