For 2015, new billing codes have been created for Digital breast Tomosynthesis (DBT). In response to a request from the American College of Radiology (ACR), the Current Procedural Terminology (CPT) Editorial Panel created three new Category I CPT codes (77061, 77062, and 77063) for CY 2015. These new codes describe the physician work and practice expense associated with screening and diagnostic DBT. However, the Centers for Medicare & Medicaid Services (CMS) recommends in the 2015 MPFS Final Rule that only 77063, (screening digital breast tomosynthesis, bilateral) be used at this time in conjunction with the digital screening mammography code G0202.

Therefore, instead of using the new diagnostic DBT CPT codes (77061, 77062), CMS has created and is recommending the new add-on G code (G0279) to be used with the existing digital diagnostic mammography codes (G0204, G0206) to reflect the work of Tomosynthesis when provided with diagnostic digital mammography. The new CPT and HCPCS codes are effective January 1, 2015. Please note that non-Medicare payers may follow Medicare direction and some may have their own specific coding recommendations regarding billing for DBT. Please check with your individual payer for coding recommendations.


For 2015, new billing codes have been created for Digital breast Tomosynthesis (DBT). In response to a request from the American College of Radiology (ACR), the Current Procedural Terminology (CPT) Editorial Panel created three new Category I CPT codes (77061, 77062, and 77063) for CY 2015. These new codes describe the physician work and practice expense associated with screening and diagnostic DBT. However, the Centers for Medicare & Medicaid Services (CMS) recommends in the 2015 MPFS Final Rule that only 77063, (screening digital breast tomosynthesis, bilateral) be used at this time in conjunction with the digital screening mammography code G0202.

The following are the new codes for 2015:

- **77061** Digital breast tomosynthesis, unilateral*
- **77062** Digital breast tomosynthesis, bilateral*
- **77063** Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
- **G0279** Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)

It is always recommended to check with your local payer, whether Medicare or non-Medicare to obtain the recommended coding and coverage information that applies to mammography, CAD, and DBT procedures.

The following provides 2015 national Medicare physician fee schedule (MPFS) and facility payment rates for CPT codes that may be used to report Digital Breast Tomosynthesis procedures. Payers or their local branches may have specific coding and reimbursement requirements and policies. Before filing any claims, it is recommended that providers verify current requirements and policies with their local payer. Payment will vary by geographic regions.

* Note that CMS will not recognize these specific CPT codes for billing of DBT for 2015
Table 1: 2015 Medicare Reimbursement for Mammography, CAD and Digital Breast Tomosynthesis Procedures
(Reflects national rates, unadjusted for locality)

<table>
<thead>
<tr>
<th>CPT/HCPCS Code²</th>
<th>Reimbursement Component</th>
<th>Medicare Physician Fee Schedule Payment³</th>
<th>APC</th>
<th>Hospital Outpatient Payment⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mammography, 2D – Screening/Diagnostic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCPCS G0202</td>
<td>Professional (-26)*</td>
<td>$35.40</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)**</td>
<td>$99.40</td>
<td></td>
<td>$99.40</td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$134.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCPCS G0204</td>
<td>Professional (-26)</td>
<td>$44.34</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>$119.78</td>
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<td>$119.78</td>
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<tr>
<td></td>
<td>Global</td>
<td>$164.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCPCS G0206</td>
<td>Professional (-26)</td>
<td>$35.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>$94.03</td>
<td></td>
<td>$94.03</td>
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<tr>
<td></td>
<td>Global</td>
<td>$129.43</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tmosynthesis – Screening/Diagnostic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77063 (New code 2015)</td>
<td>Professional (-26)</td>
<td>$30.39</td>
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<td>$25.74</td>
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<tr>
<td></td>
<td>Technical (-TC)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$56.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0279 (New code 2015)</td>
<td>Professional (-26)</td>
<td>$30.75</td>
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<td>$25.74</td>
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<td></td>
<td>Technical (-TC)</td>
<td>$25.74</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$56.49</td>
<td></td>
<td></td>
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<tr>
<td><strong>Computer Aided Detection (CAD)</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>77051</td>
<td>Professional (-26)</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Global</td>
<td>$8.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77052</td>
<td>Professional (-26)</td>
<td>$3.22</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Technical (-TC)</td>
<td>$5.72</td>
<td></td>
<td>$5.72</td>
</tr>
<tr>
<td></td>
<td>Global</td>
<td>$8.94</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Professional – is the physician payment.
** Technical – is the facility payment.

The following table summarizes the billing codes pertaining to diagnostic and screening mammograms using film or digital and indicating with or without Digital Breast Tomosynthesis. These codes pertain to Medicare billing for 2015.

<table>
<thead>
<tr>
<th></th>
<th>Film</th>
<th>Digital</th>
<th>Digital with Tomosynthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral Diagnostic Mammogram</td>
<td>77055</td>
<td>G0206</td>
<td>G0206 + G0279</td>
</tr>
<tr>
<td>Bilateral Diagnostic Mammogram</td>
<td>77056</td>
<td>G0204</td>
<td>G0204 + G0279</td>
</tr>
<tr>
<td>Screening Mammogram</td>
<td>77057</td>
<td>G0202</td>
<td>G0202 + 77063</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 mammography 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.
- 87.37 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.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf [scroll to section 102.4].)

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.

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).

Private payers may have different coverage requirements than Medicare. It is recommended that you check with your individual payer for their specific coding, coverage and payment requirements. Private payers may require preauthorization for the procedure.
Third party reimbursement amounts and coverage policies for specific procedures will vary including by payer, time period and locality, as well as by type of provider entity. This document is not intended to interfere with a healthcare professional’s independent clinical decision making. Other important considerations should be taken into account when making decisions, including clinical value. The healthcare provider has the responsibility, when billing to government and other payers (including patients), to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or healthcare consultant, as well as experienced legal counsel.

Disclaimer

The information provided with this notice is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. It is always the provider’s responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is provided as of January 1, 2015, and all coding and reimbursement information is subject to change without notice. Payers or their local branches may have distinct coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer.

Third party reimbursement amounts and coverage policies for specific procedures will vary including by payer, time period and locality, as well as by type of provider entity. This document is not intended to interfere with a healthcare professional’s independent clinical decision making. Other important considerations should be taken into account when making decisions, including clinical value. The healthcare provider has the responsibility, when billing to government and other payers (including patients), to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or healthcare consultant, as well as experienced legal counsel.

1 Information presented in this document is current as of January 1, 2015. 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.
4 Title 42 – Public Health. CFR §410.34(a).
5 ACR Practice Parameter for the Performance of Screening and Diagnostic Mammography http://www.acr.org/~/media/3484ca30845348359bad468a779d492d.pdf
7 The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. Actual Medicare payment rates may vary based on any deductibles, copayments and sequestration rules that apply.
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9 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 the Federal Register (Federal Register/Vol. 79, No. 219 /Thursday, November 13, 2014). These changes are effective for services provided from 1/1/15 through 12/31/15. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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.
10 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. The payment amounts indicated are based upon data elements published in the Federal Register Vol. 79, No. 217 published on November 10, 2014. These changes are effective for services provided from 1/1/15 through 12/31/15. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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.
11 Title 42 – Public Health. CFR §410.34.

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GE Healthcare
9900 Innovation Drive
Wauwatosa, WI 53226
U.S.A.
(888) 202-5528
www.gehealthcare.com