Medicare
Carriers Manual
Part 3 – Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1837

IF THE FINAL RULE IMPLEMENTING THESE PROVISIONS IS THE SAME AS THE PROPOSED RULE PUBLISHED ON AUGUST 2, 2001, THEN THESE INSTRUCTIONS REMAIN IN PLACE. IF THE FINAL RULE DIFFERS FROM THE NOTICE OF FINAL RULE MAKING, FURTHER INSTRUCTIONS WILL BE ISSUED UPON PUBLICATION OF THE FINAL RULE.

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	4-4.3 – 4-4.4 (2pp.)	4-4.3 – 4-4.4 (2 pp.)
4601.1- 4602.5	4-425 – 4-431 (11 pp.)	4-425 – 4-432 (10 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2002*
IMPLEMENTATION DATE: January 1, 2002

Section 4601, Screening Mammography and Diagnostic Mammography is updated based on §104 of the Benefits Improvement and Protection Act (BIPA) of 2000 which amends §1848(j)(3) of the Act to include screening mammography as a physician service for which payment is made under the Medicare Physician Fee Schedule (MPFS). The payment limitation for screening mammography no longer applies for claims with dates of service on or after January 1, 2002. Diagnostic mammography and screening mammography can both be paid when performed on the same day when provided to the same beneficiary.

Section 4601.2, Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim. In addition, a new code 76085 "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)" for computer-aided detection (CAD) conversion of standard film images to digital images has been created as an add-on code to be billed in conjunction with a regular screening mammography (code 76092); and new code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)", has been created as an add on code to be billed in conjunction with a regular diagnostic mammography (codes 76090 or 76091).

Subsection A, Specific Codes used with mammography claims on or after January 1, 2002, lists codes that will be used beginning January 1, 2002.

Subsection B, New Computer-aided Detection (CAD) Codes Used as Add-On Codes, has been added to define the new CAD codes.

Subsection C, Deleted Mammography Codes, has been added to define those codes deleted as of January 1, 2002.

Subsection D, Certified Screening Centers/Suppliers, has been modified to add a sentence that contractors are no longer required to keep track of physicians who are associated with the certified mammography facilities unless there is a specific reason for doing so.

Subsection E, Claims with dates of service prior to January 1, 2002, is being revised to include the 2001 Screening Mammography Payment Limitations as stated in Program Memorandum AB-00-91.

Subsection F, Medicare Physician Fee Schedule will be used for payment for all mammography tests beginning with claims with dates of service on or after January 1, 2002.

Subsection G, New Computer-aided detection (CAD) codes as add-on codes for screening and diagnostic mammography.

Subsection I, Special Billing Instructions When Radiologist Interpretation Results in Additional Films, is changed to effectuate new policy. When radiologist interpretation of screening mammogram results in performance of diagnostic mammogram on same day for the same beneficiary, beginning January 1, 2002, both tests will be paid by Medicare. A new modifier (GG) will be used with the diagnostic code to show that the screening test turned to additional diagnostic tests. This modifier is for tracking purposes.

Section 4601.3, Adjudicating the Claim, has been expanded.

Subsection A, Provider Education, has been added.

Subsection C, Contractor and CWF Edits (for claims with dates of Service on or after January 1, 2002), has been added.

Section 4601.6, Diagnostic and Screening Mammograms Performed with New Technologies, added to reflect payment and billing requirements for new digital mammography equipment for both screening and diagnostic mammograms based on §104 of BIPA.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER IV

Section

Submission of Claims to Medigap Insurers

Global Surgery

4600. RADIOLOGY FEE SCHEDULE

Effective April 1, l989 for radiology services rendered or supervised by an American Board of Radiology (ABR) certified physician, an ABR eligible physician, or a physician for whom at least fifty percent of his/her Medicare billings are for radiology services, pay on a fee schedule basis. (See §5261.)

Include in all EOMBs for radiology services paid under the fee schedule the following message in addition to any other necessary information: "This service was paid under a fee schedule."

4600.1 Mixed Multispecialty Clinic (Specialty Code 70).--When you determine that a mixed multispecialty clinic is subject to the radiology fee schedule provision (see §5261A), pay all radiology claims under the fee schedule unless information to the contrary is made available to you. The mixed multispecialty clinic must contact you and identify the individual physicians in the clinic that do not meet the fee schedule definition of radiologist. Your system must be capable of determining whether to pay the fee schedule amount or the reasonable charge based on the identity of the physician rendering the service.

4600.2 Radiation Therapy.--The only treatment management services to reimburse under the fee schedule are weekly treatment management services. Daily treatment management and port film interpretation services are not paid under the radiology fee schedule separately. They are considered included in the payment for the weekly treatment management services. (See §5261K.)

Physicians should indicate the number of fractions in block 24F of Form HCFA-1500. If additional fractions of less than three are submitted after payment for the treatment course, make no additional payment. Deny payment and send the following EOMB message: "Payment for less than three additional fractions is considered to be included in the payment already made." If additional fractions of three or more are submitted, follow §5261K.

Establish prepayment screens to deny the services listed in §5261K when payment is made for weekly treatment management services.

4600.3 Issue Conversion Factors to Intermediaries.--Send the radiology fee schedule conversion factors to all intermediaries that serve hospitals in your service area at the same time you issue the fee schedule amounts to the medical community.

4601. SCREENING MAMMOGRAPHY and DIAGNOSTIC MAMMOGRAPHY

4601.1 Screening Mammography Examinations.--Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiologic procedures for early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. Whether or not payment can be made is determined by a woman's age and statutory frequency parameter.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39 and waives the Part B deductible. Coverage applies as follows:

A. Age Status.--

Age	Screening Period
35-39	Baseline (only one screening allowed for women in this age group)

Over age 39	Annual (11 full months must have elapsed following the month of last screening)

NOTE: Count months between mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 1998, begin counting the next month (February 1998) until 11 months have elapsed. Payment can be made for another screening mammography in January 1999.

4601.2 Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim.—

A. Specific Codes used with mammography claims on or after January 1, 2002 are listed below. CPT codes and G codes will be paid under the Medicare Physician Fee Schedule.

CPT Code 76092	- Screening mammography, bilateral (two view film study of each breast), TOS1.
CPT Code 76090	- Diagnostic mammography, unilateral, TOS1.
CPT Code 76091	- Diagnostic mammography, bilateral, TOS1.
HCPCS Code G0202	- Screening mammography, direct digital image, bilateral, all views, TOS1.
HCPCS Code G0204	- Diagnostic mammography, direct digital image, bilateral, all views, TOS1.
HCPCS Code G0206	- Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views, TOS1.
CPT Code 76085	- Computer-aided detection add-on code for screening mammography (use with CPT code 76092)
HCPCS Code G0236	- Computer-aided detection add-on code for diagnostic mammography (use with CPT Codes 76090 or 76091)
New Modifier GG	- Performance and payment of a screening mammography and diagnostic mammography on same patient same day. Attach to Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test; contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only.
ICD-9 Code V76.12	- Diagnosis code for screening mammography

ICD-9 codes for diagnostic mammography will vary according to diagnosis.

NOTE: Plug in code V76.12 if a claim comes in for screening mammography with no ICD-9 code and the carrier file data shows this is appropriate. If there are other diagnosis codes on the claim, but not code V76.12, add it. (Do not change or overlay code V76.12 but ADD it). At a minimum, edit for age, frequency, and place of service (POS).

B. New Computer-aided Detection (CAD) codes used as Add-On Codes:

A new CPT code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography (List separately in addition to code for primary procedure)", for computer-aided detection conversion of standard film images to digital images has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. Payment will be made under the MPFS.

A separate code, G0236, has been created for "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure)" for computer aided detection. This code is also an add-on code and must be used with diagnostic mammography codes (76090 and 76091).

C. Deleted mammography codes as of January 1, 2002:

HCPCS Code G0203-Screening mammography film processed to produce digital image, bilateral all views;

HCPCS Code G0205-Diagnostic mammography, film processed to produce digital image, bilateral, all views;

HCPCS Code G0207-Diagnostic mammography, film processed to produce digital image, unilateral

D. Certified Screening Centers/Suppliers.--The law provides specific standards regarding those qualified to perform this service and how they should be certified. As of October 1, 1994, the Mammography Quality Standards Act (MQSA) requires that all mammography centers who bill Medicare get certification from the Food and Drug Administration (FDA). Certification information from FDA is then forwarded to CMS. CMS then provides certification information to carriers. Medicare will only reimburse FDA-certified mammography centers. Inform physicians and suppliers at least annually through your provider/supplier publications of those facilities centers which are certified. Encourage physicians to inform their patients about centers that are certified.

Inform mammography facilities which perform screening mammographies that they are not to release screening mammography X-rays for interpretation to physicians who are not approved under the facility's certification number unless the patient has requested a transfer of the films from one facility to another for a second opinion, or because the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed only by physicians who are associated with the certified mammography facility. Carriers are not required to maintain a list of these associations unless there is a specific reason for doing so and only on a case by case basis.

When adjudicating a screening mammography claim, refer to the table of certified facilities provided by FDA and confirm that the facility listed on the claim is in fact certified to perform the service. Deny the claim if the service was performed by a non-certified facility.

E. Claims with dates of service prior to January 1, 2002, are subject specific calculations (payment limitation). There are three categories of bills. They may be for the professional component of mammography services (the physician's interpretation of the results), the technical component (all other services), or a global charge may be made by centers for the professional and technical components together. There are payment limits for each component. The professional component is 32 percent of the total limit for the complete service. The technical component is 68 percent.

The amount of payment for the professional component equals 80 percent of the least of:

- The actual charge for the professional component;
- The amount determined with respect to the professional component for the service under the Medicare Physician Fee Schedule; or
- The professional portion of the screening mammography limit. The amount for 2001 is $22.15 ($21.69 in 2000, $21.19 in 1999 and $20.71 in 1998), determined by multiplying the screening mammography limit by 32 percent.

The payment for the technical component equals 80 percent of the least of:

- The actual charge for the technical component; or
- The amount determined with respect to the technical component for the service under the Medicare Physician Fee Schedule; or
- The technical portion of the screening mammography limit. The amount for 2001 is $47.08 ($46.12 in 2000, $45.03 in 1999 and $44.02 in 1998), determined by multiplying the screening mammography limit by 68 percent.

The amount of payment for the global charge equals 80 percent of the least of:

- The actual charge for the procedure;
- The amount determined with respect to the global procedure under the Medicare Fee Schedule; or
- The limit for the procedure. The amount for 2001 is $ 69.23 ($67.81 in 2000, $66.22 in 1999 and $64.73 in 1998).

On January 1 of each year after 1991 through 2001, CMS will update the overall limit by the percentage increase in the Medicare Economic Index.

If mammography services are furnished by nonparticipating physicians and suppliers, there is a special limiting charge. (See MCM §5256)

NOTE: The above calculations do not apply to claims with dates of service on or after January 1, 2002.

F. For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of all mammography tests (including screening mammography) under the Medicare Physician Fee Schedule (MPFS). The technical component, the professional component and the Global service will all be included on the Medicare Physician Fee Schedule. The Medicare allowed charge is the lower of the actual charge or the MPFS amount. The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. Part B deductible is waived and does not apply to screening mammography.

As with other MPFS services, the non-participation provider reduction and the limiting charge provisions apply to all mammography tests (including screening mammography).

G. In addition, a new HCPCS code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography", for computer-aided detection conversion of standard film images to digital images", has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. Payment will be made under the MPFS.

Also, a new code G0236 - "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography" for computer aided detection (CAD), which has been created as an add-on code to be billed in conjunction with a regular diagnostic mammogram (codes 76090 or 76091).

H. Special Billing Instructions When Radiologist Interpretation Results in Additional Films (For claims with dates of service October 1, 1998 **through December 31, 2001)** --Medicare allows a radiologist to order additional mammography views when a screening mammography shows a potential problem. When a radiologist interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or payment purposes. This can be done without an additional order from the treating physician. In this case, only the diagnostic x-ray(s) will be billed. The original screening test will not be billed. However, since the original intent for the exam was for a screening, for statistical purposes, the claim would be considered a screening.

When billing a diagnostic mammogram that had been converted from a screening mammogram, use Modifier GH with the code for the appropriate diagnostic mammogram. This modifier must be reported to enable us to collect statistical data.

NOTE: However, the ordering of a diagnostic test by a radiologist following a screening test that shows a potential problem need not be on the same date of service.

When submitting a claim for a screening mammogram, use CPT code 76092 (screening mammography, bilateral) and Type of Service =1. BUT, if the screening mammogram turns into a diagnostic mammogram, use CPT code 76090 (unilateral) or 76091 (bilateral), TOS=4, and use the GH modifier. You will pay the claim as a diagnostic mammography instead of a screening mammography.

In this case, where additional diagnostic tests are performed for the same beneficiary, same visit on the same day, the UPIN of the treating physician is needed on the claim. The radiologist must refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient. You need to educate radiologists and treating physicians that the treating physician's UPIN is required whenever a physician refers or orders a diagnostic lab or radiology service. If no UPIN is present for the diagnostic mammography code, the claim will reject.

I. For dates of service on or after January 1, 2002 – New billing instructions apply. Medicare allows additional films to be done without an additional order from the treating physician. Instruct providers that when submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach Modifier GG to the diagnostic mammography. We are requiring Modifier GG be appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Both the screening mammography and the diagnostic mammography will be reimbursed by Medicare.

J. Transportation Costs for Diagnostic Mammography in Mobile Units.--Transportation costs are associated with mobile units for diagnostic mammography tests only. CMS formally added diagnostic mammography to the regulation language of the portable x-ray benefit in '42 CFR 410.32 (c)(3). Carriers should seldom see transportation costs associated with diagnostic mammography

in portable units. These units are usually reserved for screening tests only. For the screening tests performed in a mobile unit, there is no separate transportation cost allowed. Carriers should investigate high volume transportation costs associated with the mobile mammography diagnostic tests.

To receive transportation payments, the approved portable x-ray supplier must also meet the certification requirements of §354 of the Public Health Service Act.

4601.3 Adjudicating the Claim.--Process the claim to the point of payment based on the information provided on the claim and in your history:

o Identify the claim as a screening mammography claim by the CPT-4 code listed in field 24D and the diagnosis code(s) listed in field 21 of Form HCFA-1500.

o Confirm that the facility listed on the claim is certified to perform the service for Medicare beneficiaries. Facilities who are certified to perform only screening mammography will be assigned physician specialty code 45. When they bill globally for screening mammography, they should use a blank in modifier position #1. When they bill for the technical component only, they should use HCPCS modifier "TC." Physicians who bill the professional component separately must use HCPCS modifier 26. If more than one modifier is necessary, e.g., if the service was performed in a rural Health Manpower Shortage Area (HMSA) facility, they should put the mammography modifier in modifier position 1 and the rural (or other) modifier in modifier position 2. All those who are qualified must include the 6 digit FDA assigned certification number of the screening center in field 32 of Form HCFA -1500 and in field 31 on the electronic NSF. Keep this number in your provider files.

o If you cannot determine that the facilities are certified by FDA, handle the claim according to the rules in §3311. A provider/facility must have FDA certification to be reimbursed by Medicare. FDA certification number must be on the claim and match the FDA file forwarded to you.

o For screening mammography, part B deductible is waived and co-pay applies.

o Plug in code V76.12 if a claim comes in for screening mammography with no ICD-9 code and the carrier file data shows this is appropriate. If there are other diagnosis codes on the claim, but not code V76.12, add it. (Do not change or overlay code V76.12 but ADD it). At a minimum, edit for age, frequency, and place of service (POS).

A. Provider Education

o Educate providers that when a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the “GG” modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.

o Educate providers that they cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.

B. Preparing the Part B Claim Record for CWF.--Fill field 63, type of service, of the CWF Part B claim record with a "B" if the patient is a high risk screening mammography patient or a "C" if she is a low risk screening mammography patient for services prior to January 1, 1998. For services on or after January 1, 1998, fill field 63 with a "1", medical care. Fill field 80, place of service, with a 11, 21, 22, 23, 25, 26, 33, 50, 51, 61, 62, 71, or 99. Fill field 67, deductible indicator, with a "1", not subject to deductible. Submit the claim to your CWF host. Trailer 17 of the Part B Basic Reply record will give the date of the last screening mammography.

If the claim is accepted or rejected, take appropriate payment actions and send the appropriate payment notices.

C. Contractor and CWF Edits (for Claims with Dates of Service on or after January 1, 2002)--Add-on Computer Aided Detection (CAD) Code G0236 (Diagnostic) must be billed in conjunction with CPT code 76090 or 76091. There are no frequency limitations on diagnostic tests or CAD-diagnostic tests. Add-on CAD Code 76085 (Screening) must be billed with 76092.

CWF will continue to edit for age and frequency for screening mammography. When a screening CAD is billed in conjunction with a screening mammogram and the screening mammogram fails the age or frequency edits then both services will be rejected. CWF will develop an edit to deny both a CAD/screening add-on code and a mammography screening code if frequency edits are not met.

Contractos must install edits to assure that if a CAD diagnostic add-on code (G0236) or CAD screening add-on code (76085) is billed, a screening mammography or a diagnostic mammography is also billed. CAD codes must be add-on codes.

CCI Edits - Use of Modifier GG will allow both a screening test and a diagnostic test to pay and by-pass the CCI edits. Contractors and CWF must make this change.

4601.4 MSN and EOMB Messages.--Use these MSN or EOMB messages in specific situations. (These messages are at the appropriate reading level.)

If the claim is denied because the beneficiary is under 35 years of age, state on the EOMB:

MSN	EOMB	
18.3	18.18	"Screening mammography is not covered for women under 35 years of age."

If the claim is denied for a woman 35-39 because she has previously received this examination, state on the EOMB:

18.6	18.19	“A screening mammography is covered only once for women age 35-39.”

If the claim is denied because the period of time between screenings for the woman based on age has not passed, state on the EOMB:

18.4	18.20	"This service is being denied because it has not been 12 months since your last examination of this kind."

If the claim is denied because the provider that performed the screening is not certified, state on the EOMB:

16.2	16.4	“Medicare does not pay for this in the place or facility where you received it.”

In addition to the above denial messages, you have the option of using the following message:

18.12	18.21	“Screening mammograms are covered annually for women 40 years of age and older.”

4601.5 Remittance Advice Messages.--If the claim is denied because the beneficiary is under 35 years of age, use existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message 6, "The procedure is inconsistent with the patient's age" along with the line level remark code M37, "Service is not covered when the beneficiary is under age 35."

If the claim is denied for a woman 35-39 because she has previously received this examination, use existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with the line level remark code M89, "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, using existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with the line level remark code M90, "Not covered more than once in a 12 month period."

If the claim is denied because the provider that performed the screening is not certified, use existing ANSI X-12-835 claim adjustment reason code/message B7, "This provider was not certified for this procedure/service on this date of service."

4601.6 Diagnostic and Screening Mammograms Performed with New Technologies.--Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled Modernization of Screening Mammography Benefit, provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, to December 31, 2001. Under this provision, payment for technologies that directly take digital images would equal 150 percent of the amount that would otherwise be paid for a bilateral diagnostic mammography. For technologies that convert standard film images to digital form, payment will be derived from the statutory screening mammography limit plus an additional payment of $15.00.

Payment restrictions for digital screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality Standards Act as described in §3660.16.

A. Payment Requirements for Claims with dates of service on or After April 1, 2001 through December 31, 2001.--Providers billing for the technical component of screening and diagnostic mammographies that utilize advanced technologies use one of six new HCPCS codes, G0202 - G0207. See below for how payment for each of the codes will be determined during the period April 1, 2001 through December 31, 2001. Payment for codes G0202 through G0205 are based, in part, on the Medicare Physician Fee Schedule payment amounts (MPFS). The amounts that are based on the MPFS that you will need in calculating the new payments for these codes were furnished to you in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

o. HCPCS code G0202, Screening mammography producing direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific technical component payment amount under the physician fee schedule for CPT code 76091, the code for bilateral diagnostic mammogram, during 2001.) Part B deductible does not apply. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o. HCPCS code G0203, Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure. The amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Part B deductible does not apply. Coinsurance is 20 percent of the charge.

o HCPCS code G0204, Diagnostic mammography, direct digital image, bilateral, all views. Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Twenty percent of the lower of charge or 150 percent of MPFS. Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

o HCPCS code G0205, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

o HCPCS code G0206, Diagnostic mammography, direct digital image, unilateral, all views. Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

o HCPCS code G0207, Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all view. Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPPS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

NOTE: Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

Payment Requirements for Services Furnished on or After January 1, 2002.—Payment will be made as follows:

Code G0202 Payment will be made under the MPFS for the technical component when performed in a hospital outpatient department, CAH or SNF. Coinsurance is the lower of the actual charge or the MPFS amount. Deductible does not apply.

Code G0204 Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made under the MPFS for the technical component when performed in a CAH or SNF. Coinsurance is the lower of the actual charge or the MPFS amount. Deductible applies.

Code G0206 Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made under the MPFS for the technical component when performed in a CAH or SNF. Coinsurance is the lower of the actual charge or the MPFS amount Deductible applies.

4602. MAGNETIC RESONANCE ANGIOGRAPHY

4602.1 Magnetic Resonance Angiography Coverage Summary--Section 1861(s)(2)(C) of the Social Security Act provides for coverage of diagnostic testing. Effective for services performed on or after July 1, 1999, Medicare provides limited coverage for magnetic resonance angiography (MRA) of the abdomen and chest. Previously, MRA of peripheral vessels of the lower extremities and MRA of the head and neck had been covered on a limited basis. These coverages are described in the Medicare Coverages Issues Manual, §50-14, "Magnetic Resonance Angiography". MRA is covered for those diagnostic applications only as a substitute for contrast angiography, except where it is medically necessary to do both tests. Medicare coverage of MRA is only extended when the service is reasonable and necessary. There is no coverage of MRA outside of the indications provided in that instruction.

Because the status codes for HCPCS codes 71555, 71555-TC, 71555-26, 74185, 74185-TC, and 74185-26 were changed in the MPFSDB from N to R on April 1, 1998, any MRA claims with those HCPCS codes with dates of service between April 1, 1998 and June 30, 1999 are to be processed according to the contractor's discretionary authority to determine payment in the absence of national policy.

4602.2 Coding Requirements--Providers must report HCPCS codes when submitting claims for MRA of the chest, abdomen, head, neck or peripheral vessels of lower extremities. The following HCPCS codes should be used to report these services:

MRA of head and/or neck	70541, 70541-26, 70541-TC
MRA of chest	71555, 71555-26, 71555-TC
MRA of abdomen	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73725-26, 73725-TC

4602.3 Payment Requirements and Methodology.--

- Medicare Part B deductible and coinsurance apply.
- Pay for MRAs undercurrent payment methodologies for radiology services.
- Claims where assignment was not taken are subject to the Medicare Limiting Charge (refer to MCM, Part 3, Chapter VII, §7555 for more information).

o Providers must report component services with -26(professional component) or -TC (technical component) modifier when appropriate. Physicians performing both the professional and technical components for such services must bill without the modifier unless the service is provided in a Health Professional Shortage Area.

4602.4 Format for Submitting Medicare Carrier Claims.--Claims for MRA are to be submitted on Health Insurance Claim Form HCFA-1500 or electronic equivalent. Follow the general instructions in §2010, Purpose of Health Insurance Claim Form HCFA-1500, Medicare Carriers Manual Part 4, Chapter 2.

4602.5 Claims Editing.--Nationwide claims processing edits for pre or post payment review of claim(s) for concurrent MRA and contrast angiography on the same beneficiary are not being required at this time. Carriers should monitor submission of claim(s) for concurrent MRA and contrast angiography and perform medical review as appropriate. Carriers may develop local medical review policy and edits for such claim(s).