

MLN Matters Number: MM5050

Related Change Request (CR) #: 5050

Related CR Release Date: April 28, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R916CP

Implementation Date: October 2, 2006

## Correct Reporting of Diagnosis Codes on Screening Mammography Claims

This article was revised on July 27, 2007 to add a reference to CR5377. MM5050 erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services (page 1) supplied to Medicare inpatients and billable under Medicare Part B. CR5377 announced that effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACS as an appropriate bill type for such services.

### Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

### Providers Action Needed

This article and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

**In addition**, CR5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It removes **12X type of bill (TOB)** from the list of applicable TOBs for diagnostic mammography; (See Note above.)
- It adds **HCPSC code G0202** to the list of valid codes for the billing of screening mammography; and

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- It adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.

## Background

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The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

## Implementation

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The implementation date for this instruction is October 2, 2006.

## Additional Information

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The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf> on the CMS website. The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR5050.

To view the instruction (CR5377) that reversed the removal of TOB 12x, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf> on the CMS website. The related MLN Matters article may be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf> on the CMS website.

If you have questions, please contact your Medicare intermediary or carrier at their toll-free number which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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