CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1519	**Date: MAY 30, 2008**
	Change Request # 6023

SUBJECT: Instructions for Institutional Providers and Suppliers Billing Self-Referred Mammography Claims Regarding the Attending/Referring Physician National Provider Identifier (NPI)

I. SUMMARY OF CHANGES: This transmittal instructs providers and suppliers of mammography services to use their facility NPI in the attending/referring physician NPI field when the services are self-referred by the beneficiary.

New / Revised Material
Effective Date: May 23, 2008
Implementation Date: June 30, 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/Table of Contents
R	18/20.4/Billing Requirements FI/A/B MAC Claims
R	18/20.5/Carrier Processing Requirements

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: 1519	Date: May 30, 2008	Change Request: 6023

SUBJECT: Instructions for Institutional Providers and Suppliers Billing Self-Referred Mammography Claims Regarding the Attending/Referring Physician National Provider Identifier (NPI)

Effective Date: May 23, 2008
Implementation Date: June 30, 2008

I. GENERAL INFORMATION

A. Background: Covered health care providers, suppliers and health plans (other than small plans) are required to use the National Provider Identifiers (NPIs) effective May 23, 2008. In reviewing the Medicare program's business needs in preparation for the implementation of the NPI, Medicare has identified that the following instruction is needed for institutional and supplier billing of self-referred mammography services. As indicated in Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 20, a doctor's prescription or referral is not necessary for screening mammography services to be covered. In self-referral cases, an NPI for an attending/referring physician is not available to the institution or supplier providing the mammography service.

In the past, Medicare fiscal intermediaries instructed providers to use the surrogate unique physician identification numbers (UPIN) "SLF000" in the Attending Physician UPIN field on the institutional claim. Since UPINs will no longer be accepted on Medicare claims after May 23, 2008, an alternate means of identifying self-referral is needed.

The business requirements below define how providers and suppliers will reflect this situation on Medicare claims.

B. Policy: Institutional providers submitting claims for self-referred mammography services will duplicate the institution's own NPI in the attending physician NPI field on their claims. Suppliers submitting claims for self-referred mammography services will duplicate the supplier's own NPI in the attending/referring physician NPI field on their claims.

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	
6023.1	Contractors shall instruct institutional providers submitting self-referred mammography claims to duplicate their own NPI in the Attending Physician NPI field on claims submitted on or after May 23, 2008.	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	
6023.2	Contractors shall instruct suppliers submitting self-referred mammography claims to duplicate their own NPI in the Attending/Referring Physician NPI field on claims submitted on or after May 23, 2008.	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	
6023.3	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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly 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.	X		X	X						

IV. SUPPORTING INFORMATION

Section 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

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): NPI Issues: Wil Gehne (410) 786-6148, wilfried.gehne@cms.hhs.gov, Part A Mammography services: William Ruiz, (410) 786-9283, william.ruiz@cms.hhs.gov, Part B Mammography services: Eric Coulson, (410)786-3352, eric.coulson@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) and Carriers, use the following statement*:

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), use the following statement*:

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.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

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(Rev. 1519, 05-30-08)

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

(Rev. 1519, Issued: 05-30-08, Effective: 05-23-08, Implementation: 06-30-08)

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*/B* 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*/B* 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*/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.

  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.

In cases where screening mammography services are self-referred and as a result an attending physician NPI is not available, the provider shall duplicate their facility NPI in the attending physician identifier field on the claim.

20.5 - Carrier Processing Requirements

(Rev. 1519, Issued: 05-30-08, Effective: 05-23-08, Implementation: 06-30-08)

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).

- *After May 23, 2008, accept the screening mammography facility's NPI number in place of the attending/referring physician NPI number for self-referred mammography claims.*

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.

- *Educate providers to submit their own NPI in place of an attending/referring physician NPI in cases where screening mammography services are self-referred.*