Medlearn Matters
Information for Medicare Providers

Medlearn Matters Number: MM4243
Related Change Request (CR) #: 4243
Related CR Release Date: February 1, 2006
Effective Date: July 1, 2006
Related CR Transmittal #: R827CP
Implementation Date: July 3, 2006

Use of 12X Type of Bill (TOB) for Billing Screening Mammography, Screening Pelvic Examinations, and Screening Pap Smears

Provider Types Affected

Providers who submit screening mammography, screening pelvic examinations, and screening pap smear claims to Medicare fiscal intermediaries (FIs)

Background

Screening mammography, screening pelvic examinations, and screening pap smears provided to inpatients of a hospital are covered under Part B, even though the patient has Part A coverage for the hospital stay, if applicable conditions of coverage are met and the applicable frequency limitations have not been exceeded by the patient.

Providers currently bill for these services using TOB 13x, since 12x TOB has not, up to this point, been a valid TOB for the billing of screening mammography, screening pelvic examinations, and screening pap smears, when provided to hospital inpatients under Part B.

Key Points

Effective for claims submitted to FIs on or after July 1, 2006, providers must use 12x TOB in place of 13x TOB to bill for the following services provided to hospital inpatients:

- Screening mammography;
- Screening pelvic examinations; and
- Screening pap smears.

TOBs used for billing of screening mammographies, screening pelvic examinations, and screening pap smears, when provided to other than hospital

inpatients under Part B, remain unchanged. These TOBs are 13x, 14X, 22x, 23x, and 85x.

For additional information about this policy, please refer to the revised *Medicare Claims Processing Manual* attachments to CR4243 (Publication 100-04, Chapter 18). The revised sections attached to CR4243 include the following:

- Section 20.4 – Billing Requirements – FI Claims;
- Section 20.4.1.2 – RHC/FQHC (Rural Health Center/Federally Qualified Health Center) Claims With Dates of Service on or After January 1, 2002;
- Section 30.7 – Type of Bill and Revenue Codes for the Centers for Medicare & Medicaid Services (CMS) Form CMS-1450; and
- Section 40.6 – Revenue Code and HCPCS (Healthcare Common Procedure Coding System) Codes for Billing.

Relevant Links

CR4243 is the official instruction issued to your FI (fiscal intermediary) regarding this change. CR4243 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R827CP.pdf on the CMS web site.

Please refer to your local FI if you have questions about this issue. To find the FI's toll free phone number, go to http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.