

# Screening Mammography

## Overview

Breast cancer is the most frequently diagnosed non-skin cancer in women, and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer also occurs in men; however, the number of new cases is few.<sup>1</sup>

Although breast cancer incidence (all ages) is slightly higher in Caucasian women than in African-American women, African-American women have a higher mortality rate and higher proportion of disease diagnosed at the advanced stage with larger tumor sizes. Fortunately, if diagnosed and treated early, the number of women who die from breast cancer can be reduced. The screening mammography benefit covered by Medicare can provide earlier detection, resulting in more prompt treatment of breast cancer.

Medicare's coverage of screening mammograms was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). This act authorized Medicare to begin covering screening mammograms on or after January 1, 1991. The Balanced Budget Act of 1997 (BBA) revised the statutory frequency parameters and age limitations Medicare uses to cover screening mammograms. The Benefits Improvement and Protection Act of 2000 (BIPA) provided for payment for the use of Computer-Aided Detection (CAD) technology in connection with the performance of a covered mammogram.

Mammography can be categorized as either a "screening mammogram" or a "diagnostic mammogram."

## Screening Mammography

A screening mammogram is a radiologic procedure, an x-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms of the disease and includes a physician's interpretation of the results. Unlike a diagnostic mammogram, there do not need to be signs, symptoms, or a history of breast disease in order for Medicare to cover the exam. It usually involves two x-rays of each breast. Mammograms make it possible to detect tumors that cannot be felt. Mammograms can also find microcalcifications (tiny deposits of calcium in the breast) that sometimes indicate the presence of breast cancer.

---

<sup>1</sup> The National Cancer Institute. Rev. 2008. Breast Cancer (PDQ®) Prevention [online]. Bethesda, MD: The National Cancer Institute, The National Institutes of Health, The U.S. Department of Health and Human Services, 2008 [cited 20 November 2008]. Available from the World Wide Web: (<http://www.cancer.gov/cancertopics/wyntk/breast>).

## Diagnostic Mammography

A diagnostic mammogram is an x-ray of the breast that is used to check for breast cancer after a lump or other sign or symptom of breast cancer has been found. Signs of breast cancer may include pain, skin thickening, nipple discharge, or a change in breast size or shape. A diagnostic mammogram may also be used to evaluate changes found during a screening mammogram, or to view breast tissue when it is difficult to obtain a screening mammogram because of special circumstances, such as the presence of breast implants.

A diagnostic mammogram is a diagnostic test covered by Medicare under the following conditions:

- ▶ An individual has distinct signs and symptoms for which a mammogram is indicated;
- ▶ An individual has a history of breast cancer; or
- ▶ An individual is asymptomatic, but based on the individual's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

## Risk Factors

A female beneficiary may be at high risk for developing breast cancer in the following situations:

- ▶ She has a personal history of breast cancer;
- ▶ She has a family history of breast cancer;
- ▶ She had her first baby after age 30; or
- ▶ She has never had a baby.

## Coverage Information

Medicare provides coverage of a breast cancer screening mammogram annually (i.e., at least 11 full months have passed following the month in which the last Medicare screening mammogram was covered) for all female beneficiaries age 40 or older. Medicare also provides coverage of one baseline mammogram for female beneficiaries between the ages of 35 and 39.

Medicare provides coverage for breast cancer screening mammography as a Medicare Part B benefit. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit. A physician's prescription or referral is not necessary for a screening mammogram to be covered by Medicare. Medicare determines whether or not to make payment for this based on a woman's age and statutory frequency parameters.

Medicare also covers digital technologies for mammogram screenings. The coinsurance or copayment applies. There is no Medicare Part B deductible for this benefit.

**NOTE:** A "diagnostic mammogram" requires a prescription or referral by a physician or qualified non-physician practitioner (i.e., clinical nurse specialist, nurse midwife, nurse practitioner, or physician assistant) to be covered.

### Coverage for Screening Mammography Services

- ▶ Under age 35: No payment allowed
- ▶ Age 35 – 39: Baseline (only one screening allowed for women in this age group)
- ▶ Over age 39: Annual (11 full months have elapsed following the month of last screening)

**NOTE:** Mammography services must be provided in a Food and Drug Administration (FDA) or a State/Mammography Quality Standards Act (MQSA) certified radiological facility and a qualified physician, who is directly associated with the facility at which the mammogram was taken, must interpret the results.

## Coding and Diagnosis Information

### Procedure Codes and Descriptors

Medicare providers must use the following Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes listed in Table 1 to report mammography services:

**Table 1 – HCPCS/CPT Codes for Mammography Services**

HCPCS/CPT Code	Code Descriptor
77051	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) (Use 77051 in conjunction with 77055, 77056)
77052	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) (Use 77052 in conjunction with 77057)
77055	Mammography; unilateral (Use 77055 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram)
77056	Mammogram; bilateral (Use 77056 in conjunction with 77051 for computer-aided detection applied to a diagnostic mammogram)
77057	Screening mammography, bilateral (2-view film study of each breast) (Use 77057 in conjunction with 77052 for computer-aided detection applied to a screening mammogram) (For electrical impedance breast scan, use 76499)
G0202	Screening mammography, producing direct digital image, bilateral, all views
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views

CPT only copyright 2008 American Medical Association. All Rights Reserved.

## Diagnosis Requirements

The Balanced Budget Act of 1997 (BBA) eliminated payment based on high risk indicators. However, to ensure proper coding, Medicare providers must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes listed in Table 2 on screening mammography claims as appropriate:

**Table 2 – Diagnosis Codes for Screening Mammography Services**

ICD-9-CM Diagnosis Code	Code Descriptor
V76.11	Special screening for malignant neoplasm, screening mammogram for high-risk patient
V76.12	Special screening for malignant neoplasm, other screening mammography

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

## Need for Additional Films

Medicare allows additional films to be taken without an order from the treating physician. In such situations, a radiologist who interprets a screening mammogram is allowed to order and interpret additional diagnostic films based on the results of the screening mammogram while the beneficiary is still at the facility for the screening exam.

## Billing Requirements

### General Information

Mammography services may be billed by the following three categories:

- ▶ **Technical Component (TC)** – services rendered outside the scope of the physician’s interpretation of the results of an examination.
- ▶ **Professional Component (PC)** – physician’s interpretation of the results of an examination.
- ▶ **Global Component** – encompasses both the technical and professional components.

Global billing is not permitted for services furnished in an outpatient facility. Critical Access Hospitals (CAHs) may not use global HCPCS codes as the TC and PC components are paid under different methodologies.

When submitting a claim for a screening mammogram and a diagnostic mammogram for the same beneficiary on the same day, the Medicare provider must attach

### Coding Tips

Even though Medicare does not require a physician’s order or referral for payment of a screening mammogram, physicians who routinely write orders or referrals for mammograms should clearly indicate the type of mammogram (screening or diagnostic) the beneficiary is to receive. The order should also include the applicable ICD-9-CM diagnosis code that reflects the reason for the test and the date of the last screening mammography. This information will be reviewed by the radiologist, who can ensure that the beneficiary receives the correct service.

Computer-Aided Detection (CAD) payment is built into the payment of the digital mammography services. Therefore, CAD is billable as a separately identifiable add-on code that must be performed in conjunction with a base mammography code. CAD can be billed in conjunction with both standard film and direct digital image screening and diagnostic mammography services.

modifier GG to the diagnostic mammogram (CPT codes 77055 and 77056 or HCPCS codes G0204 or G0206). Medicare requires that modifier GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse for both the screening mammogram and the diagnostic mammogram.

Payment for the Computer-Aided Detection (CAD) mammography (CPT codes 77051 and 77052) cannot be made if billed alone. If the beneficiary receives CAD mammography as part of a Medicare screening or diagnostic mammography service, the CAD codes must be billed in conjunction with primary service codes (Table 1).

Effective October 1, 1994, all facilities providing screening and diagnostic mammography services must have a certificate issued by the Food and Drug Administration (FDA) in order to be reimbursed by Medicare. The appropriate FDA certification number must be included on claims submitted to the carrier/AB Medicare Administrative Contractor (AB MAC) on the CMS-1500 claim form (or the electronic equivalent 837-P) for the film and/or digital mammography service. Note that this number should not be included on claims submitted to the FI/AB MAC.

### **Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)**

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS/CPT code and the corresponding diagnosis code on the HIPAA 837 Professional electronic claim format.

**NOTE:** In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/16\\_1500.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp) on the CMS website.

#### **Administrative Simplification Compliance Act Claims Requirements**

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/08\\_HealthCareClaims.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp) on the CMS website.

**NOTE:** Based on provisions in the NPI Final Rule published in January 2004, effective December 1, 2008, when a provider bills for a mammography screening or diagnostic service that has been purchased from a provider located in another Medicare Contractor's jurisdiction, the billing provider must, in addition to reporting its own NPI on a paper or electronically-submitted Medicare claim (as the billing provider), also report its own NPI as the performing provider, and annotate the claim with the name, address, and ZIP code of the performing provider.

## Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS/CPT code, the appropriate revenue code, and the corresponding diagnosis code on the HIPAA 837 Institutional electronic claim format.

**NOTE:** In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/15\\_1450.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp) on the CMS website.

**NOTE:** In the past, institutional providers used a surrogate unique physician identification number (UPIN) “SLF000” in the Attending Physician UPIN field on Form CMS-1450. Based on provisions in the NPI Final Rule published in January 2004, effective May 23, 2008, institutional providers submitting claims for self-referred mammography services are to duplicate the institution’s own NPI (not UPIN) in the attending physician NPI field on claims. Suppliers submitting claims for self-referred mammography services are to duplicate the supplier’s own NPI in the attending/referring physician NPI field on their claims.

### Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for mammography services when submitted on the following Types of Bills (TOBs) listed in Table 3:

**Table 3 – Facility Types, Types of Bills, and Revenue Codes for Mammography Services**

Facility Type	Mammography Type	Type of Bill	Revenue Code
Hospital Inpatient Part B including Critical Access Hospital (CAH)	For screening mammography	12X	0403
Hospital Inpatient Part B including CAH	For diagnostic mammography	12X	0401
Hospital Outpatient	For screening mammography	13X	0403
Hospital Outpatient	For diagnostic mammography	13X	0401
Skilled Nursing Facility (SNF) Inpatient Part B	For screening mammography	22X	0403
SNF Inpatient Part B	For diagnostic mammography	22X	0401
SNF Outpatient	For screening mammography	23X	0403
SNF Outpatient	For diagnostic mammography	23X	0401



Facility Type	Mammography Type	Type of Bill	Revenue Code
Rural Health Clinic (RHC)	For screening mammography	71X	052X (see following additional instructions)
RHC	For diagnostic mammography	71X	052X (see following additional instructions)
Federally Qualified Health Center (FQHC)	For screening mammography	73X	052X (see following additional instructions)
FQHC	For diagnostic mammography	73X	052X (see following additional instructions)
CAH*	For screening mammography	85X	0403, 096X, 097X, 098X
CAH*	For diagnostic mammography	85X	0401, 096X, 097X, 098X

**\*NOTE:** Method I – All technical components are paid using standard institutional billing practices.

Method II – Receives payment for which Method I receives payment, plus payment for professional services in one of the following revenue codes: 096X, 097X, and 098X.

**NOTE:** For further instructions, see Section 20 of Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual, at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS website.

**NOTE:** Effective April 1, 2005, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will no longer have to report additional line items when billing for preventive and screening services on TOBs 71X and 73X. Except for telehealth originating site facility fees reported using revenue code 0780, all charges for RHC/FQHC services must be reported on the revenue code line for the encounter 052X or 0900.

**NOTE:** Each FI/AB MAC may choose to accept other bill types for the technical component of the screening mammogram. If the Medicare provider would like to bill using a different bill type, the Medicare provider must contact the local FI/AB MAC to determine if a particular bill type is allowed.

## Additional Billing Instructions for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

RHCs and FQHCs should follow these additional billing instructions to ensure that proper payment is made for services and to allow the Common Working File (CWF) to perform age and frequency editing.

- ▶ **Technical Component** for Provider-Based RHCs and FQHCs:
  - ▶ For a screening or diagnostic mammography, the base provider must bill the FI/AB MAC under bill type 12X, 13X, 22X, 23X, or 85X, as appropriate using the base provider's NPI number following the billing instructions applicable to the base provider. Do not use the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.
- ▶ **Technical Component** for Independent RHCs and FQHCs:
  - ▶ For a screening or diagnostic mammography, the individual practitioner must bill the carrier/AB MAC under their own NPI number following the instructions for billing the carrier/AB MAC. Do not bill the FI/AB MAC or use the RHC/FQHC NPI number since these services are not covered as RHC/FQHC services.
- ▶ **Professional Component** for Provider-Based RHCs and FQHCs, Independent RHCs, and Freestanding FQHCs:
  - ▶ When a screening or diagnostic mammography is furnished within an RHC/FQHC by a physician or qualified non-physician, the mammography is considered an RHC/FQHC service. The RHC/FQHC must bill the FI/AB MAC under bill type 71X or 73X respectively for an encounter. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 to report the related visit.

## Reimbursement Information

### General Information

As a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, effective for claims with dates of service on or after January 1, 2005, Medicare will pay for diagnostic mammography and CAD services based on the Medicare Physician Fee Schedule (MPFS). Payment will no longer be made under the Outpatient Prospective Payment System (OPPS).

Additional information about MPFS can be found at <http://www.cms.hhs.gov/PhysicianFeeSched> on the CMS website.

The coinsurance or copayment applies for the screening mammography service. There is no Medicare Part B deductible for the screening mammography service.

The Medicare Part B deductible and coinsurance or copayment apply for diagnostic mammography.

Reimbursement for mammography services is issued for the technical and professional components of the mammography when furnished by separate physicians/suppliers. Medicare providers furnishing both components are paid the global fee, except for Method II CAHs.

Reimbursement for CAD mammography codes 77051 and 77052 cannot be made if billed alone. They must be billed in conjunction with the primary service codes (Table 1).



## Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for mammography services is the lower of the actual charge or the MPFS amount for the service billed.

### Payment Requirements for Non-Participating Physicians

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all mammography tests (screening and diagnostic).

See the National Correct Coding Initiative Edits web page for currently applicable bundled carrier processed procedures at <http://www.cms.hhs.gov/NationalCorrectCodInitEd> on the CMS website.

## Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for mammography services is the lower of the actual charge or the MPFS amount for the service billed with the exception of CAHs, RHCs, and FQHCs (Table 4).

**Table 4 – Types of Payments Received for Mammography Services Furnished by Facilities**

Provider of Service	Form of Payment
CAH	Reasonable Cost Basis (See following options)
FQHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)
Hospital Outpatient Department	Medicare Physician Fee Schedule (MPFS)
RHC	All-inclusive rate for the professional component (codes 77055, 77056, and 77057)
SNF	MPFS

### Critical Access Hospital (CAH) Payment

Medicare makes payment for CAHs using the guidelines listed below. CAHs must not use modifiers TC or -26. The technical component (TC) versus the professional component (PC) is determined by the revenue code the provider uses.

#### Method I CAHs

Payment for the TC for a diagnostic mammography provided in Method I CAHs is based on 101 percent of reasonable cost. For a diagnostic mammography, Medicare makes payment under revenue code 0401. Medicare pays for the TC of a screening mammography using the non-facility MPFS rate under revenue code 0403. For a screening mammography use the following HCPCS codes: G0202, 77057, or 77052. For a diagnostic mammography use the following HCPCS codes: G0204, G0206, 77055, 77056, or 77051.

#### Method II CAHs

Medicare pays for the TC of a screening mammography based on the non-facility MPFS rate and pays for the PC based on the facility MPFS rate.

Method II CAHs must submit claims for the TC of a screening mammography using revenue code 0403 and the following HCPCS codes: G0202, 77057, or 77052. Medicare pays for the TC at 80 percent of the non-facility rate on the MPFS.

Method II CAHs must submit claims for the PC of a screening mammography using one of the following revenue codes: 096X, 097X, or 098X. The CAH may also use any of the following HCPCS codes: G0202, 77057, or 77052. Medicare pays the PC for these claims at 115 percent of the facility rate on the MPFS.

Medicare pays for the TC of a diagnostic mammography at 101 percent of reasonable cost. For the PC of a diagnostic mammography, Medicare makes payment based on 115 percent of the facility rate on the MPFS.

Method II CAHs must submit claims for the TC of a diagnostic mammography using revenue code 0401 and the following HCPCS codes: G0204, G0206, 77055, 77056, or 77051.

Method II CAHs must submit claims for the PC of a diagnostic mammography using one of the following revenue codes: 096X, 097X, or 098X. The CAH may also use any of the following HCPCS codes: G0204, G0206, 77055, 77056, or 77051.

### Skilled Nursing Facility (SNF) Payment

A SNF can provide both screening and diagnostic mammography services. Comprehensive SNF mammography payment information and tables are available in the Medicare Claims Processing Manual, Chapter 18, Section 20.3.2.4, at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS website.

## Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of mammography screening tests:

- ▶ The beneficiary is not at least age 35.
- ▶ The beneficiary has received a covered screening mammogram during the past year.
- ▶ The beneficiary received a screening mammogram from a non-FDA or a non-State/MQSA-certified mammography provider.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at <http://www.wpc-edi.com/Codes> on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

#### Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS website.

#### Remittance Advice Information

To obtain more information about the remittance advice (RA), visit [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) on the CMS website.

## Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Please refer to the Advance Beneficiary Notice of Noncoverage (ABN) Reference Section G of this publication.

# Screening Mammography

---

## Resource Materials

### **Beneficiary Notices Initiative Website**

<http://www.cms.hhs.gov/BNI>

### **Breast Cancer (PDQ®): Prevention**

A guide to breast cancer prevention produced by the National Cancer Institute.

<http://www.cancer.gov/cancertopics/pdq/prevention/breast/Patient/page2>

### **Breast Cancer Facts & Figures 2008**

A comprehensive resource including many breast cancer statistics produced by the American Cancer Society.

<http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf>

### **Carrier/AB MAC and FI/AB MAC Contact Information**

<http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>

### **Electronic Claim Submission Information**

[http://www.cms.hhs.gov/ElectronicBillingEDITrans/08\\_HealthCareClaims.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp)

### **Form CMS-1450 Information**

[http://www.cms.hhs.gov/ElectronicBillingEDITrans/15\\_1450.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp)

### **Form CMS-1500 Information**

[http://www.cms.hhs.gov/ElectronicBillingEDITrans/16\\_1500.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp)

### **Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 280.3**

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

### **Medicare Claims Processing Manual**

<http://www.cms.hhs.gov/manuals>

### **Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 20**

<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>

### **Medicare Fee-For-Service Providers Website**

This site contains detailed provider-specific information.

<http://www.cms.hhs.gov/center/provider.asp>

### **Medicare Learning Network (MLN)**

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

### **Medicare Physician Fee Schedule Information**

<http://www.cms.hhs.gov/PhysicianFeeSched>

### **Medicare Preventive Services General Information**

<http://www.cms.hhs.gov/PrevntionGenInfo>

---

Beneficiary-related resources can be found in Reference F of this Guide.

**MLN Preventive Services Educational Resource Website**

[http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp)

**National Correct Coding Initiative Edits Website**

<http://www.cms.hhs.gov/NationalCorrectCodInitEd>

**National Provider Identifier Information**

<http://www.cms.hhs.gov/NationalProvIdentStand>

**Physician Information Resource for Medicare Website**

This site contains physician-specific information, including updates to policies (such as MPFS), regulations, coding and coverage information, program integrity information, and other valuable resources.

<http://www.cms.hhs.gov/center/physician.asp>

**Remittance Advice Information**

[http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf)

**U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services**

This website provides the USPSTF written recommendations.

<http://www.ahrq.gov/clinic/cps3dix.htm>

**Washington Publishing Company (WPC) Code Lists**

WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.

<http://www.wpc-edi.com/Codes>

**What Are the Key Statistics For Breast Cancer?**

This site provides a breast cancer fact sheet produced by the American Cancer Society.

[http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_4\\_1X\\_What\\_are\\_the\\_key\\_statistics\\_for\\_breast\\_cancer\\_5.asp?sitearea=](http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_breast_cancer_5.asp?sitearea=)

---

Beneficiary-related resources can be found in Reference F of this Guide.