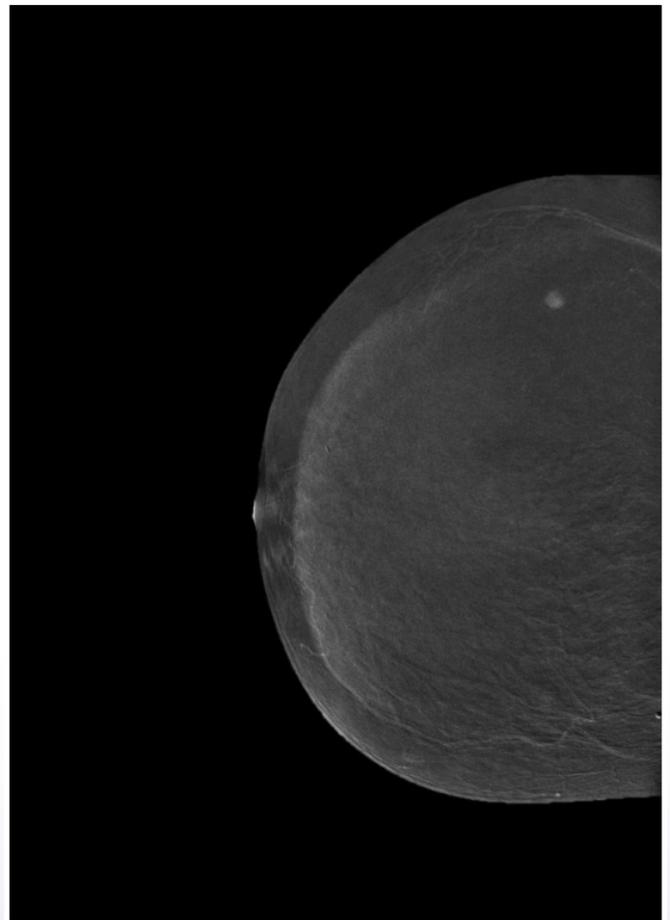
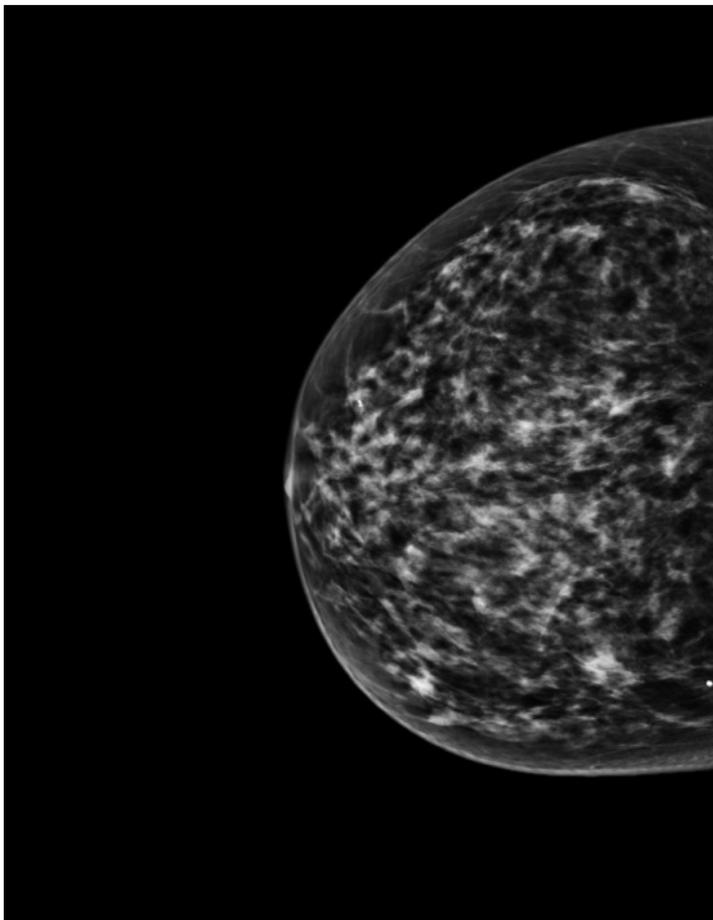


Reimbursement Information for Contrast Enhanced Spectral Mammography (CESM) Services¹

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This advisory addresses Medicare coding, coverage and payment for mammography Contrast Enhanced Spectral Mammography (CESM) procedures² performed 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 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 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 CESM is an extension of the existing indication for diagnostic mammography, and can be used as an adjunct following mammography and ultrasound exams to localize a known or suspected lesion.



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 CPT codes that may be used to report CESM 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.

Table 1: 2017 Medicare Reimbursement for Contrast Enhanced Spectral Mammography Procedures⁵
(Reflects national rates, unadjusted for locality)

Technology	CPT/HCPCS Code ⁶	Reimbursement Component	Medicare Physician Fee Schedule Payment ⁷	APC	Hospital Outpatient Payment ⁸
Digital	HCPCS G0204 Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Professional (-26)*	\$49.53	N/A	\$121.66
		Technical (-TC)**	\$121.66		
		Global	\$171.19		
	HCPCS G0206 Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Professional (-26)	\$39.84	N/A	\$95.11
		Technical (-TC)	\$95.11		
		Global	\$134.94		
Injection	CPT 96374**** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Facility***	N/A	APC 5693	\$179.69
		Non-Facility****	\$58.14		

* Professional – is the physician payment.

** Technical – is the facility payment.

*** 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.

***** Requires direct physician supervision – physician must be immediately available in office.

2017 Medicare Reimbursement for Contrast Materials

HCPCS ⁹ Code	HCPCS Code Dosage	Payment Limit ¹⁰
CPT Q9951 Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml	Not Available	Payment bundled into APC
CPT Q9965 Low osmolar contrast material, 100 – 199 mg/ml iodine concentration, per ml	1 ML	Payment bundled into APC
CPT Q9966 Low osmolar contrast material, 200 – 299 mg/ml iodine concentration, per ml	1 ML	Payment bundled into APC
CPT Q9967 Low osmolar contrast material, 300 – 399 mg/ml iodine concentration, per ml	1 ML	Payment bundled into APC

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 CEM 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.

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).

Hospital Inpatient – ICD-10-PCS Procedure Coding

ICD-10-PCS procedure codes are used to report procedures performed in a hospital inpatient setting. The following are ICD-10-PCS procedure codes that are typically used to report radiological procedures for mammography services.

- BH00ZZZ Plain radiography of right breast
- BH01ZZZ Plain radiography of left breast
- BH02ZZZ Plain radiography of bilateral breasts

ICD-10-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-10-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

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, should 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 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 is comprised of a professional component (PC), which is the amount paid for the physician’s interpretation and report, plus a technical component (TC), which the amount paid for performing the service (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.

Payment Methodologies for Mammography Services (continued)

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.¹¹ 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 https://www.cms.gov/Regulations-and-Guidance/Guidance/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). However, Medicare may consider CESM to be a new breast imaging modality. Therefore, it is best to check with your Medicare Contractor regarding the coverage of CESM.

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- 1 Information 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.
- 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 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.
- 6 Current Procedural Terminology (CPT) is 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.
- 7 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 / Vol. 81, No. 220 / Tuesday, November 15, 2016 and subsequent updates based upon 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.
- 8 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system. 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.
- 9 PMIC Digital Book Series HCPCS 2017. Copyright 2016 by Practice Management Information Corporation, Las Angeles, CA 90010. All rights reserved.
- 10 Payment allowance limits subject to the ASP methodology are based on 3Q15 ASP data. The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor processing the claim. Effective January 1, 2016 – March 31, 2016. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2016ASPFiles.html>.
- 11 Title 42- Public Health. CFR §410.34.

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