



Reimbursement Information for Molecular Breast Imaging (MBI)¹



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Molecular Breast Imaging (MBI) is a non-invasive diagnostic test that falls under the Molecular Imaging category of Breast Specific Gamma Imaging. This Nuclear Medicine technique may also be referred to as Molecular Breast Imaging or Scintimammography (SMM). MBI is a non-invasive diagnostic test that uses radiopharmaceuticals administered intravenously and a gamma camera to detect tissues within the breast that accumulate higher levels of a radioactive tracer that emit gamma radiation. Scintimammography has been proposed primarily as an adjunct to mammography and physical examination to improve selection for biopsy in patients who have palpable masses or suspicious mammograms².

This overview addresses Medicare coding, coverage and payment for MBI when performed in the hospital inpatient, hospital outpatient department, 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.

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

The following provides 2017 national Medicare physician fee schedule (MPFS) and facility payment rates for the CPT codes identified in this guide. **Payment will vary by geographic regions.**

Table 1: 2017 Medicare Reimbursement for MBI (Reflects National Rates, Unadjusted For Locality)

| CPT/HCPCS Code ⁴ | Physician | | Facility | |
|--|-------------------------|---|----------|--|
| | Reimbursement Component | Medicare Physician Fee Schedule Amount ⁵ | APC | Hospital Outpatient Payment ⁶ |
| 78800 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area | Professional (-26)* | \$34.45 | 5591 | \$333.08 |
| | Technical (-TC)** | \$167.60 | | |
| | Global | \$202.05 | | |
| 78801 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas*** | Professional (-26) | \$40.91 | 5591 | \$333.08 |
| | Technical (-TC) | \$234.71 | | |
| | Global | \$275.63 | | |
| S8080 Scintimammography (radioimmunosциntigraphy of the breast), unilateral, including supply of radiopharmaceutical (Non-Medicare payers) | Professional (-26) | Not payable by Medicare | N/A | Not payable by Medicare |
| | Technical (-TC) | Not payable by Medicare | | |
| | Global | Not payable by Medicare | | |
| Lymphoscintigraphy | | | | |
| 78195^ Lymphatics and lymph nodes imaging | Professional (-26) | \$60.29 | 5592 | \$429.13 |
| | Technical (-TC) | \$313.67 | | |
| | Global | \$373.96 | | |
| 38792^^ Injection procedure; radioactive tracer for identification of sentinel node | Facility^^^ | \$41.27 | 5591 | \$333.08 |
| | Non-Facility^^^^ | N/A | | |

*Professional (-26) - The professional component is the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding modifier 26.

**Technical (-TC) - The technical component is the equipment and technician performing the test. This is identified by adding modifier "TC" to the procedure code identified for the technical component charge.

***The ACR and the Society of Nuclear Medicine and Molecular Imaging (SNMMI) consider it inappropriate to use 78801 to report bilateral breast imaging. The original intent of the code is to report multiple sites of the body versus both sides of the same body area. The ACR and SNMMI recommend the use of code 78800 for bilateral studies. Check with your payer for specific policies and coding guidelines⁷.

^Per CPT parentheticals: (For sentinel node identification without scintigraphy imaging, use 38792) (For sentinel node excision, see 38500-38542)

^^Per CPT parentheticals: (For excision of sentinel node, see 38500-38542) (For nuclear medicine lymphatics and lymph gland imaging, use 78195) (For intraoperative identification (eg, mapping) of sentinel lymph node(s) including injection of non-radioactive dye, see 38900)

^^^Facility - is the payment made to the physician when the procedure is performed in a hospital or ASC.

^^^^Non-facility - is the payment to the physician when the procedure is performed in the physician's office. Fields in this column populated with 'N/A' indicate that CMS has not developed a PE RVU in the non-facility setting for services because it is typically performed in the hospital setting. If there is an 'N/A' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.

Table 2: 2017 Medicare Reimbursement for Radiopharmaceuticals used with MBI (Reflects National Rates, Unadjusted For Locality)

| CPT/HCPCS Code | Physician | | Facility | |
|--|-------------------------|--|----------|-----------------------------|
| | Reimbursement Component | Medicare Physician Fee Schedule Amount | APC | Hospital Outpatient Payment |
| A9500 Technetium tc-99m sestamibi, diagnostic, per study dose | | Carrier priced | NA | Packaged in APC |

Modifiers

26 – Professional Component

A physician who performs the interpretation of a MBI imaging procedure in the hospital outpatient setting may submit a charge for the professional component of the imaging service using a modifier (-26) appended to the procedure 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).

ICD-10-CM and ICD-10-PCS

ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes were implemented October 1, 2105. 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 molecular breast imaging examinations.

ICD-10-PCS procedure codes are used to report procedures performed in a hospital inpatient setting for dates of service on or after October 1, 2015. The classification system provides significant improvements through greater detailed information and the ability to expand to capture additional advancements in clinical medicine. Because of this, there are many more codes that exist to allow for greater detail and specificity for reporting of services rendered. It is recommended that you check with your payer and coding references for the applicable ICD-10-CM diagnosis and ICD-10-PCS procedure codes relating to molecular breast imaging services.

Documentation Requirements

According to the existing coverage policies and also the SNMMI, there needs to be more research done regarding MBI. The existing coverage policies consider MBI/SMM/BSGI investigational and do not typically cover or reimburse for this procedure. No documentation requirements are outlined in the existing policies.

Payment Methodologies for MBI

Medicare may reimburse for MBI procedures 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 imaging equipment and performs the service, may report the global code without a -26 modifier.

Hospital Outpatient Setting

When the MBI is performed in the hospital outpatient setting, the hospital may bill for the technical component of the service as an outpatient service.

The CPT code filed by the hospital will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

Based on the Medicare Hospital Outpatient Prospective Payment System (HOPPS), the technical components of all image-guidance procedures that are performed in the hospital outpatient department are considered a packaged service.

This means that the payment to the facility for these services is included in the payment for the primary procedure.

Hospital Inpatient Setting

Charges for the imaging 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 imaging services when the services are within the scope of the provider's license and are deemed medically necessary.

Coverage

Coverage for Molecular Breast Imaging (MBI)

There is no Medicare national coverage determination for MBI. There are currently no local Medicare contractors that have developed coverage policies for MBI. Coverage and reimbursement is at the payers discretion.

Coverage for Diagnostic Radiopharmaceuticals

There is no Medicare national coverage determination on diagnostic radiopharmaceuticals. Some Medicare local contractors have developed LCDs that address coverage for diagnostic radiopharmaceuticals. LCDs may restrict coverage to specific indications and patient conditions. Absence of a local determination does not imply non-coverage. The local contractors may review medical necessity on a case-by-case basis.

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Footnotes:

¹Information presented in this document is current as of January 1, 2017 Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

²United HealthCare Medical Policy 2011T0375H. Effective Date: May 1, 2013
https://www.unitedhealthcareonline.com/ccmcontent/Provider1/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Breast_Imaging_for_Screening_and_Diagnosing_Cancer.pdf

³The 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.

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⁵Third 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 amounts indicated are based upon data elements published in the Federal Register Vol. 81, No. 220 /Tuesday, November 15, 2016 and subsequent updates based on legislation enacted by CMS. **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.

⁶Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Only national rates unadjusted for local wage and cost differences are provided. The payment amounts indicated are based upon data elements published in the Federal Register Vol. 81, No. 219 / Monday, November 14, 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.

⁷ACR Breast Imaginf FAQ Aug 2008: <http://www.acr.org/~/media/ACR/Documents/PDF/Economics/Coding%20Source/2008%20Jul%20Aug/BreastImagingFrequentlyAskedQuestions.pdf>

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