MEDICARE PART A BULLETIN

January 15, 1998 General Medicare Bulletin G-314

TO: All Medicare Providers

FROM: Provider Relations

SUBJECT: **MAMMOGRAPHY SCREENING SERVICES**

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

The purpose of this bulletin is to share with providers the **draft** regulation changes that the Health Care Financing Administration (HCFA) has published with regards to screening mammography services.

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added Section 1834 © of the Act to provide for Part B coverage of mammography screening performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. Payment may be made for a screening mammography furnished to a woman at her direct request.

Prior to October 1, 1994, providers performing screening mammographies were required to request and be recommended for certification by the State certification agency and approved by HCFA before payment was made. Effective October 1, 1994, providers performing mammography services (diagnostic and screening) require issuance of a certificate from, the Food and Drug Administration (FDA) before payment may be made. A provider arranging for another entity to perform a screening mammography for one of its patients must assure, prior to October 1, 1994, that the entity is certified to perform the screening. On or after October 1, 1994, the provider must assure that the entity has been issued a certificate by the FDA. If the entity performing the screening mammography is not certified, the claim will be denied.

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:

- No payment may be made for a screening mammography performed on a woman under 35 years of age;
- Payment can only be made on one screening mammography performed on a woman between her 35th and 40th birthday (ages 35 thru 39); or
- **For a woman over 39, payment can be considered for a screening mammography performed after 11 full months have passed following the month in which the last**

screening mammography was performed.

DETERMINING 11 MONTH PERIOD

To determine the 11-month period, begin counting with the month following the month in which a previous screening mammography was performed.

EXAMPLE: The beneficiary received a screening mammography in January 1998. Begin counting with February 1998. The beneficiary is eligible to receive another screening mammography in January 1999 (the month after 11 full months have elapsed).

PAYMENT LIMITATIONS

There is no Part B deductible; however, coinsurance is applicable. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is, for the physician's interpretation of the results of the examination),
- Technical component (all other services), or
- Both professional and technical components (global), however, global billing is not permitted for services furnished in provider outpatient departments.

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 (i.e., $59.63 in calendar year 1994, $60.88 in calendar year 1995, $62.10 in calendar year 1996, $63.34 in calendar year 1997, and $64.73 in calendar year 1998) is allocated between the professional and technical components as set forth by regulations. For example, in calendar year 1998, 32 percent of the $64.73 limit, or $20.71, is used in determining payment for the professional component and 68 percent of the $64.73 limit, or $44.02, is used in determining payment for the technical component.

Payment for the technical component equals 80 percent of the least of the:

- Actual charge for the technical component of the service;
- Amount determined for the technical component of a bilateral diagnostic mammogram (HCPCS code 76091; revenue code 41X) for the service under the radiology fee schedule in 1991; or for services furnished on or after January 1, 1992, under the Medicare physicians' fee schedule; or
- Technical portion of the screening mammography limit. This is an amount determined by multiplying the screening mammography payment limit ($59.63 in calendar year 1994 by 63 percent, $60.88 in calendar year 1995, $62.10 in calendar year 1996, $63.34 in calendar year 1997, and $64.73 in calendar year 1998) by 68 percent.

On January 1 of each subsequent year, the overall limit is updated by the percentage increase in the Medicare Economic Index.

Providers bill the intermediary via the HCFA-1450 (UB-92) claims format for the technical component portion of the screening mammography; and the carrier via the HCFA-1500 claims format for the professional component portion.

BILLING REQUIREMENTS

Providers bill for the technical component portion of the screening mammography on Form HCFA-1450 (UB-92) under bill types 14X, 23X, 71X (provider number ranges, 3400-3499, 3975-3999 and 8500-8899) or 85X, using revenue code 403 and HCPCS code 76092. A separate bill is required. **Providers include on the bill only charges for the mammography screening.**

Provider-based RHCs and FQHCs bill the intermediary for the technical component and their carrier for the professional component of the screening mammography. Independent RHCs and free-standing FQHCs bill their carrier for both the technical and professional components. Provider-based FQHCs utilize bill type 14X when billing their intermediary for this service.

HCFA-1450 (UB-92) - Technical Component

On every screening claim with dates of service October 1, 1997, thru December 31, 1997, where the patient is not a high risk individual, the provider enters in (Form Locator (FL) 67 of the HCFA 1450 (UB-92) claims format), the following "Principal Diagnosis Code":

- V76.12 "Other screening mammography."

If the screening is for a high risk individual, the provider enters "Principal Diagnoses Code":

- V76.11 "Screening mammogram for high risk patient."

In addition, for high risk individuals, providers must also report one of the following applicable codes in FL 68, "Other Diagnoses Codes":

- V10.3 "Personal history - Malignant neoplasm female breast;"
- V16.3 "Family history - Malignant neoplasm breast;" or
- V15.89 "Other specified personal history representing hazards to health."

SPECIAL BILLING INSTRUCTIONS WHEN A RADIOLOGIST INTERPRETATION RESULTS IN ADDITIONAL FILMS

In accordance with the Medicare Physician Fee Schedule effective January 1, 1998, radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. This is an exception (for physicians who interpret screening mammograms) to the requirement that all diagnostic tests must be ordered by the treating physician. Where a radiologist interpretation results in the need for additional films, the mammography is no longer considered a "screening" exam. The claim should be submitted as a diagnostic mammography reflecting revenue code 41X instead of 403. HCFA's requirement for a physician's order for diagnostic mammography services is still applicable. (Please reference Hospital Medicare Bulletin H-82, dated August 29, 1997 for more information on

"physician order.") Payment will be made on a cost reimbursement basis. Beneficiary age and frequency standards will not apply.

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