Medicare Hospital Manual

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

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CHANGE REQUEST 2332

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
451 (Cont.) - 451 (Cont.)	4-493 – 4-494 (2 pp.)	4-493 – 4-494 (2 pp.)
459 - 459 (Cont.)	4-500.13 – 4-500.16 (4 pp.)	4-500.13 - 4-500.15 (3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: April 1, 2003*
IMPLEMENTATION DATE: April 1, 2003

Section 451, Billing for Mammography Screening, is being updated to include a cross reference for billing of Computer Aided Detection (CAD) device in conjunction with digital screening and diagnostic mammograms.

Section 458, Diagnostic Mammography, is being updated to include a cross-reference for billing of CAD device in conjunction with digital screening and diagnostic mammograms.

Section 459, Diagnostic and Screening Mammograms Performed with New Technologies, has been updated to clarify that both a screening film and screening digital mammography or a diagnostic film and a diagnostic digital mammography should not be billed together since payment will not be made for both. Claims will be returned to you when both a screening film and screening digital or a diagnostic film and diagnostic digital mammography are reported on the same claim.

In addition, this instruction allows for billing and payment of Computer Aided Detection (CAD) device in conjunction with new technology screening and diagnostic mammography services. Claims that contain only a CAD device will be returned to you.

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

- Technical component (all other services), and

- 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:

- Actual charge for the technical component of the service;

- 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

- 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 CMS-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 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. (See §459D for billing and payment of CAD when billed in conjunction with digital screening or diagnostic mammograms.)

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:

o Eighty percent of the actual charge of the CAH for the screening mammography, including both the radiologic procedure and the physician's interpretation, or

o 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:

o Billed charges for HCPCS code 76092;

o $46.12 limit; or

o 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.

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 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. (See §459D for billing and payment of CAD when billed in conjunction with digital screening or diagnostic mammograms)

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 CMS-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).

HCPCS codes 76092 (screening mammography-film) and G0202 or G0203 (screening mammography-digital) should not be billed together since only one type of screening mammography will be paid. Therefore, do not submit claims reflecting both a film screening mammography (76092) and a digital screening mammography (G0202 or G0203). Also do not submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Your intermediary will install an edit to return claims to you when both a film and digital screening or diagnostic mammography are reported.

D. Billing and Payment of Computer Aided Detection (CAD).--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. Payment will be made under the MPFS for code 76085. There is no Part B deductible. However, coinsurance is applicable. (See §451.B for billing and payment of CAD when billed in conjunction with a film screening mammography.)

Claims containing code 76085 that do not also contain G0202 will be returned to you with an explanation that payment for code 76085 cannot be made when billed alone.

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. For code G0236, payment will be made under OPPS for hospital outpatient departments, and on a reasonable cost basis for CAHs. The Part B deductible and coinsurance apply. (See §458 for billing and payment of CAD when billed in conjunction with a film diagnostic mammography.)

Claims containing code G0236 that do not also contain G0204 or G0206 will be returned to you with an explanation that payment for code G0236 cannot be made when billed alone.

NOTE: Add-on codes cannot be billed by themselves. They must be accompanied by one of the other mammography codes. Add-on code 76085 must be billed with 76092 or G0202. Add-on code G0236 must be billed with 76091, G0204 or G0206.