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

Due to the delay in implementation of the 2002 outpatient prospective payment system (OPPS) rates, the effective date for payment at the 2002 rates for HCPCS codes 76090, 76091, G0204 and G0206 provided in hospital outpatient departments subject to OPPS is April 1, 2002. In addition, hospitals subject to the OPPS cannot bill new HCPCS codes 76085 and G0236 for services furnished during the period January 1, 2002, through March 31, 2002. As a result of the delay, hospitals that are subject to the OPPS are not permitted to bill any new 2002 HCPCS codes for outpatient services furnished during that period.

Section 451, Billing for Mammography Screening, is being updated based on the §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 service for which payment is made under the Medicare Physician Fee Schedule (MPFS). The payment limitation for screening mammographies no longer applies for claims with dates of service on or after January 1, 2002.

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), has been created as an add-on code to be billed in conjunction with a regular screening mammography (code 76092).

This section also changes billing procedures for Critical Access Hospitals (CAHs), as a result of the new payment method for screening mammographies and payment for Computer-Aided Detection (CADs).

In addition, for claims with dates of service on or after January 1, 2002, Medicare will pay for both a screening and diagnostic mammogram when a radiologist's interpretation of a screening mammography results in additional films.

Section 458, Diagnostic Mammography, has been added to provide coverage and payment criteria for diagnostic mammograms. In addition, 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).

Section 459, Diagnostic and Screening Mammograms Performed with New Technologies, has been 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.

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450. SPECIAL INSTRUCTIONS FOR BILLING DYSPHAGIA

This section has been moved to the Program Integrity Manual, which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

451. BILLING FOR MAMMOGRAPHY SCREENING

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening for certain women entitled to Medicare for screenings performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. Payment may be made for a screening mammography furnished to a woman at her direct request.

Prior to October 1, 1994, if you perform screening mammographies, you must request and be recommended for certification by the State certification agency and approved by HCFA before payment is made. Effective October 1, 1994, if you perform mammography services (diagnostic and screening), you must be issued a certificate from the Food and Drug Administration (FDA) before payment is made. (See §454 for more detailed instructions.) If you arrange for another entity to perform a screening mammography for one of your patients prior to October 1, 1994, you must assure that the entity is certified to perform the screening, or on or after October 1, 1994, you must assure that the entity has been issued a certificate by FDA. Your intermediary will deny claims when it determines the entity that performed the screening is not certified. It will utilize denial language in subsection F.

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

- o No payment may be made for a screening mammography performed on a woman under 35 years of age;

- o You will be paid for only one screening mammography performed on a woman between her 35th and 40th birthdays (ages 35 thru 39); and

- o For a woman over 39, you will be paid for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A. Determining 11 Month Period.--To determine the 11-month period, your intermediary starts their count beginning with the month after the month in which a previous screening mammography was performed.

EXAMPLE: The beneficiary received a screening mammography in January 1991. Intermediaries start their count beginning with February 1991. The beneficiary is eligible to receive another screening mammography in January 1992 (the month after 11 full months have elapsed).

B. Payment.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for screening mammography services:

- o Professional component of mammography services (that is, for the physician's interpretation of the results of the examination),

o Technical component (all other services), and

o Both professional and technical components (global). However, global billing is not permitted for services furnished in your outpatient department, except for critical access hospitals (CAHs) electing the optional method of payment for mammography services furnished on or after January 1, 2002.

Claims with dates of service prior to January 1, 2002, (prior to April 1, 2002, for hospitals subject to the OPPS), are subject to a payment limitation. When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation ($62.10 in calendar year 1996, $63.34 in calendar year 1997, $64.73 in calendar year 1998, $66.22 in calendar year 1999, $67.81 in calendar year 2000, and $69.23 in calendar year 2001), applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. For example, in calendar year 2000, 32 percent of the $67.81 limit, or $21.69, is used in determining payment for the professional component, and 68 percent of the $67.81 limit, or $46.12, is used in determining the payment for the technical component.

Payment for the technical component equals 80 percent of the least of the:

o Actual charge for the technical component of the service;

o Amount determined for the technical component of a bilateral diagnostic mammogram (HCPCS code 76091) for the service under the radiology fee schedule in 1991 or for services furnished on or after January 1, 1992 under the Medicare physicians' fee schedule; or

o Technical portion of the screening mammography limit. This is an amount determined by multiplying the screening mammography limit ($59.63 in calendar year 1994 by 63 percent, $60.88 in calendar year 1995, $62.10 for calendar year 1996, $63.34 for calendar year 1997, and $64.73 in calendar year 1998, $66.22 in calendar year 1999, and $67.81 in calendar year 2000) by 68 percent.

Bill your intermediary on Form HCFA-1450 for the technical component portion of the screening mammography and your carrier on Form HCFA-1500 for the professional component portion.

See subsection C below for payment examples.

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) for such services furnished in hospitals, skilled nursing facilities (SNFs), and in CAHs not electing the optional method of payment for outpatient services. (For hospitals subject to OPPS the MPFS was implemented for claims with dates of services on or after April 1, 2002). 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.

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 (List separately in addition to code for primary procedure)" for computer aided detection (CAD), 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. There is no Part B deductible. However, coinsurance is applicable.

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

Claims containing code 76085 that do not also contain HCPCS code 76092 will be returned to you with an explanation that payment for code 76085 cannot be made when billed alone.

For CAHs, see §415.19 for those that have elected the optional method of payment for outpatient services. Payment for these CAHs for screening mammography furnished on or after January 1, 2002, at 115 percent of the lesser of:

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

C. Determining Payment Amount for Technical Component for Claims with Dates of Service Prior to January 1, 2001, (April 1, 2002, for hospitals subject to the OPPS).--This provides for the payment calculation of the technical portion of a screening mammography. For services in 2000, your intermediary will pay the lower of:

- Billed charges for HCPCS code 76092;
- $46.12 limit; or
- The physicians' fee schedule amount for the technical component of HCPCS code 76091.

EXAMPLE: $90.00 Hospital charges;
$75.00 Physicians' fee schedule amount; and
$46.12 Technical portion of the screening mammography limit (68% of $67.81).

Payment is 80 percent of the lower of:

$90.00 Hospital charges;
$75.00 Physicians' fee schedule amount for the technical component; or
$46.12 Technical portion of the screening mammography limit.

To calculate the payment, your intermediary selects the lower of:

$90.00 Hospital charges;
$75.00 Physicians' fee schedule amount for the technical component; or
$46.12 Technical portion of the screening mammography limit.

Pay 80 percent of the remainder. It does not apply to your interim rate. This is a final payment to you.

In this case:

$46.12 x 80% = $36.90

To determine the patient's liability to you, multiply the actual charge by 20 percent. The result is the patient's liability.

In this case:

$90.00 x 20% = $18.00 (coinsurance)

In this example, $18.00 is applied to the coinsurance.

NOTE: This payment limitation does not apply to claims with dates of service on or after January 1, 2002, (April 1, 2002, for hospitals subject to the OPPS).

D. Billing Requirements.--Bill for the technical component portion of the screening mammography on Form HCFA-1450 under bill type 14X and 85X, using revenue code 403 and HCPCS code 76092, except for CAHs who have elected the optional method of reimbursement who bill the carrier on Form HCFA-1500 for the global amount. See subsection B for payment requirements. Separate bills are required for claims with dates of service prior to January 1, 2002. You should include on the bill only charges for the mammography screening. Separate bills are not required for claims with dates of service on or after January 1, 2002, (April 1, 2002, for hospitals subject to the OPPS).

On every screening claim with dates of service October 1, 1997 through December 31, 1997, where the patient is not a high risk individual, enter in FL 67, "Principal Diagnosis Code," the following code:

- o V76.12 “Other screening mammography".

If the screening is for a high risk individual, enter in FL 67, “Principal Diagnoses Code,” the following code:

- o V76.11 “Screening mammogram for high risk patient.”

In addition, for high-risk individuals, report one of the following applicable codes in Item 68, "Other Diagnoses Codes”:

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

The following chart indicates the ICD-9 diagnosis codes to be 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

On every screening claim with dates of service on or after January 1, 1998, you must enter in FL 67, “Principal Diagnosis Code,” the following code:

- o V76.12 “Other screening mammography.”

NOTE: Code ICD-9 diagnosis codes for mammography to the appropriate fourth or fifth digit. Omit decimal points for data entry purposes. In addition, due to the BBA of 1997, there is no need for you to continue to report the high-risk diagnosis code effective January 1, 1998.

E. Actions Required.--Your intermediary will consider the following when determining whether payment may be made:

- o Presence of revenue code 403;
- o Presence of HCPCS code 76092;
- o Presence of high-risk diagnosis code indicator;
- o Date of last screening mammography; and
- o Age of beneficiary.

F. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films (Claims with Dates of Service October 1, 1998 through December 31, 2001).--Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at your facility for the screening exam. Where a radiologist interpretation results in additional films the mammography is no longer considered a screening exam for application of age and frequency standards or for payment purposes. When this occurs, the claim will be paid as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for a screening, for statistical purposes, the claim is considered a screening.

Prepare the claim reflecting the diagnostic revenue code (401) along with HCPCS code 76090, 76091 or G0204 as appropriate and modifier GH "Diagnostic mammogram converted from screening mammogram on same day." Payment will be made to you on a cost reimbursement basis. Statistics will be collected based on the presence of modifier GH. A separate claim is not required. Regular billing instructions remain in place for the mammographies that do not fit this situation. See subsection C for appropriate bill types.

G. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films (Claims with Dates of Service on or After January 1, 2002, (or on or after April 1, 2002, for hospitals subject to the OPPS)).--Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. When a radiologist's interpretation results in additional films, Medicare will now pay for both the screening and diagnostic mammogram.

The diagnostic claim must be prepared reflecting the diagnostic revenue code (401 along with HCPCS code 76090, 76091, G0204, G0206 or G0236 and modifier GG "Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day." Reporting of this modifier is needed for data collection purposes. Regular billing instructions remain in place for screening mammographies that do not fit this situation. See §458 for detailed information regarding HCPCS code G0236 and §459 for detailed information regarding HCPCS codes G0204 and G0206.

H. Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--If your intermediary has converted to MSN, they should utilize the following MSN messages. If your intermediary has NOT converted to MSN, they should utilize the following EOMB messages.

If the claim is denied because the beneficiary is under 35 years of age, your intermediary states on the EOMB or MSN the following message:

> "Screening mammography is not covered for women under 35 years of age."
> (MSN message number 18-3 or EOMB message number 18.18)

If the claim is denied because the period of time between screening for the woman based on age has not passed, your intermediary states on the EOMB or MSN the following message:

"This service is being denied because it has not been 12 months since your last examination of this kind."
(MSN message number 18-4 or EOMB message number 18.20)

If the claim is denied because the provider that performed the screening is not certified, your intermediary states on the EOMB or MSN the following message:

"This service cannot be paid when provided in this location/facility."
(MSN message number 16-2 or EOMB message number 16.4)

In addition to the above denial messages, your intermediary has the option of using the following EOMB or MSN message:

"Screening mammograms are covered annually for women 40 years of age and older"
(MSN message number 18-12 or EOMB message number 18-21)

If the claim is denied for a woman 35-39 because she has previously received this examination, your intermediary states on the EOMB or MSN the following message:

"A screening mammography is covered only once for women age 35-39."
(MSN message number 18-6 or EOMB message number 18.19)

I. Remittance Advice Messages.--If the claim is denied because the beneficiary is under 35 years of age, your intermediary uses existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message 6, "The procedure code is inconsistent with the patient's age" along with 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, your intermediary uses existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with 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, your intermediary uses existing ANSI X-12-835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with 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, your intermediary uses 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."

458. Diagnostic Mammography.--A radiological mammogram is a covered diagnostic test under the following conditions:

- o A patient has distinct signs and symptoms for which mammogram is indicated;
- o A patient has a history of breast cancer; or
- o A patient is asymptomatic, but on the basis of the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.

Payment for diagnostic mammograms is made under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs.

A new HCPCS 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), has been established as an add-on code that can be billed only in conjunction with the primary service diagnostic mammography code 76090 or 76091. Payment will be made under OPPS for hospital outpatient departments. The Part B deductible and coinsurance apply.

Claims containing code G0236 that do not also contain HCPCS code 76090 or 76091 will be returned to you with an explanation that payment for code G0236 cannot be made when billed alone.

For CAHs, see §415.19 for those that have elected the optional method of payment for outpatient services. Pay these CAHs for the professional component (PC) of the diagnostic mammographies furnished on or after January 1, 2002 at 115 percent of the lesser of:

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

459. 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, through December 31, 2001.

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 §454.

A. Payment Requirements for Claims with Dates of Service on or After April 1, 2001 through December 31, 2001, (through March 31, 2002, for hospitals subject to the OPPS).--When 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 MPFS payment amounts.

- o HCPCS code G0202, Screening mammography producing direct digital image, bilateral,

all views. Payment will be the lesser of the 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.) 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). 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 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.

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 has been 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 you, under the payment method applicable to the specific provider type (e.g., hospital, CAHs) 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 you under the payment method applicable to the specific provider type (e.g., hospital, CAHs,) 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.

B. Payment Requirements for Services Furnished on or After January 1, 2002, (on or after April 1, 2002, for hospitals subject to the OPPS).--Payment will be made as follows:

Code 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, or CAH. Coinsurance is 20 percent of the lower amount, the Program pays 80 percent.

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 on a reasonable cost basis for CAHs and coinsurance is based on charges.

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 on a reasonable cost basis for CAHs and coinsurance is based on charges.

Deductible applies.

For CAHs, see §415.19 for those that have elected the optional method of payment for outpatient services. For codes G0202, G0204 and G0206, see above.

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

Bill for digital screening mammographies on Form HCFA-1450, utilizing revenue code 403 and HCPCS G0202 or G0203.

Bill for digital diagnostic mammographies on Form HCFA-1450, utilizing revenue code 401 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, (April 1, 2002, for hospitals subject to the OPPS).