

Reimbursement Information for Mammography Services¹



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This overview addresses coding, coverage and payment for mammography services² provided in the hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings³. While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

For purposes of this advisory, **diagnostic mammography** refers to a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer or a personal history of biopsy-proven benign breast disease. **Screening mammography** refers to a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer.⁴

Current Procedural Terminology (CPT) Coding, Definitions and Medicare Payment Rates

The following provides 2010 national Medicare physician fee schedule (MPFS) and facility payment rates, for example, CPT codes that may be used for radiologic mammography services. **Payment will vary by geographic regions.**

Table 1: 2010 Medicare Reimbursement for Mammography Procedures

(Reflects National Rates, Unadjusted For Locality)

Technology	CPT/HCPCS Code ⁵	Reimbursement Component	Hospital Outpatient/ IDTF/Physician Office ⁶
Computer Aided Detection (CAD)	CPT 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]	Professional (-26)*	\$3.25
		Technical (-TC)**	\$8.30
		Global	\$11.55
	CPT 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]	Professional (-26)	\$3.25
		Technical (-TC)	\$8.30
		Global	\$11.55
Plain Film	CPT 77055 Mammography; unilateral	Professional (-26)	\$35.36
		Technical (-TC)	\$47.27
		Global	\$82.63
	CPT 77056 Mammography; bilateral (Use 77055, 77056 in conjunction with 77051 for CAD applied to diagnostic mammogram)	Professional (-26)	\$44.02
		Technical (-TC)	\$61.34
		Global	\$105.37
	CPT 77057 Screening mammography, bilateral (2-view film study of each breast) (Use 77057 in conjunction with 77052 for CAD applied to a screening mammogram)	Professional (-26)	\$35.36
		Technical (-TC)	\$42.94
		Global	\$78.30
Digital	HCPCS G0202 Screening mammography, producing direct digital image, bilateral, all views	Professional (-26)	\$35.00
		Technical (-TC)	\$94.18
		Global	\$129.18
	HCPCS G0204 Diagnostic mammography, producing direct digital image, bilateral, all views	Professional (-26)	\$43.66
		Technical (-TC)	\$110.42
		Global	\$154.08
	HCPCS G0206 Diagnostic mammography, producing direct digital image, unilateral, all views	Professional (-26)	\$35.00
		Technical (-TC)	\$86.60
		Global	\$121.61

*Professional-is the physician payment. ** Technical-is the facility payment

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of radiologic procedures for mammography services.

26 – Professional Component

A physician who performs the interpretation of a mammography exam in the hospital outpatient setting may submit a charge for the professional component of the mammography service using a modifier-26 appended to the appropriate radiology code.

TC – Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

Hospital Inpatient – ICD-9-CM Procedure Coding

ICD-9-CM procedure codes are used to report procedures performed in a hospital inpatient setting. The following are ICD-9-CM procedure codes that are typically used to report radiological procedures for mammography services.
87.37 Other mammography

ICD-9-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the mammography.

Documentation Requirements

Medicare will reimburse providers for medically necessary screening and diagnostic mammography procedures that are performed on the same patient on the same day. The modifier –GG "Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day," must be attached to the appropriate diagnostic mammography procedure code. In a scenario where a patient has a screening mammogram performed on one day and returns on another day for the additional diagnostic mammogram, both the screening mammogram and diagnostic mammogram services should be coded separately without the use of modifier –GG. This policy applies to both film and digital mammography procedures. [Refer to the Medicare Claims Processing Manual at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> (scroll to section 20.2).]

Payment Methodologies for Mammography Services

Medicare reimburses for mammography services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service.

Medicare reimbursement for mammography services, including the add-on payment for CAD, is comprised of a **professional component**, the amount paid for the physician's interpretation and report, and a **technical component**, the amount paid for all other services (including staffing and equipment costs). When combined and paid to the same individual or entity, this amount is often referred to as the **total** or **global reimbursement**. Regardless of the site of service, **diagnostic and screening** mammography services are paid under the Medicare physician fee schedule. Table 1 provides information concerning Medicare national payment amounts for both screening and diagnostic mammography services performed in the hospital outpatient department, IDTF and physician office sites of care. Note that Medicare payment amounts and coverage policies for specific procedures will vary by geographic location. For more information about reimbursement rates in your area, consult your local Medicare contractor.

Site of Service

Physician Office Setting

In the office setting, a physician who owns the radiology equipment and performs the service may report the global code without a –26 modifier.

Hospital Outpatient Setting

When the mammography service is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service.

If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the mammography service as an outpatient service.

Hospital Inpatient Setting

Charges for the mammography services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless. Note: Medicare reimburses for services when the services are within the scope of the provider's license and are deemed medically necessary.

Coverage

As established in legislation, Medicare provides conditions of coverage for both screening and diagnostic mammography services. Coverage guidelines address the types of services covered; requirements for providers of service; patient's eligibility; and frequency limitations.⁷ To review information on Medicare's coverage conditions for mammography services, refer to Medicare's National Coverage Determination, Mammograms, in the Internet Manual for Medicare National Coverage Determinations at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> (scroll to section 220.4), as well as information located in the Internet Manual for Medicare Benefit Policy at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> (scroll to section 280.3).

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Footnotes:

¹ Information presented in this document is current as of January 1, 2010. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

² The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment's FDA-approved labeling as a non-covered service.

³ The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

⁴ Title 42-Public Health. CFR §410.34(a).

⁵ CPT codes and descriptions only are copyright © 2009 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

⁶ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 74, No. 226, November 25, 2009 and the Federal Register, Vol. 74, No. 236, December 10, 2009, and updated as per Transmittal R1887CP, dated January 6, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

⁷ Title 42-Public Health. CFR §410.34.

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