CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

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CHANGE REQUEST 3662

SUBJECT: Manualization of Payment Change for Diagnostic Mammography and Diagnostic Computer Aided Detection

I. SUMMARY OF CHANGES: Manualizes changes to the payment methodology for diagnostic mammography and diagnostic computer aided detection services provided by hospitals subject to the Outpatient Prospective Payment System. This instruction also adds clarifying language regarding age criteria for screening mammographies.

NEW/REVISED MATERIAL - EFFECTIVE DATE: N/A
***IMPLEMENTATION DATE: N/A**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	18/Table of Contents
R	18/Screening Mammography Services
R	18/20.2.1.1/CAD Billing Charts
R	18/20.3.1/Payment for Screening Mammography Services Provided Prior to January 1, 2002
R	18/20.3.2/Payment for Screening Mammography Services Provided On and After January 1, 2002
R	18/20.3.2.1/Outpatient Hospital Mammography Payment Table
R	18/20.3.2.2/Payment for Computer Add-On Diagnostic and Screening Mammograms for FIs and Carriers
R	18/20.7/Mammograms Performed With New Technologies

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents

(Rev. 482, 02-25-05)

20.3.1 - Payment for *Screening Mammography* Services *Provided* Prior to January 1, 2002
20.3.2 - Payment for *Screening Mammography* Services *Provided* On or After January 1, 2002.

20 - Mammography Services

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

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 the Medicare Benefit Policy Manual, chapter 15, 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 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 30	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*.

A - Definition of a 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.

20.2.1.1 - CAD Billing Charts

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

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 and later
76085	76092	76092, G0202	N/A
76083	N/A	N/A	76092, 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 and later
G0236	76090	76090	N/A
	76091	76091	
		G0204	
		G0206	
76082	N/A	N/A	76090
			76091
			G0204
			G0206

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

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

See 20.5.1 for Carrier CWF edits

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

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

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 update*s* the overall limit annual*ly* 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:

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

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. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

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 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.

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. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

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***
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 76092
G0202 Screening Mammography, producing direct digital image, bilateral, all views. No deductible Coinsurance applies	N/A	Lesser of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lesser of: 1. Actual charge, 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

PAYMENT FOR DIAGNOSTIC MAMMOGRAPHY

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

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***
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*
76083 CAD with screening mammography (may bill with 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 76083*
76082 CAD with diagnostic mammography (may bill with 76090, 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 76082*

TC = technical component
MPFS= Medicare Physician Fee Schedule
OPPS= Outpatient Prospective Payment System
APC= Ambulatory Payment Classification

*Note that code 76085 is a deleted code as of December 31, 2003. The new code to be used for dates of service beginning January 1, 2004 and later is 76083. Code G0236 is a deleted code as of December 31, 2003. The new code to be used for dates of service beginning January 1, 2004 and later is 76082.

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. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

Payment for computer add-on diagnostic mammogram HCPCS code G0236 or 76082 when billed with CPT code 76090, 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
Independent RHC	All-inclusive rate for professional component (codes 76090 and 76091)
Freestanding FQHC	All-inclusive rate for professional component (codes76090 and 76091)

** 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 and later, 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.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes G0236 or 76082 with an explanation that payment for code G0236 or 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 Sept 12, 2002).

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

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 Medicare physician fee schedule.

Effective for claims with dates of service January 1, 2004 and later, 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 apply.

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

20.7 - Mammograms Performed With New Technologies

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

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

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 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 14X, 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.
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.