CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1070	**Date: SEPTEMBER 29, 2006**
	Change Request 5327

NOTE: This instruction is being re-communicated. The attached instruction was previously communicated as sensitive. This instruction is no longer sensitive and has been updated to include the correct type of service (TOS) for the new Mammography codes: 77051, 77052, 77055, 77056 and 77057. The Transmittal Number, date of issuance and all other information remains the same.

Subject: New 2007 Current Procedural Terminology (CPT) Mammography Codes

I. SUMMARY OF CHANGES: New 2007 Current Procedural Terminology (CPT) mammography codes have been assigned for screening and diagnostic services. These codes will replace the current CPT codes, however the CPT code descriptors for the services are unchanged.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	4/250/250.4/CAH Outpatient Services Part B Deductible and Coinsurance
R	18/Table of Contents
R	18/20/Mammography Services
R	18/20/20.2/HCPCS and Diagnosis Codes for Mammography Services
R	18/20/20.2.1/Computer-Aided Detection (CAD) Add-On Codes
R	18/20/20.2.1.1/CAD Billing Charts
R	18/20/20.3.1/Payment for Screening Mammography Services Provided Prior to January 1, 2002

R	18/20/20.3.2/Payment for Screening Mammography Services Provided On and After January 1, 2002
R	18/20/20.3.2.1/Outpatient Hospital Mammography Payment Table
R	18/20/20.3.2.2/Payment for Computer Add-On Diagnostic and Screening Mammograms for FIs and Carriers
R	18/20/20.3.2.3/Critical Access Hospital Payment
R	18/20/20.3.2.3.1/CAH Mammography Payment Table
R	18/20/20.3.2.4/SNF Mammography Payment Table
R	18/20/20.4/Billing Requirements - FI Claims
R	18/20/20.4.1.2/RHC/FQHC Claims With Dates of Service on or After January 1, 2002
R	18/20/20.4.2/FI Requirements for Nondigital Screening Mammographies
R	18/20/20.4.2.1/FI Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)
R	18/20/20.5.1.1/Carrier and CWF Edits
R	18/20/20.6/Instructions When an Interpretation Results in Additional Films
R	18/20/20.7/Mammograms Performed With New Technologies

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1070	Date: September 29, 2006	Change Request: 5327

NOTE: This instruction is being re-communicated. The attached instruction was previously communicated as sensitive. This instruction is no longer sensitive and has been updated to include the correct type of service (TOS) for the new Mammography codes: 77051, 77052, 77055, 77056 and 77057. The Transmittal Number, date of issuance and all other information remains the same.

SUBJECT (Change Request Title): New 2007 Current Procedural Terminology (CPT) Mammography Codes

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

I. GENERAL INFORMATION

A. Background: New 2007 Current Procedural Terminology (CPT) mammography codes have been assigned for screening and diagnostic mammography services. These codes will replace the current CPT codes; however the CPT code descriptors for the services are unchanged.

B. Policy: : Effective for claims with dates of service January 1, 2007 and later, providers report new CPT codes 77051, 77052, 77055, 77056, and 77057 in place of current CPT codes 76082, 76083, 76090, 76091, and 76092 respectively.

II. BUSINESS REQUIREMENTS

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5327.1	Upon release of the 2007 CPT codes by the American Medical Association (AMA), contractors shall advise providers that effective for claims with dates of service January 1, 2007 and later, the following new CPT codes have been assigned to mammography services: 77051 77052 77055 77056 77057 The CPT code descriptors for the services are unchanged.	X		X	X							
5327.2	Contractors shall advise providers to report new	X		X	X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	codes for mammography claims effective January 1, 2007 as follows: • report code 77051 in place of code 76082; • report code 77052 in place of code 76083; • report code 77055 in place of code 76090; • report code 77056 in place of code 76091; • report code 77057 in place of code 76092;											
5327.2.1	Contractors shall use the following type of service (TOS) for the new codes: 77051—TOS 4 77052—TOS 1 77055---TOS 4 77056---TOS 4 77057---TOS 1	X			X						X	
5327.3	Contractors shall return to providers claims with dates of service on or after January 1, 2007, containing CPT codes 76082, 76083, 76090, 76091, or 76092.	X		X	X			X	X			OPPS/ OCE
5327.4	Contractors and CWF shall update their systems to discontinue CPT codes 76082, 76083, 76090, 76091, and 76092 and replace them with new CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.	X		X	X			X	X		X	
5327.5	Contractors shall update any edits in their systems that contain CPT codes 76082, 76083, 76090, 76091, 76092 to replace them with CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.	X		X	X			X	X		X	
5327.6	CWF shall apply existing frequency standards for new screening mammography CPT codes 77052 and 77057 effective January 1, 2007.										X	

III. PROVIDER EDUCATION

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5327.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Bill Ruiz for (FIs) 410-786-9283 william.ruiz@cms.hhs.gov

Antoinette Johnson (FIs) 410-786-9326 antoinette.johnson@cms.hhs.gov

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Wendy Knarr (Carriers) Dial relay 711 then 410-786-0843 wendy.knarr@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

250.4 - CAH Outpatient Services Part B Deductible and Coinsurance

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for outpatient services of a CAH is subject to applicable *Medicare* Part B deductible and coinsurance amounts *unless waived based on statute.*

For information on the application of deductible and coinsurance for screening and preventive services, see Chapter 18 of Pub. 100-04, Medicare Claims Processing Manual.

Payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, are made on a reasonable cost basis with no beneficiary cost-sharing – no coinsurance, deductible, copayment, or any other cost-sharing.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 1070, 09-29-06)

20 - Mammography Services

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

A. Screening Mammography

Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiologic procedures for early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. Whether payment can be made is determined by a woman's age and statutory frequency parameter. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.3 for additional coverage information for a screening mammography.

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

Age Groups	Screening Period
Under age 35	No payment allowed for screening mammography.
35-39	Baseline (pay for only one screening mammography performed on a woman between her 35th and 40th birthday)
Over age 39	Annual (11 full months have elapsed following the month of last screening

NOTE: Count months between screening mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2005, begin counting the next month (February 2005) until 11 months have elapsed. Payment can be made for another screening mammography in January 2006.

B. Diagnostic Mammography

A diagnostic mammography is a radiological mammogram and is a covered diagnostic test under the following conditions:

- A patient has distinct signs and symptoms for which a mammogram is indicated;
- A patient has a history of breast cancer; or
- A patient is asymptomatic, but based on the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.
- Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, § 644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare will pay based on the MPFS in lieu of OPPS or the lower of the actual change.

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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

HCPCS Code	TOS	Definition
77051 (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). ***Code 76082 is effective*** **January 1, 2004** ***thru December 31, 2006. Code 77051 is effective January 1, 2007.***
77052 (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). ***Code 76083 is effective*** **January 1, 2004** ***thru December 31, 2006. Code 77052 is effective January 1, 2007.***
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 *January 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 *April 1, 2002*. Deleted as of December 31, 2003.**
77055 (76090*)*	*4*	Diagnostic mammography, unilateral.
77056 (76091*)*	*4*	Diagnostic mammography, bilateral.
77057 (76092*)*	*1*	Screening mammography, bilateral (two view film study of each breast).
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. **Code Effective *April 1, 2001*.**

HCPCS Code	TOS	Definition
G0203		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views; **Code Effective *April 1, 2001* and terminated *December 31, 2001*, with the exception of hospitals subject to OPPS, who may bill this code through *March 31, 2002*.**
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; **Code Effective *April 1, 2001*.**
G0205		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views; **Code Effective *April 1, 2001* and terminated *December 31, 2001*, with the exception of hospitals subject to OPPS, who may bill this code through *March 31, 2002*.**
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; **Code Effective *April 1, 2001*.**
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; **Code Effective *April 1, 2001* and terminated *December 31, 2001*, with the exception of hospitals subject to OPPS, who may bill this code through *March 31, 2002*.**
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 *January 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 *April 1, 2002*. Deleted as of December 31, 2003.**

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.*

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 BBA of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

> V76.11 – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;
>
> V76.12 - "Special screening for malignant neoplasm, other screening mammography."

Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9-CM 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.

Providers report on Form CMS-1450 diagnosis code V76.11 or V76.12 in FL 67, "Principal Diagnosis Code" or in Loop 2300 of ANSI-X12 837 if the screening mammography is the only services reported on the claim. If the claim contains other services in addition to the screening mammography, diagnostic codes V76.11 or V76.12 are reported, as appropriate, in FL's 68-75, "Other Diagnostic Codes" or in Loop 2300 of ANSI-X12 837. Carriers receive this diagnosis in field 21 and field 24E with the appropriate pointer code of Form CMS-1500 or in Loop 2300 of ANSI- X12 837.

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

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.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Screening Add-on Codes 76085 and *77052* (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, 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.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082* *(77051*)* under the 13X bill type. The 14X bill type is no longer applicable. Appropriate TOBs for providers other than hospitals are 22X, 23X, and 85X.

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 (76092 or 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 *thru December 31, 2006*, 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.

Effective with claims with dates of service January 1, 2007 and later, HCPCS code 77052, which replaces 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 77057 or G0202.

Contractors must assure that claims containing code *77052* (76083*)* also contain HCPCS code *77057* (76092*)* or G0202. FIs return claims containing code *77052* (76083*)* that do not also contain HCPCS code *77057* (76092*)* or G0202 with an explanation that payment for code *77052* (76083*)* cannot be made when billed alone. Carriers deny payment for *77052* (76083*)* when billed without *77057* (76092*)* or G0202.

NOTE: When screening CAD *77052* (76083*)* is billed in conjunction with a screening mammography (*77057* (76092*)* or G0202) and the screening mammography (*77057* (76092*)* or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092 or G0202. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 or G0202, respectively.*

Diagnostic Add-on Codes *G0236* and *77051* (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 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.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082* *(77051*)* under the 13X bill type. The 14X bill type is no longer applicable. Appropriate TOBs for providers other than hospitals are 22X, 23X, and 85X.

There are no frequency limitations on *film or digital* 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 *thru December 31, 2006*, 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.

Effective for claims with dates of service January 1, 2007 and later, HCPCS code 77051, which replaces 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 77055, 77056, G0204, or G0206.

Contractors must assure that claims containing code *77051* (76082*)* also contain HCPCS codes *77055*(76090*)*, *77056* (76091*)*, G0204 or G0206. FIs return claims containing code *77051* (76082*)* that do not also contain HCPCS code *77055* (76090*)*, *77056* (76091*)*, G0204, or G0206 with an explanation that payment for code *77051* (76082*)*, cannot be made when billed alone. Carriers deny payment for *77051* (76082*)* when billed without *77055* (76090*)*, *77056* (76091*)*, G0204, or G0206.

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, G0204 or G0206 with 76082. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, G0204, or G0206 with 77051, respectively.*

20.2.1.1 - CAD Billing Charts

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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 Codes

CAD Codes	**Effective 01-01-02 thru 03-31-03**	**Effective 04-01-03 thru 12-31-03**	**Effective 01-01-04** ***thru 12-31-06***	***Effective 01-01-07 and later***
76085	76092	76092, G0202	N/A	*N/A*
76083	N/A	N/A	76092, G0202	*N/A*
77052	*N/A*	*N/A*	*N/A*	*77057, 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** ***thru 12-31-06***	***Effective 01-01-07 and later***

G0236	76090	76090	N/A	*N/A*
	76091	76091		
		G0204		
		G0206		
76082	N/A	N/A	76090	*N/A*
			76091	*N/A*
			G0204	*N/A*
			G0206	*N/A*
77051	*N/A*	*N/A*	*N/A*	*G0204*
				G0206
				77055
				77056

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, G0204 or G0206 with 76082. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, G0204, or G0206 with 77051, respectively.*

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

CAD Codes	**Effective 01-01-02 thru 03-31-03**	**Effective 04-01-03 thru 12-31-03**	**Effective 01-01-04** ***thru 12-31-06***	***Effective 01-01-07 and later***
76085	76092	76092, G0202	N/A	*N/A*

76083	N/A	N/A	76092, G0202	*N/A*
77052	*N/A*	*N/A*	*N/A*	*77057, G0202*

See section 20.5.1, for carrier CWF edits

**For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 respectively.*

20.3.1 - Payment for Screening Mammography Services Provided Prior to January 1, 2002

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Claims with dates of service prior to January 1, 2002, are subject to a payment limitation. The professional component is 32 percent of the total limit for the complete service. The technical component is 68 percent.

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 applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. Below are the limitation amounts applicable each calendar year:

Calendar Year	Global Payment Limit	Technical Component Amount	Professional Component Amount
1996	$62.10	$42.23	$19.87
1997	$63.34	$43.07	$20.27
1998	$64.73	$44.02	$20.71
1999	$66.22	$45.03	$21.19
2000	$67.81	$46.11	$21.69
2001	$69.23	$47.08	$22.15

NOTE: The CMS annually updates the overall limit annually by the percentage increase in the Medicare Economic Index.

EXAMPLE: In calendar year 2001, 32 percent of the $69.23 limit, or $22.15, is used in determining payment for the professional component; and 68 percent of the $69.23 limit, or $47.08, is used in determining payment for the technical component.

FI Payment

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

- The actual charge for the technical component (HCPCS code *77057* (76092*)*) of the service;
- The physicians' fee schedule amount for the technical component of HCPCS code *77056* (76091*)* (a bilateral diagnostic mammogram); or
- The technical portion of the screening mammography limit as identified in the chart above.

For claims with dates of service prior to January 1, 2007, providers report CPT codes 76091 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77056 and 77057 respectively.

Carrier Payment - Technical Component

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

- The actual charge for the technical component of the service;
- The amount determined with respect to the technical component for the service under Medicare Physicians' Fee Schedule; or
- The technical portion of the screening mammography limit as identified in the chart above.

Carrier Payment - Professional Component

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

- The actual charge for the professional component;
- The amount determined with respect to the professional component for the service under the Medicare Physician Fee Schedule; or
- The professional portion of the screening mammography limit based on the year of service according to the chart above.

FI or Carrier Payment - Global

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

- The actual charge for the procedure;
- The amount determined with respect to the global procedure under the Medicare Fee Schedule; or
- The limit for the procedure based on the year of service according to the chart above.

Carriers may receive bills for global, professional, or technical components. If mammography services are furnished by nonparticipating physicians and suppliers, there is a special limiting charge. Carriers must apply the appropriate payment reductions to screening mammography procedures furnished by new physicians.

Providers bill the technical component of mammography services to FIs. Only a CAH may bill globally if the CAH elected the optional method of payment for mammography services furnished on or after January 1, 2002.

FI Payment Example

$90.00	Provider charges for HCPCS;
$75.00	Physician' fee schedule amount; and
$47.08	Technical portion of the screening mammography limit (68% of $69.23 (year 2001))

Payment is 80 percent of the lower of the following amounts. To calculate the payment, select the lower of:

$90.00	Provider charges;
$75.00	Physician' fee schedule amount for the technical component; or
$47.08	Technical portion of the screening mammography limit (year 2001).

Payment is 80 percent of the remainder. FIs do not apply the provider's interim rate. This is a final payment to the provider. In this example, payment is calculated as follows:

$47.08 x 80% = $ 37.66 payment to the provider

To determine the patient's liability, multiply the actual charge by 20 percent. The result is the patient's liability. In this example, the calculation is:

$90.00 x 20% = $18.00 (coinsurance).

20.3.2 - Payment for Screening Mammography Services Provided On and After January 1, 2002

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

The payment limitation methodology does not apply to claims with dates of service on or after January 1, 2002.

FI Claims

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 mammography under the Medicare physician fee schedule (MPFS) when furnished in hospitals, skilled nursing facilities (SNFs), and CAHs not electing the optional method of payment for outpatient services. However, payment under the physician fee schedule is not applicable to hospitals subject to the Outpatient Prospective Payment System (OPPS) until April 1, 2002.

The payment for code *77057* (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. Part B deductible does not apply. This is a final payment.

FIs use the benefit-pricing file provided by CMS to pay mammography codes.

Payment for the add-on code 76085 is made under the Medicare Physician Fee Schedule. Deductible does not apply, however, coinsurance is applicable.

**For claims with dates of service prior to January 1, 2007, providers report CPT code 76092. For claims with dates of service January 1, 2007 and later, providers report CPT code 77057.*

Carrier Claims

Physicians and suppliers are paid by the carrier for all mammography tests (including screening mammography) under the MPFS. Separate prices for the technical component, the professional component and the global service are included on the MPFS.

The Medicare allowed charge is the lower of:

- The actual charge, or
- The MPFS amount for the service billed.

The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Part B deductible is waived and does not apply to screening mammography.

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

20.3.2.1 - Outpatient Hospital Mammography Payment Table

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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.

PAYMENT FOR SCREENING MAMMOGRAPHY

Screening Mammography (Revenue Code 403)	**Year 2000**	**2001 (April 1, 01 thru March 31, 2002)**	**April 1, 2002 - forward**
77057 (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 *77057* (76092*)*
G0202 Screening Mammography,	N/A	Lesser of:	Lesser of: 1. Actual charge,

Screening Mammography (Revenue Code 403)	**Year 2000**	**2001 (April 1, 01 thru March 31, 2002)**	**April 1, 2002 - forward**
producing direct digital image, bilateral, all views. No deductible Coinsurance applies		1. Charge, or 2. 150% TC of MPFS for code 76091	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

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76091 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77056 and 77057 respectively.*

PAYMENT FOR DIAGNOSTIC MAMMOGRAPHY

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**April 1*, 2001 thru* March 31, 2002**	**April 1, 2002 *thru December 31, 2004***	**January 1, 2005 - *forward***
77056 (76091*)*Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS	Lesser of charge or TC or the MPFS for *77056* (76091*)*
77055 (76090*)* Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS	Lesser of charge or TC or the MPFS for *77055* (76090*)*

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**April 1*, 2001 thru* March 31, 2002**	**April 1, 2002 *thru December 31, 2004***	**January 1, 2005 - *forward***
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	Lesser of charge or TC or the MPFS for G0204
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	OPPS	Lesser of charge or TC or the MPFS for G0206
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	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	N/A

For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090 and 76091. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055 and 77056 respectively.

Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, § 644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

COMPUTER-AIDED DETECTION (CAD) DEVICES

Computer-aided Detection (CAD)	**Year 2000**	**2001 (April 1 - Dec 31)**	**Year 2002 - 2003**	**January 1, 2004**	**January 1, 2005 - *forward***
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	N/A	N/A
G0236* CAD with diagnostic mammography (may bill with 76090 or 76091) Deductible and coinsurance apply	N/A	N/A	OPPS	N/A	N/A
77052 (76083*)* CAD with screening mammography (may bill with *77057* (76092*)* or G0202) No deductible applies	N/A	N/A	N/A	Lesser of: 1. Charge, or 2. TC of MPFS for code 76083	Lesser of: 1. Charge, or 2. TC of MPFS for code *77052* (76083*)*

77051 (76082*)* CAD with diagnostic mammography (may bill with *77055* (76090*)*, *77056* (76091*)*, G0204, or G0206) Deductible and coinsurance apply	N/A	N/A	N/A	OPPS	Lesser of: 1. Charge, or 2. TC of MPFS for code *77051* (76082*)*

TC = technical component

MPFS= Medicare Physician Fee Schedule

OPPS= Outpatient Prospective Payment System

APC= Ambulatory Payment Classification

* *C*ode 76085 is a deleted code as of December 31, 2003. The code to be used for dates of service beginning January 1, 2004 *thru December 31, 2006* is 76083. *For claims with dates of service January 1, 2007 and later, the new code is 77052.* Code G0236 is a deleted code as of December 31, 2003. The code to be used for dates of service beginning January 1, 2004 *thru December 31, 2006,* is 76082. *For claims with dates of service January 1, 2007 and later the new code is 77051.*

Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, §644, Public Law 108-173 has changed the way Medicare pays for diagnostic CAD services. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

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

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for computer add-on **diagnostic** mammogram HCPCS code G0236 or *77051* (76082*)* when billed with CPT code *77055* (76090*)*, *77056* (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 – technical component

Independent RHC	All-inclusive rate for professional component (codes 76090 and 76091)**
Freestanding FQHC	All-inclusive rate for professional component (codes 76090 and 76091)**

** Only for dates of service prior to April 1, 2005.

NOTE: Effective for claims with dates of service on or after January 1, 2005 computer add-on diagnostic mammography services provided in a hospital are paid under the MPFS. Payment is no longer made under the OPPS.

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 *thru December 31, 2006*, 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.

Effective for claims with dates of service January 1, 2007 and later, add-on HCPCS code 77051, "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 77055 or 77056. 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 *77051* (76082*)* with an explanation that payment for code G0236 or *77051* (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 September 12, 2002).

Payment for computer add-on **screening** mammogram HCPCS code 76085 or *77052* (76083*)* when billed with CPT code *77057* (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 – technical component
Independent RHC	All-inclusive rate for professional component (code 76092**)
Freestanding FQHC	All-inclusive rate for professional component (code 76092**)

** Only for dates of service prior to April 1, 2005.

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 technical component of the Medicare physician fee schedule.

Effective for claims with dates of service January 1, 2004 *thru December 31, 2006*, 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 applies.

Effective for claims with dates of service January 1, 2007 and later, HCPCS code 77052, "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 77057. There is no Part B deductible but coinsurance applies.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes 76085 or *77052* (76083*)* with an explanation that payment for code 76085 or *77052* (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).

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.*

20.3.2.3 - Critical Access Hospital Payment

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment to a CAH for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. 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 *77057* (76092*)*. They also include the professional component on a separate line, *with* revenue code *96X, 97X, or 98X* and HCPCS code *77057* (76092*).*

***For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 respectively.*

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 *77057* (76092*)*.

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.

***For claims with dates of service prior to January 1, 2007, providers report CPT code 76092. For claims with dates of service January 1, 2007 and later, providers report CPT code 77057.*

20.3.2.3.1 – CAH *Screening* Mammography Payment Table

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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	85X	403	76092	FI payment is

	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 for the technical component.

Services on or after July 1, 2001 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.
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	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" *for dates of service prior to January 1, 2006. For more information on HPSA modifiers see Chapter 4, Section 250.2.2 in Pub. 100-04.*	If HPSA area, FI payment is 115% of 110% of the lower of the charge or MPFS amount after coinsurance is deducted *times 110%.*

	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 *77057* (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	*96X,* 97X*, or 98X*	*76085 *77057* (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 *thru December 31, 2006 and 77052 for claims with dates of service January 1, 2007 and later. Also, for claims with dates of service prior to January 1, 2007 CAHs report CPT code 76092. For claims of service with dates of service January 1, 2007 and later CAHs report CPT code 77057.*				

20.3.2.4 - SNF Mammography Payment Table

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for *Screening Mammography*

Screening Mammography (Revenue Code 0403)	**Year 2000**	**2001 (April 1 - March 31, 2002)**	**April 1, 2002 *and later***
77057 (76092*)* Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges or, 2. TC of MPFS 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 *77057* (76092*)*
G0202 Screening Mammography, producing direct digital image,	N/A	Lower of: 1. Charge, or 2. 150% TC of	Lower of: 1. Charge, or 2. TC of MPFS

Screening Mammography (Revenue Code 0403)	**Year 2000**	**2001 (April 1 - March 31, 2002)**	**April 1, 2002 *and later***
bilateral, all views. No deductible Coinsurance applies		MPFS for code 76091	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*

***** For claims with dates of service prior to January 1, 2007, SNFs report CPT codes 76091 and 76092. For claims with dates of service January 1, 2007 and later, SNFs report CPT codes 77056 and 77057 respectively.*

Payment for Diagnostic Mammography

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1- March 31, 2002)**	**April 1, 2002 *and later***
77056 (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
77055 (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

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1-March 31, 2002)**	**April 1, 2002 *and later***
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)	*N/A*
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

***** *For claims with dates of service prior to January 1, 2007, SNFs report CPT codes 76090 and 76091. For claims with dates of service January 1, 2007 and later, SNFs report CPT codes 77055 and 77056 respectively.*

Payment for Screening and Diagnostic **Computer-Aided Detection (CAD)**

Computer-aided Detection (CAD)	**Year 2000**	**2001 (April 1-Dec 31)**	**Year 2002 *and later***
76085** CAD with screening mammography (may bill with *77057* (76092**))* No Deductible Coinsurance Applies	N/A	N/A	Lower of: 1. Charge or, 2. TC of MPFS for code 76085

Computer-aided Detection (CAD)	**Year 2000**	**2001 (April 1-Dec 31)**	**Year 2002 *and later***
G0236 CAD with diagnostic mammography Deductible and coinsurance apply	N/A	N/A	SNFs cannot be paid for this service

TC = technical component

MPFS= Medicare Physician Fee Schedule

* 76085 *is a* deleted code after December 31, 2003. Use code *76083** instead of 76085 *for claims with dates of service through December 31, 2006 and code 77052 for claims with dates of service January 1, 2007 and later.*

***** *For claims with dates of service prior to January 1, 2007, SNFs report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, SNFs report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.*

20.4 - Billing Requirements - FI Claims

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Except as provided in the following sections for RHCs and FQHCs, the following procedures apply to billing for screening mammographies.

The technical component portion of the screening mammography is billed on Form CMS-1450 under bill type 12X, 13X, *14X***, 22X, 23X or 85X using revenue code 0403 and HCPCS code *77057* (76092*)*.

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type 13X, *14X***, 22X, 23X or 85X using revenue code 0401 and HCPCS code *77055* (76090*), 77056* (76091*),* G0204 and G0206.

Separate bills are required for claims with dates of service prior to January 1, 2002. Providers 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.

See separate instructions below for rural health clinics (RHCs) and federally qualified health centers (FQHCs).

***** *For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, and 77057 respectively.*

*** *For claims with dates of service April 1, 2005 and later, hospitals bill for all mammography services under the 13X type of bill. The 14X type of bill is no longer applicable. Appropriate bill types for providers other than hospitals are 22X, 23X, and 85X.*

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

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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 base provider. The provider of that service bills the FI under bill type 12X, 13X, 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 *77057*, (76092)*, G0202, 76085, 77052*, and (76083)*.* Payment is based on the payment method for the base provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are *77055* (76090*)*, *77056* (76091*)* , *G0204,G0206,77051*, (76082)** , and G0236**.

G0236 is a deleted code after December 31, 2003. Use *76082 for claims with dates of service January 1, 2004 *through December 31, 2006 and code 77051 for claims with dates of service January 1, 2007 and later.*

******* *For claims with dates of service prior to January 1, 2007, report CPT codes 76082, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, report CPT codes 77051, 77055, 77056, and 77057 respectively.*

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 practitioner that renders 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

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, 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 on or after January 1, 2004 but before April 1, 2005.

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, 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). The claim must also contain a visit revenue code 0520 or 0521. Payment is made for the professional component under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0403.

For claims with dates of service on or after April 1, 2005, 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. Payment is made for the professional component under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the professional component. Use revenue code 0520 or 0521 as appropriate.

For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography. Use revenue code 0520 or 0521 as appropriate. No HCPCS coding is required for the diagnostic mammography.

20.4.2 - FI Requirements for Nondigital Screening Mammographies

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

The FI will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code *77057* (76092*)*;
- Presence of high risk diagnosis code indicator where appropriate;
- Date of last screening mammography; and
- Age of beneficiary.

The FIs must accept revenue code 0403 for bill types 13X, 22X, 23X, 71X, 73X, or 85X.

***** *For claims with dates of service prior to January 1, 2007, providers report CPT code 76092. For claims with dates of service January 1, 2007 and later, providers report CPT code 77057.*

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

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

The 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.

The 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 (*77057* (76092*)*) and the screening mammography (*77057* (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 *through December 31, 2006 and code 77052 for claims with dates of service January 1, 2007 and later*.

The 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.

***** *For claims with dates of service prior to January 1, 2007, providers report CPT codes 76083 and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77052 and 77057 respectively.*

20.5.1.1 – Carrier and CWF Edits

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

The 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 *through December 31, 2006. For claims with dates of service January 1, 2007 and later, add on CAD code 77052 must be billed in conjunction with screening mammography code 77057 or G0202.* 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 *through December 31, 2006. For claims with dates of service January 1, 2007 and later, add- on CAD code 77051 must be billed in conjunction with diagnostic mammography codes 77055,77056, G0204 and G0206*. 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.

20.6 - Instructions When an Interpretation Results in Additional Films

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

A. Claims With Dates of Service October 1, 1998 Through December 31, 2001

A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at the 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. This can be done without an additional order from the treating physician. When this occurs, the claim will be billed and paid as a diagnostic mammography instead of a screening mammography. However, since

the original intent for the exam was for screening, for statistical purposes, the claim is considered a screening.

The claim should be prepared for FI processing reflecting the diagnostic revenue code (0401) along with HCPCS code 76090, 76091, G0204, G0206 or G0236 as appropriate and modifier "-GH" "Diagnostic mammogram converted from screening mammogram on same day." Statistics will be collected based on the presence of modifier "-GH." A separate claim is not required. Regular billing instructions remain in place for mammograms that do not fit this situation.

Carriers should receive a claim for a screening mammogram with CPT code 76092 (screening mammography, bilateral) (Type of Service = 1) **but**, if the screening mammogram turns into a diagnostic mammogram, the claim is billed with CPT code 76090 (unilateral) or 76091 (bilateral), (TOS= 4), with the "-GH" modifier. Carriers pay the claim as a diagnostic mammography instead of a screening mammography.

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

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

B. Claims With Dates of Service On or After January 1, 2002, (or On or After April 1, 2002 for Hospitals Subject to OPPS)

A radiologist who interprets a screening mammography is 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 pay for both the screening and diagnostic mammogram.

Carrier Claims

For carrier claims, providers submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier "-GG" to the diagnostic mammography. A modifier "-GG" is appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse both the screening mammography and the diagnostic mammography.

FI Claims

FIs require the diagnostic claim be prepared reflecting the diagnostic revenue code (0401) along with HCPCS code *77055* (76090*)*, *77056* (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 a screening mammography that does not fit this situation.

Both carrier and FI systems must accept the GH and GG modifiers where appropriate.

** For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090 and 76091. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055 and 77056 respectively.*

20.7 - Mammograms Performed With New Technologies

(Rev.1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

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 *77057* (76092*)* or G0202, may be billed in a calendar year. Therefore, providers/suppliers must not submit claims reflecting both a film screening mammography (*77057* (76092*)*) and a digital screening mammography G0202. Also, they must not submit claims reflecting HCPCS codes *77055* (76090*)* or *77056* (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.

** For claims with dates of service prior to January 1, 2007, providers report CPT codes 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77055, 77056, and 77057 respectively.*

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).

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.

NOTE: Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

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.

NOTE: Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

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).

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

Code	Payment
	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. **NOTE:** Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.
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. **NOTE:** Effective January 1, 2005, payment will be made under MPFS for claims from hospitals subject to OPPS.

Providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 under bill type 13X, 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.

Code	Payment
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.