CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
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CHANGE REQUEST 2632

I. SUMMARY OF CHANGES: This instruction manualizes Change Request 2632, new CAD codes for film and digital mammography services.

NEW/REVISED MATERIAL - EFFECTIVE DATE: N/A
***IMPLEMENTATION DATE: N/A**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/Table of Contents
R	18//20.2/HCPCS and Diagnosis Codes for Mammography Services
R	18/20.2.1/Computer-Aided Detection (CAD) Add-on Codes
N	18/20.2.1.1/CAD Billing Charts
R	18/20.3.2.1/Outpatient Hospital Mammography Payment Table
R	18/20.3.2.2/Payment for Computer Add-on Diagnostic and Screening Mammograms for FIs and Carriers
R	18/20.3.2.3/Critical Access Hospital Payment
R	18/20.3.2.3.1/CAH Mammography Payment Table
R	18/20.3.2.4/SNF Mammography Payment Table
R	18/20.4.1.2/RHC/FQHC Claims with Dates of Service on or After January 1, 2002
R	18/20.4.2.1/FI Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)
R	18/20.5/Carrier Processing Requirements
R	18/20.5.1/Part B Carrier Claim Record for CWF
N	18/20.5.1.1/Carrier and CWF Edits
R	18/20.7 Mammograms Performed with New Technologies

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These instructions should be implemented within your current operating budget.

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***Medicare contractors only**

Medicare Claims Processing Manual

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B3-4601.2, B3-4601.2.C, B3-5266, A3-3660.16, SNF-537.A-F, HO-451.B-F, RHC-623.B-E, B3-5266B.1.c, 5266B.2.c, or 5266B.3.c, B3-5258

The following HCPCS *and TOS* codes are used to bill for mammography services.

HCPCS Code	TOS	Definition
76082	*4*	*Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography (List separately in addition to code for primary procedure)* ***Effective January 1, 2004.***
76083	*1*	*Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (List separately in addition to code for primary procedure)* ***Effective January 1, 2004.***
76085	1	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.) Use with CPT code 76092 **Code 76085 was effective 1-1-2002 for all claims submitted to a carrier or an FI, except hospital outpatient prospective payment (OPPS) claims, which are billed to the FI. For OPPS claims billed to the FI, this code is effective 4-1-2002.** ***Deleted as of December 31, 2003.***
76090	1	Diagnostic mammography, unilateral.
76091	1	Diagnostic mammography, bilateral.
76092	1, B, C	Screening mammography, bilateral (two view film study of each breast).
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. **Code Effective 4-1-2001.**
G0203		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views;

HCPCS Code	TOS	Definition
		images analyzed for potential abnormalities, bilateral all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; **Code Effective 4-1-2001.**
G0205		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; **Code Effective 4-1-2001.**
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
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). Use with CPT Codes 76090 or 76091. **Code G0236 was effective 1-1-2002 for all claims submitted to a carrier or an FI except hospital OPPS claims, which are billed to the FI. For OPPS claims billed to the FI, the code is effective 4-1-2002.** ***Deleted as of December 31, 2003.***

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the 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. *This applies to claims with dates of service on or after January 1, 2002*.

A - Diagnosis for Services On or After January 1, 1998

The following diagnosis code must be submitted on every screening claim with dates of service on or after January 1, 1998.

V76.12 - “Special screening for malignant neoplasm, other screening mammography.”

Carriers add diagnosis code V76.12 if a claim is received for screening mammography with no ICD-9 code or if there are other diagnosis codes on the claim without V76.12 and the carrier file data shows this is appropriate. Carriers do not change or overlay code V76.12 but **ADD** it.

NOTE: *Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9 code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.*

FI claims receive this diagnosis in FL 67, “Principal Diagnosis Code.” Carriers receive this diagnosis in field 21 of Form CMS-1500.

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

The BBA of 1997 eliminates the requirement to report the high-risk diagnosis codes effective January 1, 1998.

B - Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - “Screening mammogram for high risk patient.”

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as “Other Diagnoses codes” (Form CMS-1450, FL 68)

- V10.3 “Personal history - Malignant neoplasm female breast”;
- V16.3 “Family history - Malignant neoplasm breast”; or
- V15.89 “Other specified personal history representing hazards to health.”

The following chart indicates the ICD-9 diagnosis codes reported for each high-risk category:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

20.2.1 - Computer-Aided Detection (CAD) Add-On Codes

(Rev. 60, 01-09-04)

B3-4601.2.B, B3-4601.2.G, A3-3660.10.B, A3-3660.20

Screening Add-on Codes 76085 and 76083

Effective for services on or after January 1, 2002 *through December 31, 2003*, (or April 1, 2002 for hospitals subject to OPPS) a new CPT code 76085, for computer-aided detection (CAD) 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. The definition of 76085 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, mammography (List separately in addition to code for primary procedure)."

NOTE: *For claims with dates of service April 1,2003 – December 31, 2003, code G0202 may be billed in conjunction with 76085.*

Carriers and FIs make payment under the Medicare physician fee schedule. There is no Part B deductible. However, coinsurance is applicable.

Contractors must assure that claims containing code 76085 also contain HCPCS code 76092 *or G0202*. If not, FIs return claims to the provider with an explanation that payment for code 76085 cannot be made when billed alone. Carriers deny payment for 76085 when billed without 76092 or G0202.

NOTE: *When screening CAD 76085 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.*

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without

digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76092 or G0202.

Contractors must assure that claims containing code 76083 also contain HCPCS code 76092 or G0202. FIs return claims containing code 76083 that do not also contain HCPCS code 76092 or G0202 with an explanation that payment for code 76083 cannot be made when billed alone. Carriers deny payment for 76083 when billed without 76092 or G0202.

NOTE: *When screening CAD 76083 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.*

Diagnostic Add-on Codes G0236 *and 76082*

Effective for services on or after January 1, 2002 *thru December 31, 2003, (or April 1, 2002 for hospital claims subject to OPPS)*, HCPCS code G0236 was established for diagnostic mammography computer-aided detection (CAD) that can be billed only on the same claim with the primary service of either 76090 or 76091. The definition of G0236 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation." The code must be listed separately in addition to code for the primary procedure.

NOTE: *For claims with dates of service April 1,2003 - December 31, 2003, code G0204 and G0206 may be billed in conjunction with G0236.*

There are no frequency limitations on diagnostic tests or CAD-diagnostic tests.

Contractors must assure that claims containing code G0236 also contain *HCPCS code 76090, 76091, G0204, or G0206*. If not, FIs return claims to the provider with an explanation that payment for code G0236 cannot be made when billed alone. Carriers deny payment for G0236 when billed without *76090, 76091, G0204 or G0206.*

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76090, 76091, G0204, or G0206.

Contractors must assure that claims containing code 76082 also contain HCPCS codes 76090, 76091, G0204 or G0206. FIs return claims containing code 76082 that do not also contain HCPCS code 76090, 76091, G0204, or G0206 with an explanation that payment for code 76082 cannot be made when billed alone. Carriers deny payment for 76082 when billed without 76090, 76091, G0204, or G0206.

20.2.1.1 - CAD Billing Charts

(Rev. 60, 01-09-04)

A3-3660.21

The following chart provides guidance for billing of CAD add-on codes. It reflects appropriate coding combinations that may be billed and the time frames associated with each.

Chart I – Screening CAD Code

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 and later
76085	76092	76092, G0202	N/A
76083	N/A	N/A	76092, G0202

Chart II – Diagnostic CAD Codes

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 and later
G0236	76090	76090	N/A
	76091	76091	
		G0204	
		G0206	
CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 and later
76082	N/A	N/A	76090
			76091
			G0204
			G0206

CWF Application of Age and Frequency Edits,--The following chart reflects proper application of CWF age and frequency edits applied to CADs billed in conjunction with screening mammographies.

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 and later
76085	76092	76092, G0202	N/A
76083	N/A	N/A	76092, G0202

See 20.5.1 for Carrier CWF edits

20.3.2.1 - Outpatient Hospital Mammography Payment Table

(Rev. 60, 01-09-04)

Payment for Mammography in the Hospital Outpatient PPS Setting. For all other hospitals, the effective date for column 1 is April 1, 2001, through December 31, 2001, and for column 2, the effective date is January 2002.

Screening Mammography (Revenue Code 403)	**Year 2000**	**2001 (April 1, 01 thru March 31, 2002)**	**April 1, 2002**
76092 Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges, 2. TC of PFS for 76091, or 3. Annual payment limit	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. Annual payment limit $47.08	Lesser of: 1. Charge, or 2. TC of MPFS for code 76092
G0202 Screening Mammography, producing direct digital image, bilateral, all views. No deductible Coinsurance applies	N/A	Lesser of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lesser of: 1. Actual charge, or 2. TC of MPFS for code G0202
G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. No Deductible Coinsurance Applies	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	N/A

PAYMENT FOR DIAGNOSTIC MAMMOGRAPHY

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1 - March 31, 2002)**	**April 1, 2002**
76091 Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS
76090 Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS
G0204 Diagnostic Mammography, direct digital image, bilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, or 2. 150% TC of MPFS for code 76091	OPPS
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	OPPS

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1 - March 31, 2002)**	**April 1, 2002**
G0205 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	N/A
G0207 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	N/A

COMPUTER-AIDED DETECTION (CAD)

Computer-aided Detection (CAD)	**Year 2000**	**2001 (April 1 - Dec 31)**	**Year 2002**
76085* CAD with screening mammography (may bill with 76092) No Deductible Coinsurance Applies	N/A	N/A	Lesser of: 1. Charge, or 2. TC of MPFS for code 76085
G0236* CAD with diagnostic mammography (may bill w. 76090 or 76091). Deductible and coinsurance apply	N/A	N/A	OPPS

TC = technical component

MPFS= Medicare Physician Fee Schedule

OPPS= Outpatient Prospective Payment System

APC= Ambulatory Payment Classification

Note that code 76085 is a deleted code as of December 31, 2003. The new code to be used for dates of service beginning January 1, 2004 and later is 76083. Code G0236 is a deleted code as of December 31, 2003. The new code to be used for dates of service beginning January 1, 2004 and later is 76082.

20.3.2.2 - Payment for Computer Add-On Diagnostic *and Screening* Mammograms *for FIs and Carriers*

(Rev. 60, 01-09-04)

A3-3660.19, B3-4601.2.A

Payment for computer add-on diagnostic mammogram HCPCS code G0236 or 76082 when billed with CPT code 76090, 76091, G0204, or G0206 is as follows:

Place/Provider of Service	Payment
Physician	Medicare physicians' fee schedule
Outpatient Hospital	Outpatient Prospective Payment System (OPPS)
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians' fee schedule
Independent RHC	All-inclusive rate for professional component (*codes 76090 and 76091)*
Freestanding FQHC	All-inclusive rate for professional component *(codes76090 and 76091)*

Code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography," for CAD has been established as an add on code that can be billed in conjunction with primary service code G0204 or G0206, as well as existing codes 76090 or 76091. The Part B deductible and coinsurance apply. *HCPCS code G0236 is deleted as of December 31, 2003.*

Effective for claims with dates of service January 1, 2004 and later, add-on HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with primary service codes G0204 or G0206 as well as codes 76090 or 76091. The Part B deductible and coinsurance apply.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes G0236 or 76082 with an explanation that payment for code G0236 or 76082 cannot be made when billed alone.

Carriers deny the claim using remark code N122, "Mammography add-on code can not be billed by itself" (effective Sept 12, 2002).

Payment for computer add-on screening mammogram HCPCS code 76085 or 76083 when billed with CPT code 76092 or G0202 is as follows:

Place/Provider of Service	*Payment*
Physician	*Medicare physicians' fee schedule*
Outpatient Hospital	*Medicare physicians' fee schedule*
Critical Access Hospital (CAH)	*Reasonable Cost*
SNF	*Medicare physicians' fee schedule*
Independent RHC	*All-inclusive rate for professional component (code 76092)*
Freestanding FQHC	*All-inclusive rate for professional component (code 76092)*

Code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography," for CAD has been established as an add on code that can be billed in conjunction with primary service code G0202 as well as 76092. *HCPCS code 76085 is deleted as of December 31, 2003. The Part B Deductible does not apply. However, coinsurance is applicable. FIs use the benefit pricing file provided by CMS to pay the above codes where payment is based on the Medicare physician fee schedule.*

Effective for claims with dates of service January 1, 2004 and later, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service code G0202 as well as code 76092. There is no Part B deductible but coinsurance apply.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes 76085 or 76083 with an explanation that payment for code 76085 or 76083 cannot be made when billed alone. Carriers deny the claim using remark code N122 "Mammography add-on code cannot be billed by itself" (effective September 12, 2002).

20.3.2.3 - Critical Access Hospital Payment

(Rev. 60, 01-09-04)

A3-3660.10.B, A3-3610.22.B.2, A3-3660.10.A

For the technical component, professional component should be billed with revenue code 097X and HCPCS code G0202, 79092, or 76085**,** *(use 76083 for claims with dates of service January 1, 2004 and later)*. Payment to a CAH for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. Both deductible and coinsurance apply on a diagnostic mammography.

Any deductible or coinsurance collected is deducted from the payment.

A - Under the Optional (All Inclusive) Method

Section 403(d) of the BBRA amended §1834(g) of the Act to permit a CAH to elect an optional method of payment for outpatient services. This option is effective for cost reporting periods beginning on or after October 1, 2001. A CAH may elect to be paid for outpatient services by reasonable costs for facility services and §202 of BIPA allows an amount equal to 115 percent of the allowed amount for professional component. (Costs related to professional services are excluded from the cost payment.)

CAHs electing the optional method of reimbursement bill the FI with type of bill 85X, revenue code 0403 and HCPCS code 76092. They also include the professional component on a separate line, repeating revenue code 0403 and HCPCS code 76092, and add modifier "-26" to designate the professional component.

Payment to the CAH will be the sum of the following amounts:

- The interim rate times the charge for facility services, plus
- 115% of the MPFS for the professional services, minus
- Any coinsurance collected by the CAH based on charges.

A screening mammogram furnished on or after January 1, 2002, by a CAH, under the optional method, is paid at 115 percent of the lesser of:

- 80 percent of the actual charges of the CAH for the screening mammography, including both the radiologic procedure and the physician's interpretation, or
- 80 percent of the global payment amount under the MPFS for the screening mammography.

CAHs who have elected the optional method of reimbursement may bill the carrier on the Form CMS 1500 for the global amount.

CAHs that have elected the optional method of payment for outpatient services are paid for the professional component (PC) of a diagnostic mammography furnished on or after January 1, 2002 at 115 percent of the lesser of:

- 80 percent of the actual charges of the CAH for the physicians interpretation of the diagnostic mammography, or
- 80 percent of the PC determined under the MPFS for the diagnostic mammography.

B - Under the Standard Method

CAHs reimbursed on the standard method of payment bill the technical component of a screening mammography to the FI on type of bill 85X, revenue code 0403 and HCPCS

code 76092. Payment is eighty percent of the lesser of the fee schedule or the actual charge.

Professional services are billed to the carrier and paid based on the fee schedule by the carrier.

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 screening mammographies under the Medicare physician fee schedule (MPFS) in CAHs not electing the optional method of payment for outpatient services. The payment for code 76092 is equal to the lower of the actual charge or locality specific technical component payment amount under the MPFS. Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. This is a final payment.

Payment to CAHs for diagnostic mammograms is based on reasonable cost.

20.3.2.3.1 - CAH Mammography Payment Table

(Rev. 60, 01-09-04)

Payment for Screening Mammography in the Critical Access Hospital Outpatient Setting

Method 1 (Standard)

	TOB	Rev Code	HCPCS	Payment
Services prior to cost reporting periods ending October 1, 2001 and services prior to July 1, 2001 (BIPA)				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	FI payment is 80% of the reasonable cost.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			76092	Carrier payment is 80% of the lower of the charge or MPFS amount for the technical component.
Services on or after July 1, 2001 to January 1, 2002				
Technical Component	85X	403	76092	FI payment is 80% of the

	TOB	Rev Code	HCPCS	Payment
Deductible does not apply. Coinsurance based on charge.				80% of the reasonable cost.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			76092	Carrier payment is 80% of the lower of the charge or MPFS amount.
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	*76092 *76085 G0202	FI payment is 80% of the lower of the charge or the fee schedule amount.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			*76092 *76085 G0202	Carrier payment is 80% of the lower of the charge or MPFS amount for the technical component. The new A3 states payment for 76092 is lower of charge or locality specific TECHNICAL component amount under MPFS.
*Codes must be billed together on the same claim. *Also note that 76085 is deleted after December 31, 2003. Use code 76083 for claims with dates of service January 1, 2004 and later.*				

Method 2 (Optional Method) - Option available with cost reporting periods starting on or after October 1, 2001 and dates of service on or after July 1, 2001.

	TOB	Rev Code	HCPCS	Payment
Services for cost reporting periods on or after October 1, 2001 and service dates on or after July 1 and prior to January 1, 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	FI payment is 80% of the reasonable cost. (Interim rate times charge)
Professional Component Deductible does not apply. Coinsurance based on charge.	85X	96X, or 97X or 98X	76092 with Modifier "-"26	FI payment is 115% of the lower of the charge or MPFS amount after coinsurance is deducted.
Professional Component service in a rural or urban HPSA area. Deductible does not apply. Coinsurance based on charge	85X	96X, or 97X or 98X	Modifier "-QB" or "-QU"	If HPSA area, FI payment is 115% of 110% of the lower of the charge or MPFS amount after coinsurance is deducted.

	TOB	Rev Code	HCPCS	Payment
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	*76085 *76092 G0202	FI payment is 80% of the lower of the charge or the fee schedule amount.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.	85X	97X	*76085 *76092 G0202	FI pays 115% of 80% (that is 92%) of the lower of the charge or the MPFS amount.
* Codes must be billed together on the same claim. *Also note that 76085 is deleted after December 31, 2003. Use code 76083 for claims with dates of service January 1, 2004 and later.*				

20.3.2.4 - SNF Mammography Payment Table

(Rev. 60, 01-09-04)

Payment for Part B Mammography in the Skilled Nursing Facility Setting

Screening Mammography (Revenue Code 0403)	**Year 2000**	**2001 (April 1 - March 31, 2002)**	**April 1, 2002**
76092 Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges or, 2. TC of MPFS for 76091, or 3. Annual payment limit	Lesser of: 1. Charge or, 2. TC of MPFS for code 76091, or 3.Annual payment limit $47.08	Lower of: 1. Charge, or 2. TC of MPFS for code 76092
G0202 Screening Mammography, producing direct digital image, bilateral, all views. No deductible Coinsurance applies	N/A	Lower of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lower of: 1. Charge, or 2. TC of MPFS for code G0202
G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. No Deductible Coinsurance Applies	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	Replaced by code 76085

Payment for Diagnostic Mammography

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1-March 31, 2002)**	**April 1, 2002**
76091 Mammography, bilateral Deductible and coinsurance apply	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS
76090 Mammography, bilateral Deductible and coinsurance apply	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS
G0204 Diagnostic Mammography, direct digital image, bilateral, all views Deductible and coinsurance apply	N/A	Lower of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lower of charge or MPFS
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	Lower of charge or MPFS	Lower of charge or MPFS
G0205 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	Replaced by G0236

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1-March 31, 2002)**	**April 1, 2002**
G0207 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lower of charge or MPFS	N/A

Computer-Aided Detection (CAD)

Computer-aided Detection (CAD)	**Year 2000**	**2001 (April 1-Dec 31)**	**Year 2002**
76085* CAD with screening mammography (may bill with 76092) No Deductible Coinsurance Applies	N/A	N/A	Lower of: 1. Charge or, 2. TC of MPFS for code 76085
G0236* CAD with diagnostic mammography (may bill w. 76090 or 76091). Deductible and coinsurance apply	N/A	N/A	SNFs cannot be paid for this service

TC = technical component

MPFS= Medicare Physician Fee Schedule

** 76085 and G0236 are deleted codes after December 31, 2003. Use code 76083 instead of 76085 and 76082 instead of G0236 for claims with dates of service January 1, 2004 and later.*

20.4.1.2 - RHC/FQHC Claims With Dates of Service on or After January 1, 2002

(Rev. 60, 01-09-04)

A3-3660.10.D

A - Provider-Based RHC & FQHC - Technical Component

The technical component of a screening or diagnostic mammography for provider-based RHCs/FQHCs is typically furnished by the parent provider. The provider of that service bills the FI under bill type 14X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code for a screening mammography is 0403, and the appropriate HCPCS codes are 76085 and 76092. Payment is based on the payment method for the parent provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are 76090, 76091 and G0236*.

**G0236 is a deleted code after December 31, 2003. Use 76082 for claims with dates of service January 1, 2004 and later.*

B - Independent RHCs and Freestanding FQHCs - Technical Component

The technical component of a screening or diagnostic mammography is outside the scope of the RHC/FQHC benefit. The provider of the technical service bills their carrier on Form CMS-1500. Payment is based on the MPFS.

C - Provider-Based RHC & FQHC, Independent RHCs and Freestanding FQHCs - Professional Component

A3-3660.10.D

For claims with dates of service on or after January 1, 2002, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 0403 and HCPCS code 76085* or 76092. Payment is made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

**76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service January 1, 2004 and later*

RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography along with revenue code 0401 and HCPCS codes 76090 or 76091.

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. FIs should assure payment is not made for revenue code 0403 (screening mammography) or 0401(diagnostic mammography) unless the claim also contains a visit revenue code 0520 or 0521.

20.4.2.1 - FI Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)

(Rev. 60, 01-09-04)

A3 0 3660.10.E, A3-3660.10.F

CWF records are annotated with the date of the first (technical) screening mammography claim received. The record is updated based on the next covered (technical) claim received. Contractors assume the claim is the first received for the beneficiary where records do not contain a date of last screening and process accordingly.

FIs include revenue code, HCPCS code, units, and covered charges in the CWF record fields with the same name. They report the payment amount for revenue code 0403 in the CWF field named "Rate" and the billed charges in the field named "Charges" of the CWF record. In addition, FIs report special override code 1 in the field named "Special Action" of the CWF record to avoid application of the Part B deductible.

When a screening CAD (76085*) is billed in conjunction with a screening mammography (76092) and the screening mammography (76092 or *G0202*) fails the age and frequency edits in CWF, both services will be rejected by CWF.

**76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service January 1, 2004 and later*

FIs include in the financial data portion of the PS&R record, revenue code, HCPCS code, units, charges, and rate (fee schedule amount).

The PS&R system will include screening mammographies on a separate report from cost-based payments. See the PS&R guidelines for specific information.

20.5 - Carrier Processing Requirements

(Rev. 60, 01-09-04)

B3-4601.3, B3-4601.3.A

Carriers complete the following activities in processing mammography claims:

- Process the claim to the point of payment based on the information provided on the claim and in carrier claims history.
- 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 CMS-1500.
- Confirm that the facility listed on the claim is certified to perform the service for Medicare beneficiaries.

- Assigned physician specialty code 45 to facilities who are certified to perform only screening mammography.

- Ensure that entities that bill globally for screening mammography contain a blank in modifier position #1.

- Ensure that entities that bill for the technical component use only HCPCS modifier "-TC."

- Ensure that physicians who bill the professional component separately use HCPCS modifier "-26."

- Send the mammography modifier to CWF in the first modifier position on the claim. If more than one modifier is necessary, e.g., if the service was performed in a rural Health Manpower Shortage Area (HMSA) facility, instruct providers to bill the mammography modifier in modifier position 1 and the rural (or other) modifier in modifier position 2.

- Ensure all those who are qualified include the 6-digit FDA assigned certification number of the screening center in field 32 of Form CMS-1500 and in field 31 on the electronic NSF. Carriers retain this number in their provider files.

- Handle a claim according to current rules if it is determined that a facility is not FDA-certified. 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 contractors.

- Waive Part B deductible and apply coinsurance for a screening mammography.

- Add diagnosis code V76.12 if a claim comes in for screening mammography without a diagnosis and the carrier file data shows this is appropriate. If there are other diagnoses 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).

NOTE: *Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9 code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.*

Carrier Provider Education

- 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.

- 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.

20.5.1 - Part B Carrier Claim Record for CWF

(Rev. 60, 01-09-04)

B3-4601.3.B

Carriers complete the type of service field in 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, the type of service field on CWF must have a value of "1" for medical care (screening) or a "4" for diagnostic radiology (diagnostic). Fill in POS. Fill in deductible indicator field with a "1"; not subject to deductible if screening mammography. Submit the claim to the CWF host. Trailer 17 of the Part B Basic Reply record will give the date of the last screening mammography.

CWF edits for age and frequency for screening mammography. There are no frequency limitations on diagnostic tests or CAD-diagnostic tests. 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.

20.5.1.1 – Carrier and CWF Edits

(Rev. 60, 01-09-04)

CWF will not edit for POS for screening mammography. Disable 76X1 edit.

Add-on CAD Code 76083 must be billed in conjunction with screening mammography code 76092 or G0202 for claims with dates of service on or after January 1, 2004. Use Type of Service "1".

Add-on CAD Code 76082 must be billed in conjunction with diagnostic mammography code 76090, 76091, G0204, or G0206 for claims with dates of service on or after January 1, 2004. Use Type of Service "4".

Frequency edits apply to screening mammography with or without the CAD code.

Screening and diagnostic mammographies (film and digital) are subject to the FDA certification. However, CAD equipment does not require FDA Certification.

Correct Coding Initiative (CCI) Edits

Use modifier GG to allow both screening and diagnostic mammography to by-pass the CCI edits and pay. All Mammography CCI edits for Part B will be by-passed by CWF. CCI edits do not apply to mammography services.

20.7 - Mammograms Performed With New Technologies

(Rev. 60, 01-09-04)

B3-4601.6, 4602, A3-3660.20

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 (to March 31, 2002 for hospitals subject to OPPS). 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 for carrier claims and $10.20 for FI (technical component only) claims.

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. *However, CAD codes billed in conjunction with digital mammographies or film mammographies are not subject to FDA certification requirements. Mammography related CAD equipment* ***does not require FDA certification.***

Mammography utilizes a direct x-ray of the breast. By contrast, the CAD process uses laser beam to scan the mammography film from a film (analog) mammography, converts it into digital data for the computer, and analyzes the video display for areas suspicious for cancer. The CAD process used with digital mammography analyzes the data from the mammography on a video display for suspicious areas. The patient is not required to be present for the CAD process.

Only one screening mammogram, either 76092 or G0202, may be billed in a calendar year. Therefore, providers/suppliers must not submit claims reflecting both a film screening mammography (76092) and a digital screening mammography G0202. Also, they must not submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Contractors deny the claim when both a film and digital screening or diagnostic mammography is reported. However, a screening and diagnostic mammography can be billed together.

A - Payment Requirements for FI Claims With Dates of Service On or After April 1, 2001 Through December 31, 2001 (Through March 31, 2002 for Hospitals Subject to OPPS).

A3-3660.20.A, B3-4601.6.A

Providers bill the FI for the technical component of screening and diagnostic mammographies that utilize advanced technologies with one of six new HCPCS codes, G0202 - G0207. See payment methodology below for each of the codes during the period April 1, 2001 through December 31, 2001 (or March 31, 2002 for hospitals subject to OPPS). Payments for codes G0202 through G0205 are based, in part, on the MPFS

payment amounts. The amounts that are based on the MPFS that both carriers and FIs use in calculating the payments for these codes were furnished in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

HCPCS	Definition
G0202	Screening mammography producing direct digital image, bilateral, all views

Payment Method:

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.

HCPCS	Definition
G0203	Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that is 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.

HCPCS	Definition
G0204	Diagnostic mammography, direct digital image, bilateral, all views

Payment Method:

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.) 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.

HCPCS Definition

G0205 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

Payment Method:

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.

HCPCS Definition

G0206 Diagnostic mammography, direct digital image, unilateral, all views.

Payment Method:

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 (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, and 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.

HCPCS Definition

G0207 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views.

Payment Method:

Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, and 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.

B - Payment Requirements for Claims with Dates of Service on or After January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

A3-3660.20.B, A3-3660.20.C

Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

FI Payment

Code	Payment
G0202	Payment will be equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS when performed in a hospital outpatient department, CAH, or SNF. Coinsurance is 20 percent of the lower amount; the Program pays 80 percent. Deductible does not apply.
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 on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF and coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies.
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 on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies.

Providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 under bill type 14X, 22X, 23X, or 85X. The professional component is billed to the carrier on Form CMS-1500 (or electronic equivalent).

Providers bill for digital screening mammographies on Form CMS-1450, utilizing revenue code 0403 and HCPCS G0202 or G0203.

Providers bill for digital diagnostic mammographies on Form CMS-1450, utilizing revenue code 0401 and HCPCS G0204, G0205, G0206 or G0207.

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

CAHs electing the optional method of payment for outpatient services are paid according to §20.3.2.3 of this chapter.

Carrier Payment

All codes paid by the carrier are based on the Medicare Physician Fee Schedule (MPFS).

Code	Payment
G0202	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Part B deductible does not apply, however, coinsurance applies.
G0204	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Deductible and coinsurance apply.
G0206	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Deductible and coinsurance apply.

Contractors were furnished a mammography benefit pricing file to pay claims containing the above codes.