Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2235

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4601.1 – 4601.2	4-425- 4-426 (2 pp.)	4-425 – 4-426 (2pp.)

CORRECTION:--*EFFECTIVE DATE: September 11, 2002*
IMPLEMENTATION DATE: September 11, 2002

Section 4601.2, Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim has been revised to correct the CPT and HCPCS code descriptors to match the CPT descriptors in the manuals.

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

These instructions should be implemented within your current operating budget.

4600. RADIOLOGY FEE SCHEDULE

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

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

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

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

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

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

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

4601. SCREENING MAMMOGRAPHY and DIAGNOSTIC MAMMOGRAPHY

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

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

A. Age Status.--

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

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

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

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

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

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

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

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

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