

2017 Reimbursement Information for Mammography, CAD and Digital Breast Tomosynthesis¹

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This advisory addresses Medicare coding, coverage and payment for mammography examinations including Computer-Aided Detection (CAD) and Digital Breast Tomosynthesis procedures (DBT)² performed in the hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings.³ While it focuses on Medicare program policies, this information may also be applicable to selected private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

For purposes of this advisory, diagnostic mammography refers to a radiologic procedure furnished to a woman or man 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 or man without signs or symptoms of breast disease for the purpose of early detection of breast cancer.⁴ The ACR recommends that screening examinations should be limited to technically adequate craniocaudal and mediolateral oblique views of each breast.⁵ DBT goes beyond the current 2D image of mammography by producing a series of parallel planar slice images of the entire breast volume, further clarifying areas of overlapping tissue. The CPT and HCPCS codes^(a) referenced in this reimbursement advisory are reportable for the on-label imaging protocols of all GE mammography systems, but may be applicable examinations performed with non-GE mammography systems.

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

Overview

Two significant changes affect 2017 mammography reimbursement for Medicare patients. These include:

- 1) CPT® and HCPCS Coding changes
- 2) Reimbursement reductions for exams performed on film mammography systems

Coding Changes

Coding changes for 2017 are intended to simplify the mammography family of codes that had included separate groups of codes for FFDM, film mammography, and computeraided detection in addition to those for digital breast tomosynthesis (DBT). The CPT Editorial Panel deleted CPT codes 77051, 77052, 77055, 77056, 77057 for 2017 and created three new CPT codes, 77065, 77066, and 77067, to describe mammography services bundled with CAD. The new CPT codes for mammography with CAD services are:

- 77061** Digital breast tomosynthesis, unilateral*
- 77065** Diagnostic mammography, including computer-aided detection (CAD) when performed unilateral
- 77066** Diagnostic mammography, including computer-aided detection (CAD) when performed bilateral
- 77067** Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Despite these codes being released and active for 2017, CMS has declared that their claims processing systems were unable to be updated to reliably process claims using CPT codes 77065, 77066, and 77067 beginning in January. Therefore, for 2017 CMS has revised the descriptions of the current G-codes (G0202, G0204 and G0206) and will require the use of the G-codes rather than the 77XXX codes for screening and diagnostic mammography services. CMS anticipates adoption in 2018 of the 77XXX code series for mammography services.

For reporting screening and diagnostic mammography services to Medicare payers, mammography service providers should utilize the following HCPCS codes depending on what service is provided:

- G0202** Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
- G0204** Diagnostic mammography, including computer-aided detection (CAD) when performed bilateral
- G0206** Diagnostic mammography, including computer-aided detection (CAD) when performed unilateral

Note that while Medicare will not reimburse mammography claims for services reported with 77065-77067 CPT codes, some private payers claims processing systems may and may also continue to accept claims with the HCPCS G-codes. It is recommended that providers confirm coding requirements or preferences with payers in their commercial networks.

Screening mammography with 2D projection images alone has traditionally involved two independent views of each breast. Combined screening with 2D mammography and DBT using FDA-approved protocols has resulted in various FDA-approved protocols consisting of direct-acquisition or synthetic 2D planar images in combination with single- or two-view DBT acquisitions. For reporting mammography screening exams with DBT, the American College of Radiology's (ACR) Radiology Coding SourceTM has provided the following guidance on its website:

" Whether a mammography image is derived from a single larger-exposure or a series of smaller exposures, it is still considered a mammogram and should be reported as such." ⁷

GE V-Preview^(b) synthetic images have been approved by U.S. FDA for the screening and diagnosis of breast cancer when used in conjunction with DBT images and fall within the ACR's coding guidance.

Film Reimbursement Penalty

Also new for 2017, the Consolidated Appropriations Act of 2015 (Section 502^{(a)(1)}) is titled "Medicare Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Medicare Imaging Payment Provision."

To reflect this, CMS will reduce the payment amounts under the Physician Fee Schedule (PFS) by 20 percent for the technical component (and the technical component of the global fee) of imaging services that are X-rays taken using film. This is effective for services provided on or January 1, 2017. As a consequence, the technical component of mammography services will be reduced 20% when procedures are performed in any of the following locations:

- Clinic or physician office
- Hospital outpatient

Mammography services performed on non-Medicare patients are not subject to payment reductions specified in the Consolidated Appropriations Act of 2015.

Digital Breast Tomosynthesis

The following are the codes that describe DBT examinations:

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|--------------|------------------------------------------------------------------------------------------------------------------|
| 77061 | Digital breast tomosynthesis, unilateral ^(c) |
| 77062 | Digital breast tomosynthesis, bilateral ^(c) |
| 77063 | Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure) |
| G0279 | Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206) |

Although CPT codes 77061 and 77062 are available for reporting diagnostic DBT examinations, these codes may not be used for CMS claims reporting. Instead, HCPCS code G0279 must be used for reporting DBT when utilized for imaging CMS patients. For screening DBT examinations, CMS accepts claims that include CPT code 77063 and HCPCS code G0202

Please note that non-Medicare payers may follow Medicare direction and some may have their own specific coding recommendations regarding billing for DBT. It is recommended to always consult with local payers, whether Medicare or non-Medicare to obtain their recommended coding and coverage information applicable to mammography, CAD, and DBT procedures.

2017 Payment Rates

The following provides 2016 national Medicare Physician Fee Schedule (MPFS) and facility payment rates for CPT codes that may be used to report Digital Breast Tomosynthesis procedures. Payers or their local branches may have specific coding and reimbursement requirements and policies. Before filing any claims, it is recommended that providers verify current requirements and policies with their local payer. Payment will vary by geographic regions.

- (a) Current Procedural Terminology (American Medical Association), Healthcare Common Procedure Coding System (Centers for Medicare and Medicaid Services).
- (b) V-Preview, Revision 3.
- (c) CMS does not recognize these specific CPT codes for 2017 DBT billing.

Table 1: 2017 Medicare Reimbursement for Mammography, With or Without CAD and Digital Breast Tomosynthesis Procedures⁸
(Reflects national rates, unadjusted for locality)

CPT/HCPCS Code ⁹	Reimbursement Component	Medicare Physician Fee Schedule Payment ¹⁰	APC	Hospital Outpatient Payment ¹¹
Mammography, 2D – Screening/Diagnostic				
HCPCS G0202*** Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Professional (-26)*	\$37.68	N/A	\$100.49 / \$80.39****
	Technical (-TC)**	\$100.49 / \$80.39****		
	Global	\$138.17 / \$118.07****		
HCPCS G0204*** Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Professional (-26)	\$49.53	N/A	\$121.66 / \$97.33****
	Technical (-TC)	\$121.66 / \$97.33****		
	Global	\$171.19 / \$146.86****		
HCPCS G0206*** Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Professional (-26)	\$39.84	N/A	\$95.11 / \$76.10****
	Technical (-TC)	\$95.11 / \$76.10****		
	Global	\$134.94 / \$115.94 ****		
Tomosynthesis – Screening/Diagnostic				
77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Professional (-26)	\$30.86	N/A	\$25.48
	Technical (-TC)	\$25.48		
	Global	\$56.35		
G0279 Diagnostic digital breast tomosynthesis, unilateral or bilateral	Professional (-26)	\$30.86	N/A	\$25.48
	Technical (-TC)	\$25.48		
	Global	\$56.35		

* Professional – The physician payment

*** These codes, when applied to SenoClaire, assume directly-acquired planar FFDM images

** Technical – The facility payment

**** Payment if images acquired with X-Ray film: 20% reduction of TC & APC

The following table summarizes the billing codes pertaining to diagnostic and screening mammograms using film or digital systems with or without supplemental DBT. These codes pertain to 2017 Medicare billing.

	HCPCS Code	CPT Code	Mammography with Tomosynthesis
Unilateral Diagnostic Mammogram	G0206	77065	G0206 or 77065 + G0279
Bilateral Diagnostic Mammogram	G0204	77066	G0204 or 77066 + G0279
Screening Mammogram	G0202	77067	G0202 or 77067 + 77063

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 mammography services.

FX – X-ray Taken Using Film

To implement the incentive to transition to digital imaging included in the Consolidated Appropriations Act of 2015, the Centers for Medicare & Medicaid Services (CMS) has created modifier FX (X ray taken using film). Beginning in 2017, claims for X-rays using film must include modifier FX that will result in the applicable payment reduction for which payment is made under the Medicare Physician Fee Schedule (MPFS).²

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.

GG – Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

When a screening mammogram and a diagnostic mammogram are performed on the same patient on the same day, modifier – GG would be appended to the appropriate procedure code. The screening mammogram is reported and the diagnostic mammogram is reported (different encounters on the same day).

GH – Diagnostic mammogram converted from screening mammogram on same day

When a diagnostic mammogram is converted from a screening mammogram on the same day, modifier – GH would be appended to the appropriate procedure code. A potential problem was detected by the interpreting radiologist and, therefore, the radiologist will also perform a diagnostic mammogram at the same visit.

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).

ICD-10 CM and ICD-10-PCS Coding

ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes were implemented October 1, 2015. The physician is responsible for selecting codes that appropriately represent the service performed, and reporting ICD-10-CM diagnosis codes based on findings or pre-service signs symptoms or conditions that reflect the reason for performing the examinations. The following are examples of ICD-10-PCS codes that relate to mammography and DBT:

BH06ZZZ	Plain Radiography of Right Breast
BH06ZZZ	Plain Radiography of Left Breast
BH06ZZZ	Plain Radiography of Bilateral Breasts
BH06ZZZ	Plain Radiography of Left Single Mammary Duct
BH06ZZZ	Plain Radiography of Right Multiple Mammary Ducts
BH06ZZZ	Plain Radiography of Left Multiple Mammary Ducts

For more information on ICD-10-CM/PCS, please go to:
<https://www.cms.gov/medicare/Coding/ICD10/index.html>

Documentation Requirements

As with any procedure performed, Medicare requires documentation to support that the procedure(s) performed are medically necessary. Medical necessity, as determined by the payer, must be thoroughly documented in the patient's medical record. 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 Chapter 18 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/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.

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.⁵ To review these for mammography, 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).

Private payers and Medicare coverage may differ. Check with your individual payer for their specific coding, coverage and payment requirements. Private payers may require prior authorization for the procedure.

1. Information presented in this document is current as of February 1, 2017. 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. ACR Practice Parameter for the Performance of Screening and Diagnostic Mammography. <https://www.acr.org/~media/3484ca30845348359bad4684779d492d.pdf>.
6. American College of Radiology News & Publications. <https://www.acr.org/News-Publications/News/News-Articles/2014/Economics/20141105-CMS-Establishes-Values-for-Breast-Tomosynthesis-in-2015-Final-Rule>.
7. ACR Radiology Coding Source™ for November-December 2014. <https://www.acr.org/Advocacy/Economics-Health-Policy/Billing-Coding/Coding-Source-List/2014/Nov-Dec-2014/QAAssociation>.
8. The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. Actual Medicare payment rates may vary based on any deductibles, copayments and sequestration rules that apply.
9. Current Procedural Terminology (CPT) Copyright 2016, American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
10. 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 the Federal Register (Federal Register / Vol. 81, No. 220 / Tuesday, November 15, 2016). These changes are effective for services provided from 1/1/17 through 12/31/17. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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.

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11. The CPT codes in this section have a Status Indicator of "A." This means that they are not reimbursed under the OPPS fee schedule. They are paid by fiscal intermediaries under a fee schedule or payment system other than OPPS. In this case they are reimbursed under the Medicare Physician Fee Schedule (MPFS) based on the Technical Portion for the MPFS amount. The MPFS payments are based on relative value units published in the Federal Register - Federal Register / Vol. 81, No. 219 / Monday, November 14, 2016.
12. MLN Matters® Number: MM9727 Effective Date: January 1, 2017. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9727.pdf>.
13. Title 42 – Public Health. CFR §410.34.

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