Reimbursement Information for Contrast Enhanced Spectral Mammography (CESM) Services

www.gehealthcare.com/reimbursement
This advisory addresses Medicare coding, coverage, and payment for mammography Contrast Enhanced Spectral Mammography (CESM) procedures performed in the hospital outpatient, independent diagnostic testing facility (IDTF), and physician office settings. While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

For purposes of this advisory, diagnostic mammography refers to a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. Screening mammography refers to a radiologic procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. CESM is an extension of the existing indication for diagnostic mammography, and can be used as an adjunct following mammography and ultrasound exams to help localize the lesion and image contrast uptake of a known or suspected lesion.


The following provides 2011 national Medicare physician fee schedule (MPFS) and facility payment rates for CPT codes that may be used for CESM procedures.

Payment will vary by geographic regions.

#### Table 1: 2011 Medicare Reimbursements for Contrast Enhanced Spectral Mammography Procedures

(Reflects National Rates, Unadjusted For Locality)

<table>
<thead>
<tr>
<th>Technology</th>
<th>CPT/HCPCS Code</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment</th>
<th>Hospital Outpatient Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital</td>
<td>HCPCS G0204: Diagnostic mammography, producing direct digital image, bilateral, all views</td>
<td>Professional (-26)*</td>
<td>$43.66</td>
<td>$110.42</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)**</td>
<td>$110.42</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$154.08</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HCPCS G0206: Diagnostic mammography, producing direct digital image, unilateral, all views</td>
<td>Professional (-26)*</td>
<td>$35.00</td>
<td>$86.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical (-TC)**</td>
<td>$86.60</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
<td>$121.61</td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td>CPT 96374: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug</td>
<td>Facility***</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Facility****</td>
<td>$55.72</td>
<td>APC 0437</td>
</tr>
</tbody>
</table>

*Professional—is the physician payment  
** Technical—is the facility payment  
***Facility—Hospital setting  
****Non-facility—physician's office or setting other than hospital
2011 Medicare Reimbursement for Contrast Materials

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Code Dosage</th>
<th>Payment Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Q9951</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT Q9965</td>
<td>1 ML</td>
<td>1.059</td>
</tr>
<tr>
<td>Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT Q9966</td>
<td>1 ML</td>
<td>0.29</td>
</tr>
<tr>
<td>Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT Q9967</td>
<td>1 ML</td>
<td>0.166</td>
</tr>
<tr>
<td>Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of radiologic procedures for CESM services.

26—Professional Component

A physician who performs the interpretation of a mammography exam in the hospital outpatient setting may submit a charge for the professional component of the mammography service using a modifier -26 appended to the appropriate radiology code.

GG—Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

When a screening mammogram and a diagnostic mammogram are performed on the same patient on the same day, modifier –GG would be appended to the appropriate procedure code. The screening mammogram is reported and the diagnostic mammogram is reported (different encounters on the same day).

GH—Diagnostic mammogram converted from screening mammogram on same day

When a diagnostic mammogram is converted from a screening mammogram on the same day, modifier GH would be appended to the appropriate procedure code. A potential problem was detected by the interpreting radiologist and, therefore, the radiologist will also perform a diagnostic mammogram at the same visit.

TC—Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

Hospital Inpatient—ICD-9-CM Procedure Coding

ICD-9-CM procedure codes are used to report procedures performed in a hospital inpatient setting. The following are ICD-9-CM procedure codes that are typically used to report radiological procedures for mammography services.

- 87.36 Xerography of breast
- 87.37 Other mammography

ICD-9-CM Diagnosis Coding

It is the physician’s ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms, or conditions that reflect the reason for doing the mammography.

Documentation Requirements

As with any procedure performed, Medicare requires documentation to support that the procedure(s) performed are medically necessary. Medical necessity, as determined by the payer, should be thoroughly documented in the patient’s medical record. Medicare will reimburse providers for medically necessary screening and diagnostic mammography procedures that are performed on the same patient on the same day. The modifier –GG (“Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day”) must be attached to the appropriate diagnostic mammography procedure code. In a scenario where a patient has a screening mammogram performed on one day and returns on another day for the additional diagnostic mammogram, both the screening mammogram and diagnostic mammogram services should be coded separately without the use of modifier –GG. This policy applies to both film and digital mammography procedures. [Refer to the Medicare Claims Processing Manual at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf (scroll to section 20.2).]
Payment Methodologies for Mammography Services

Medicare reimburses for mammography services when the services are within the scope of the provider’s license and are deemed medically necessary. The following describes the various payment methods by site of service.

Medicare reimbursement for mammography services is comprised of a professional component (PC), which is the amount paid for the physician’s interpretation and report, plus a technical component (TC), which is the amount paid for performing the service (including staffing and equipment costs). When combined and paid to the same individual or entity, this amount is often referred to as the total or global reimbursement. Regardless of the site of service, diagnostic and screening mammography services are paid under the Medicare physician fee schedule.

Table 1 provides information concerning Medicare national payment amounts for both screening and diagnostic mammography services performed in the hospital outpatient department, IDTF, and physician office sites of care. Note that Medicare payment amounts and coverage policies for specific procedures will vary by geographic location. For more information about reimbursement rates in your area, consult your local Medicare contractor.

Site of Service

Physician Office Setting

In the office setting, a physician who owns the radiology equipment and performs the service may report the global code without a –26 modifier.

Hospital Outpatient Setting

When the mammography service is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service. If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the mammography service as an outpatient service.

Hospital Inpatient Setting

Charges for the mammography services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless. Note: Medicare reimburses for services when the services are within the scope of the provider’s license and are deemed medically necessary.

Coverage

As established in legislation, Medicare provides conditions of coverage for both screening and diagnostic mammography services. Coverage guidelines address the types of services covered; requirements for providers of service; patient’s eligibility; and frequency limitations. To review information on Medicare’s coverage conditions for mammography services, refer to Medicare’s National Coverage Determination, Mammograms, in the Internet Manual for Medicare National Coverage Determinations at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf [scroll to section 220.4], as well as information located in the Internet Manual for Medicare Benefit Policy at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf [scroll to section 280.3]. However, Medicare may consider CESM to be a new breast imaging modality. Therefore, it is best to check with your Medicare Contractor regarding the coverage of CESM.

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1. Information presented in this document is current as of November 2, 2011. Any subsequent changes which may occur in coding, coverage, and payment are not reflected herein.

2. The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment’s FDA-approved labeling as a non-covered service.

3. The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.


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6. Third-party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 75, No. 228 November 29, 2010 and updated with data files from Transmittal 828 Emergency Update to the CY 2011 Medicare Physician Fee Schedule (MPFS) Database December 29, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

7. Third-party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol. 75, No. 226, November 24, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.


9. Payment allowance limits subject to the ASP methodology are based on 1Q11 ASP data. Note 2: The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor processing the claim. Effective July 1, 2011 through September 30, 2011.

10. Title 42-Public Health. CFR §410.34.