

MEDICARE REIMBURSEMENT FOR MAMMOGRAPHY SERVICES¹

This advisory discusses coding, coverage and payment for mammography services² provided in the hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings.³ While it focuses on Medicare program policies, these policies may also be applied 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

Coding

Medicare's reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify some **mammography services** provided to Medicare patients.⁵ The CPT coding system was developed and is maintained by the American Medical Association (AMA) and the codes are updated annually.

In addition to the use of CPT codes, Medicare utilizes Healthcare Common Procedure Coding System (HCPCS) Level II (national) codes to report **digital mammography services**. The agency developed the alphanumeric HCPCS level II coding system to describe and identify many supplies and services that are not included in the CPT coding system. Table 1 lists the CPT codes and HCPCS Level II codes that should be reported for mammography services.

Medicare also reimburses for computer aided detection (CAD) as a separate, add-on payment when used with either film-based or digital mammography. The CPT codes for computer aided detection (CAD), listed in Table 1, distinguish between diagnostic and screening mammography applications.

For diagnostic services, it should be noted that the CAD CPT code 77051 can be reported in conjunction with the primary service mammography CPT codes 77055 or 77056, as well as HCPCS codes G0204 or G0206. For screening services, CAD CPT code 77052 can be reported in conjunction with the primary service mammography code, CPT code 77057 or HCPCS code G0202. [Refer to the Medicare Claims Processing Manual at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> (scroll to section 20.2.1).]

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).]

The preceding coding guidance has been provided by authoritative sources; however, individual circumstances can be an important factor in appropriate coding for imaging procedures. It is the provider’s responsibility to consult an authoritative coding resource to determine and submit appropriate codes. The existence of a code does not mean the procedure is covered and payable.

Reimbursement

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.

Table 1: 2008 Medicare Reimbursement for Mammography Services
(Reflects National Rates, Unadjusted for Locality)

Technology	CPT/HCPCS Code	Reimbursement Component	Hospital Outpatient/ IDTF/ Physician Office⁶
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]	Technical	\$11.81
		Professional	\$3.05
		Total	\$14.86
	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]	Technical	\$11.81
		Professional	\$3.05
		Total	\$14.86
Plain Film	CPT 77055 Mammography; unilateral	Technical	\$48.75
		Professional	\$33.90
		Total	\$82.65
	CPT 77056 Mammography; bilateral	Technical	\$62.46
		Professional	\$41.90
		Total	\$104.36
	CPT 77057 Screening mammography, bilateral (2-view film study of each breast)	Technical	\$49.13
		Professional	\$33.90
		Total	\$83.03
Digital	HCPCS G0202 Screening mammography, producing direct digital image, bilateral, all views	Technical	\$100.17
		Professional	\$33.52
		Total	\$133.69
	HCPCS G0204 Diagnostic mammography, producing direct digital image, bilateral, all views	Technical	\$109.31
		Professional	\$41.90
		Total	\$151.21
	HCPCS G0206 Diagnostic mammography, producing direct digital image, unilateral, all views	Technical	\$87.22
		Professional	\$33.52
		Total	\$120.74

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/ncd103c1_Part4.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).

¹ Information presented in this document is current as of January 15, 2008. 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 © 2007 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 amount is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008 and an update to the conversion factor of 0.5%. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these technical and professional payment amounts are applicable through June 30, 2008. 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.