CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 426 | **Date: JANUARY 14, 2005**

CHANGE REQUEST 3562

SUBJECT: Modification to Reporting of Diagnosis Codes for Screening Mammography Claims

I. SUMMARY OF CHANGES: Modifies instructions to allow reporting of either Diagnosis code V76.11 or V76.12

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2005
IMPLEMENTATION DATE: July 5, 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)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/20.2/HCPCS and Diagnosis Codes for Mammography Services

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

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SUBJECT: Modification to Reporting of Diagnosis Codes for Screening Mammography Claims

I. GENERAL INFORMATION

A. Background: Effective as of January 1, 1998, providers only reported diagnosis code V76.12 on screening mammography claims. CMS will now allow reporting of either V76.11 or V76.12 as appropriate.

B. Policy: Allow either diagnosis code V76.11 or V76.12 to assure proper coding for screening mammography claims.

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 ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3562.1	Contractors shall advise their providers to report either diagnosis code V76.11 or V76.12 as appropriate on screening mammography claims.	X		X						
3562.2	FISS shall edit to assure that payment is made for screening mammography claims when submitted with either V76.11 or V76.12 diagnosis codes.					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*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Wendy Knarr (410) 786-0843 (Contact Relay at 711 then have agent call Phone #) (Part B) or William Ruiz at (410) 786-9283 (Part A) **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev. 426, Issued: 01-14-05, Effective: 07-01-05, Implementation: 07-05-05)

The following HCPCS and TOS codes are used to bill for mammography services.

HCPCS Code	TOS	Definition
76082	4	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). **Effective January 1, 2004.**
76083	1	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). **Effective January 1, 2004.**
76085	1	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation screening mammography (list separately in addition to code for primary procedure). Use with CPT code 76092 **Code 76085 was effective 1-1-2002 for all claims submitted to a carrier or an FI, except hospital outpatient prospective payment (OPPS) claims, which are billed to the FI. For OPPS claims billed to the FI, this code is effective 4-1-2002. Deleted as of December 31, 2003.**
76090	1	Diagnostic mammography, unilateral.
76091	1	Diagnostic mammography, bilateral.
76092	1, B, C	Screening mammography, bilateral (two view film study of each breast).
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. **Code Effective 4-1-2001.**
G0203		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**

HCPCS Code	TOS	Definition
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; **Code Effective 4-1-2001.**
G0205		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; **Code Effective 4-1-2001.**
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0236		Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). Use with CPT Codes 76090 or 76091. **Code G0236 was effective 1-1-2002 for all claims submitted to a carrier or an FI except hospital OPPS claims, which are billed to the FI. For OPPS claims billed to the FI, the code is effective 4-1-2002. Deleted as of December 31, 2003.**

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. Contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A - Diagnosis for Services On or After January 1, 1998

The BBA of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

> *V76.11 – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;*

V76.12 - "Special screening for malignant neoplasm, other screening mammography."

Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9-CM 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.

FI claims receive the diagnosis in FL 67, "Principal Diagnosis Code" *of Form CMS-1450.* Carriers receive this diagnosis in field 21 of Form CMS-1500.

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

B - Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - "Screening mammogram for high risk patient."

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as "Other Diagnoses codes" (Form CMS-1450, FL 68)

- V10.3 "Personal history - Malignant neoplasm female breast";
- V16.3 "Family history - Malignant neoplasm breast"; or
- V15.89 "Other specified personal history representing hazards to health."

The following chart indicates the ICD-9 diagnosis codes reported for each high-risk category:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89