MEDICARE PART A BULLETIN

August 29, 1997 Hospital Medicare Bulletin H-82

TO: All Participating Hospital Medicare Providers

FROM: Government Program Operations

SUBJECT: **REITERATION OF DIAGNOSTIC MAMMOGRAPHY COVERAGE**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care facility personnel.

In March 1995, Medicare Part A, Blue Cross and Blue Shield of Florida, Inc., initiated 100% review of diagnostic mammography services via the Artificial Intelligence (AI) knowledge-based system. An average of 5,000 claims per month were reviewed via the AI system. After two (2) years of reviewing diagnostic mammography claims via the AI system, the monthly submission is down to an average of 3,000 claims per month. Even with the decrease in claims submission for diagnostic mammography services, there continues to be a high denial rate for these services. Therefore, via this bulletin, we will address the issues that continue to result in payment denial.

PHYSICIAN'S ORDER FOR MAMMOGRAPHY SERVICES

All diagnostic mammography services must be ordered by a physician. Orders for mammography services must clearly indicate the type of mammography to be performed (i.e., diagnostic or screening). Several bulletins have been published regarding physician orders on mammography services. For more information providers may reference Hospital Medicare Bulletin H-49 and H-58, published October 17, 1995, and March 27, 1996, respectively.

When a patient presents an unclear order for mammography to your facility, you should not assume that the patient's physician intended for the patient to have diagnostic mammography services. A symptomatic woman with a history of breast biopsies and/or cancer may only require periodic screening. Therefore, providers should ensure that a process is in place to contact the patient's physician to verify which type of mammography service is to be performed. The need for diagnostic mammography services is up to the discretion of the patient's physician. However, the reimbursement for diagnostic mammography is based upon criteria established by HCFA. Providers may reference Hospital Medicare Bulletin H-57, published February 9, 1996, for more information pertaining to diagnostic mammography coverage.

The following information is additional clarification from HCFA regarding the physician's orders pertaining to all diagnostic mammography services:

Entities performing diagnostic mammography services must maintain evidence' that the services they are rendering are ordered by a physician.

HCFA has no regulation that entities performing diagnostic mammography services must obtain an actual written prescription order for the diagnostic services they are rendering. However, entities performing diagnostic mammography services may have this or other requirements placed upon them

by other regulatory bodies (e.g., state laws).

Evidence' of a physician's order could be:

- a hardcopy of your centralizing scheduling area record which minimally indicates the service
- to be performed, a diagnosis code, and who ordered the service;
- a verbal order which is documented and co-signed by the physician; or other forms of medical
- documentation that support the need and physician's intent to request diagnostic service (e.g., an office, clinic, or progress note).
- Stamped signatures on actual prescriptions for diagnostic services are acceptable. Physicians should secure this practice and attest to the utilization of their stamped signature.
- Office personnel, appointed by the physician, may sign for and initial an order for diagnostic services. To help eliminate the possibility of fraud, this practice can only be accepted by Medicare on a preprinted prescription pad that contains the physician's name, address, and telephone number.

Providers should ensure that the format they utilize to show "evidence" of the physician order clearly indicates the mammography services to be performed (e.g., diagnostic/screening). The radiology department in your facility must know whether they are to perform a screening or diagnostic mammography so that the appropriate number of views of each breast is taken.

RADIOLOGY REPORT

The Radiologist is encouraged to note, in the radiology mammography report, any patient history that would document why a diagnostic mammography was performed. Any patient complaints, specific findings (i.e., biopsy scarring), etc., should be included by the radiologist in their report. Please note that although reimbursement is never based upon the actual radiology findings, a patient's personal history and/or acute symptoms will often support established coverage criteria. Many beneficiaries that appear to have acute symptoms are shown to be negative for breast cancer after a diagnostic mammography is performed.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling (904) 355-8899.