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# Medicare Carriers Manual Part 3 - Claims Process

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Department of Health &  
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## CHANGE REQUEST 2332

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
4601.1- 4601.2	4-425 – 4-428 (4 pp.)	4-425 – 4-428 (4 pp.)
4601.6 (Cont.) – 4603.1	4-430.3 - 4-431 (3 pp.)	4-430.3 – 4-431 (3 pp.)

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

Section 4601.2, Identifying a Screening Mammography Claim and a Diagnostic Mammography Claim has been modified to state that G0236 has been established as an add-on code that can be billed in conjunction with the primary service diagnostic mammography codes 76090, 76091, G0204, or G0206.

Section 4601.6, Diagnostic and Screening Mammography Performed With New Technologies has been updated to clarify that both a film and digital screening mammography or film and digital diagnostic mammography should not be billed together since payment will not be made for both. It also requires you to deny the claims when both a film and digital screening mammography or film and digital diagnostic are reported. See §4601.2 I for the only exception to this policy.

In addition, this instruction allows for billing and payment of computer aided detection devices in conjunction with new technology screening and diagnostic mammography services.

**These instructions should be implemented within your current operating budget.**

**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.

#### 4600. RADIOLOGY FEE SCHEDULE

Effective April 1, 1989 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.--

<u>Age</u>	<u>Screening Period</u>
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 - **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)

HCPCS Code 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)

**New Modifier GG** - **Performance and payment of a screening mammogram and diagnostic mammography on the same patient, same day.**

**NOTE:** **Modifier GG should be used to show that the diagnostic test performed on the same date as the screening test is appropriate. 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:

A new CPT 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 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 **as well as G0202**. Payment will be made under the MPFS.

A separate code, G0236, has been created for “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)” for computer aided detection, **and has been established as the add-on code that can be billed in conjunction with the primary service diagnostic mammography codes 76090, 76091, G0204 or G0206. (See 4601.6 for billing and payment instructions when billed in conjunction with digital or screening mammography)**

C. Deleted Mammography Codes as of January 1, 2002:

HCPCS Code G0203-Screening mammography film processed to produce digital image, bilateral all views;

HCPCS Code G0205-Diagnostic mammography, film processed to produce digital image, bilateral, all views; and

HCPCS Code G0207-Diagnostic mammography, film processed to produce digital image, unilateral.

D. Certified Screening Centers/Suppliers.--The law provides specific standards regarding those qualified to perform this service and how they should be certified. As of October 1, 1994, the Mammography Quality Standards Act (MQSA) requires that all mammography centers who bill Medicare get certification from the Food and Drug Administration (FDA). Certification information from FDA is then forwarded to CMS. CMS then provides certification information to carriers. Medicare will only reimburse FDA-certified mammography centers. Inform physicians and suppliers at least annually through your provider/supplier publications of those facilities centers which are certified. Encourage physicians to inform their patients about centers that are certified.

Inform mammography facilities which perform screening mammographies that they are not to release screening mammography X-rays for interpretation to physicians who are not approved under the facility’s certification number unless the patient has requested a transfer of the films from one facility to another for a second opinion, or because the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed only by physicians who are associated with the certified mammography facility. Carriers are not required to maintain a list of these associations unless there is a specific reason for doing so and only on a case by case basis.

When adjudicating a screening mammography claim, refer to the table of certified facilities provided by FDA and confirm that the facility listed on the claim is in fact certified to perform the service. Deny the claim if the service was performed by a non-certified facility.

Claims with dates of service prior to January 1, 2002, are subject specific calculations (payment limitation). There are three categories of bills. They may be for the professional component of mammography services (the physician's interpretation of the results), the technical component (all other services), or a global charge may be made by centers for the professional and technical components together. There are payment limits for each component. The professional component is 32 percent of the total limit for the complete service. The technical component is 68 percent.

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

- o The actual charge for the professional component;
- o The amount determined with respect to the professional component for the service under the Medicare Physician Fee Schedule; or
- o The professional portion of the screening mammography limit. The amount for 2001 is \$22.15 (\$21.69 in 2000, \$21.19 in 1999 and \$20.71 in 1998), determined by multiplying the screening mammography limit by 32 percent.

The payment for the technical component equals 80 percent of the least of:

- o The actual charge for the technical component; or
- o The amount determined with respect to the technical component for the service under the Medicare Physician Fee Schedule; or
- o The technical portion of the screening mammography limit. The amount for 2001 is \$47.08 (\$46.12 in 2000, \$45.03 in 1999 and \$44.02 in 1998), determined by multiplying the screening mammography limit by 68 percent.

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

- o The actual charge for the procedure;
- o The amount determined with respect to the global procedure under the Medicare Fee Schedule; or
- o The limit for the procedure. The amount for 2001 is \$ 69.23 (\$67.81 in 2000, \$66.22 in 1999 and \$64.73 in 1998).

On January 1 of each year after 1991 through 2001, CMS will update the overall limit by the percentage increase in the Medicare Economic Index.

If mammography services are furnished by nonparticipating physicians and suppliers, there is a special limiting charge. (See MCM §5256)

**NOTE:** The above calculations do not apply to claims with dates of service on or after January 1, 2002.

F. 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 all mammography tests (including screening mammography) under the Medicare Physician Fee Schedule (MPFS). The technical component, the professional component and the Global service will all be included on the Medicare Physician Fee Schedule. The Medicare allowed charge is the lower of the actual charge or the MPFS amount. The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is made at 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 non-participation provider reduction and the limiting charge provisions apply to all mammography tests (including screening mammography).

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). Part B 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 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.) Twenty percent of the lower of charge or 150 percent of MPFS. 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 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.

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 the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic, etc.) 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 the provider, under the payment method applicable to the specific provider type (i.e., hospital, rural health clinic) 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.

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

**B. Billing Requirements.**--Only one screening mammogram, either 76092 or G0202 may be billed in a calendar year. Therefore, advise your providers not to submit claims reflecting both a film screening mammography (76092) and a digital screening mammography G0202. Also advise your providers not to submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Deny the claim when both a film and digital screening or diagnostic mammography are reported. However, a screening and diagnostic mammography can be billed together.

**C. Billing and Payment of Computer Aided Detection (CAD) Services.**--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. There is no Part B deductible. However, coinsurance is applicable. The add-on code cannot be billed alone. Deny the claim if only the add-on code is billed.

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 co-insurance apply. The add-on code cannot be billed alone. Deny the claim if only the add-on code is billed.

**NOTE:** Contractors should use remark code N122, "Mammography add-on code can not be billed by itself" (Effective Sept 12, 2002), when deny a claim if only the add-on code is billed.

#### 4602. MAGNETIC RESONANCE ANGIOGRAPHY

**4602.1 Magnetic Resonance Angiography Coverage Summary.**--Section 1861(s)(2)(C) of the Social Security Act provides for coverage of diagnostic testing. Effective for services performed on or after July 1, 1999, Medicare provides limited coverage for magnetic resonance angiography (MRA) of the abdomen and chest. Previously, MRA of peripheral vessels of the lower extremities and MRA of the head and neck had been covered on a limited basis. These coverages are described in the Medicare Coverage Issues Manual, §50-14, "Magnetic Resonance Angiography". MRA is covered for those diagnostic applications only as a substitute for contrast angiography, except where it is medically necessary to do both tests. Medicare coverage of MRA is only extended when the service is reasonable and necessary. There is no coverage of MRA outside of the indications provided in that instruction.

Because the status codes for HCPCS codes 71555, 71555-TC, 71555-26, 74185, 74185-TC, and 74185-26 were changed in the MPFSDB from N to R on April 1, 1998, any MRA claims with those HCPCS codes with dates of service between April 1, 1998 and June 30, 1999 are to be processed according to the contractor's discretionary authority to determine payment in the absence of national policy.

**4602.2 Coding Requirements.**--Providers must report HCPCS codes when submitting claims for MRA of the chest, abdomen, head, neck or peripheral vessels of lower extremities. The following HCPCS codes should be used to report these services:

MRA of head and/or neck	70541, 70541-26, 70541-TC
MRA of chest	71555, 71555-26, 71555-TC
MRA of abdomen	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73725-26, 73725-TC

4602.3 Payment Requirements and Methodology--

- o Medicare Part B deductible and coinsurance apply.
- o Pay for MRAs undercurrent payment methodologies for radiology services.
- o Claims where assignment was not taken are subject to the Medicare Limiting Charge (refer to MCM, Part 3, Chapter VII, §7555 for more information).
- o Providers must report component services with -26(professional component) or -TC (technical component) modifier when appropriate. Physicians performing both the professional and technical components for such services must bill without the modifier unless the service is provided in a Health Professional Shortage Area.

4602.4 Format for Submitting Medicare Carrier Claims--Claims for MRA are to be submitted on Health Insurance Claim Form CMS-1500 or electronic equivalent. Follow the general instructions in §2010, Purpose of Health Insurance Claim Form CMS-1500, Medicare Carriers Manual Part 4, Chapter 2.

4602.5 Claims Editing--Nationwide claims processing edits for pre or post payment review of claim(s) for concurrent MRA and contrast angiography on the same beneficiary are not being required at this time. Carriers should monitor submission of claim(s) for concurrent MRA and contrast angiography and perform medical review as appropriate. Carriers may develop local medical review policy and edits for such claim(s).