Breast Imaging Reimbursement Compendium 2017
Reimbursement Information for Contrast-Enhanced Spectral Mammography (CESM) Services


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.

This advisory addresses Medicare coding, coverage and payment for mammography Contrast-Enhanced Spectral Mammography (CESM) procedures performed in the hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings. 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. 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.
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).
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 is 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.

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](http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf) (scroll to section 20.2).

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

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. 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](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](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.
Reimbursement Information for Automated Breast Ultrasound Screening

Coding and Payment Information

The following provides 2017 national Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT® codes identified in this guide. Payment rates reflect DRA-imposed payment reductions for services that are subject to the regulations.

Payment will vary in geographic locality.

The Invenia™ ABUS is indicated as an adjunct to mammography for breast cancer screening in asymptomatic women for whom screening mammography findings are normal or benign (BI-RADS™ Assessment Category 1 or 2), with dense breast parenchyma (BI-RADS Composition/Density C or D), and have not had previous clinical breast intervention. The device is intended to increase breast cancer detection in the described patient population. The Invenia ABUS may also be used for diagnostic ultrasound imaging of the breast in symptomatic women.

ABUS Reimbursement Hotline Resources

☎ Toll free phone number: 1-844-386-0099
✉ Email: GEABUS@emersonconsultants.com
Table 3: 2017 Medicare reimbursement for procedures related to breast ultrasound (Reflects national rates, unadjusted for locality)

<table>
<thead>
<tr>
<th>HCPCS Code/Description Medicare</th>
<th>Reimbursement Component</th>
<th>Medicare Freestanding Facility/Physician Office Payment</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 76641* Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete</td>
<td>Technical***</td>
<td>$72.14</td>
<td>APC 5522 Status Indicator = Q1**</td>
</tr>
<tr>
<td>CPT 76642* Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited</td>
<td>Professional****</td>
<td>$37.32</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$109.46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technical***</td>
<td>$55.27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional****</td>
<td>$34.81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$90.08</td>
<td></td>
</tr>
</tbody>
</table>

* Four-quadrant and retroareolar region imaging required for “complete” examination. Axilla imaging may or may not be performed.
** The STVX-packaged codes (status indicator Q1) are packaged when billed on the same date of service with any other code with a status indicator of S, T, V, or X. If not, they are separately payable under a separate APC. If you report more than one STVX- or T-packaged code without a separately payable service into which it would otherwise be packaged, CMS makes separate payment only for the highest-paying service and packages all others into that code. Reference information may be found at the online resource: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf

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 ultrasound for breast procedures.

26 – Professional Component
A physician who performs the interpretation of an ultrasound exam in the hospital outpatient setting may submit a charge for the professional component of the ultrasound service using a modifier (-26) appended to the ultrasound code.

50 – Bilateral Procedure
This modifier would be used to bill bilateral procedures that are performed at the same operative session, unless otherwise identified in the listings. To appropriately adjust payment when bilateral procedures are furnished under the PFS, payments are adjusted to 150 percent of the unilateral payment when a service has a bilateral payment indicator assigned.

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 (diagnosis)
- R92.0 Mammographic microcalcification found on diagnostic imaging of breast
- R92.1 Mammographic calcification found on diagnostic imaging of breast
- R92.2 Inconclusive mammogram
- R92.8 Other abnormal and inconclusive findings on diagnostic imaging of breast
- Z12.39 Encounter for other screening for malignant neoplasm of breast

ICD-10-PCS
- BH40ZZZ Ultrasonography of Right Breast
- BH41ZZZ Ultrasonography of Left Breast
- BH42ZZZ Ultrasonography of Bilateral Breasts

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

Documentation Requirements
Ultrasound performed using either a compact portable ultrasound or a console ultrasound system are reported using the same CPT codes as long as the studies that were performed meet all the following requirements:
- Medical necessity as determined by the payer
- Completeness
- Documented in the patient’s medical record

A separate written record of the diagnostic ultrasound or ultrasound-guided procedure must be completed and maintained in the patient record. This should include a description of the
structures or organs examined, the findings and reason for the ultrasound procedure. Diagnostic ultrasound procedures require the production and retention of image documentation. It is recommended that permanent ultrasound images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or other appropriate archive.

Note: The description of the new code 76641 states that axilla imaging is not required, but included in the code description if performed. Therefore, if this is part of the examination, it should be documented in the patient files that it was performed.

Payment Methodologies for Ultrasound Services
Medicare may reimburse for ultrasound 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 ultrasound equipment and performs the service, or a sonographer who performs the service, may report the global code without a -26 modifier.

Hospital Outpatient
When the ultrasound is performed in the hospital outpatient, 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 ultrasound 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.

Hospital Inpatient Setting
Although this service would not typically be performed in the inpatient hospital setting, if it is performed in this setting, charges for the ultrasound 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 may reimburse for ultrasound services when the services are within the scope of the provider’s license and are deemed medically necessary.

Coverage information
Procedures may be a covered benefit if such usage meets all requirements established by the particular payer. However, it is advisable that you verify coverage policies with your local Medicare Administrative Contractor. Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record. Coverage by private payers varies by payer and by plan with respect to which medical specialties may perform ultrasound services. Some private payer plans will reimburse for ultrasound procedures performed by any physician specialist while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, plans may require providers to submit applications requesting these diagnostic ultrasound and ultrasound-guided services be added to the list of services performed in their practice. It is important that you contact the payer prior to submitting claims to determine their requirements.

ABUS Reimbursement Hotline Services
GE Healthcare agrees to abide by the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any other relevant state or federal privacy laws and regulations concerning the use and/or disclosure of protected health information during the course of providing this support.
Reimbursement Information for Mammography, CAD and Digital Breast Tomosynthesis


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 computer-aided 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
This advisory addresses Medicare coding, coverage and payment for mammography examinations including Computer-Aided Detection (CAD) and Digital Breast Tomosynthesis procedures (DBT) performed in the hospital outpatient, independent diagnostic testing facility (IDTF) and physician office settings. 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. The ACR recommends that screening examinations should be limited to technically adequate craniocaudal and mediolateral oblique views of each breast. 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 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.

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: 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 Source™ 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.”

GE V-Preview™ 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[4]) 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 after 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:

- 77061 Digital breast tomosynthesis, unilateral[6]
- 77062 Digital breast tomosynthesis, bilateral[6]
- 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

Note: 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.


(b) V-Preview, Revision 3.

(c) CMS does not recognize these specific CPT codes for 2017 DBT billing.

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### Table 4: 2017 Medicare Reimbursement for Mammography, With or Without CAD and Digital Breast Tomosynthesis Procedures

(Reflects national rates, unadjusted for locality)

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment</th>
<th>APC</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mammography, 2D – Screening/Diagnostic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HCPCS G0202</strong>***</td>
<td>Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed</td>
<td>Professional (-26)'</td>
<td>$37.68</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)**</td>
<td>$100.49/$80.39***</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$138.17/$118.07***</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>HCPCS G0204</strong>***</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral</td>
<td>Professional (-26)</td>
<td>$49.53</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)</td>
<td>$121.66/$97.33***</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$171.19/$146.86***</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>HCPCS G0206</strong>***</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral</td>
<td>Professional (-26)</td>
<td>$39.84</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)</td>
<td>$95.11/$76.10***</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$134.94/$115.94***</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| **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 | N/A | $25.48 |
| | | Global | $56.35 | N/A | $56.35 |
| **G0279** | Diagnostic digital breast tomosynthesis, unilateral or bilateral | Professional (-26) | $30.86 | N/A | $25.48 |
| | | Technical (-TC) | $25.48 | N/A | $25.48 |
| | | Global | $56.35 | N/A | $56.35 |

* Professional – The physician payment
** Technical – The facility payment
*** These codes, when applied to SenoClaire™, assume directly-acquired planar FFDM images
**** Payment if images acquired with X-Ray film: 20% reduction of TC & APC

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### Table 5: 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.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>CPT Code</th>
<th>Digital with Tomosynthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral Diagnostic Mammogram</td>
<td>G0206</td>
<td>77065</td>
</tr>
<tr>
<td>Bilateral Diagnostic Mammogram</td>
<td>G0204</td>
<td>77066</td>
</tr>
<tr>
<td>Screening Mammogram</td>
<td>G0202</td>
<td>77067</td>
</tr>
</tbody>
</table>
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).

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 on 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**


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.
Reimbursement Information for Molecular Breast Imaging (MBI)\textsuperscript{18}


The following provides 2017 national Medicare physician fee schedule (MPFS) and facility payment rates for the CPT codes identified in this guide.

\textbf{Payment will vary by geographic regions.}

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 mammograms\textsuperscript{19}.

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 settings\textsuperscript{3}. While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.
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.

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).

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Table 6: 2017 Medicare Reimbursement for MBI (Reflects national rates, unadjusted for locality)

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment</th>
<th>APC</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>78800 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area</td>
<td>Professional (-26)</td>
<td>$34.45</td>
<td>5591</td>
<td>$333.08</td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>$167.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$202.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78801 Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas</td>
<td>Professional (-26)</td>
<td>$40.90</td>
<td>5591</td>
<td>$333.08</td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>$234.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$275.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8080 Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical (Non-Medicare payers)</td>
<td>Professional (-26)</td>
<td>Not payable by Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>Not payable by Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>Not payable by Medicare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lymphoscintigraphy

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment</th>
<th>APC</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>78195 Lymphatics and lymph nodes imaging</td>
<td>Professional (-26)</td>
<td>$60.29</td>
<td>5592</td>
<td>$429.13</td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>$313.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$373.96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38792 Injection procedure; radioactive tracer for identification of sentinel node</td>
<td>Facility</td>
<td>$41.27</td>
<td>5591</td>
<td>$333.08</td>
</tr>
<tr>
<td></td>
<td>Non-Facility</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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 guidelines.
^ 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 (e.g., 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 7: 2017 Medicare Reimbursement for Radiopharmaceuticals used with MBI (Reflects national rates, unadjusted for locality)

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment</th>
<th>APC</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9500 Technetium tc-99m sestamibi, diagnostic, per study dose</td>
<td>Carrier priced</td>
<td>NA</td>
<td>Packaged in APC</td>
<td></td>
</tr>
</tbody>
</table>
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.
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.

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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.

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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 do 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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13 Certain Medicare carriers require that the physician who performs and/or interprets some types of ultrasound examinations to prove that they have undergone training through recent residency training or post-graduate CME and experience.

14 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.


17 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.


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Imagination at work

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