

How to Code When a Screening Mammogram Is Changed to a Diagnostic Mammogram

One of the most common requests to the ACR's economics and health policy department is to clarify how to code a mammogram when a screening study is ordered, but the radiologist determines that a diagnostic study is needed instead. The following article answers that question and provides additional reference material.

When a radiologist changes a screening mammogram to a diagnostic mammogram at the time of service, based on the patient's clinical indications, either a unilateral mammogram (CPT code 76090) or bilateral mammogram (CPT code 76091) should be billed with a GH modifier. The GH modifier designates to the carrier that a diagnostic mammogram has been converted from a screening mammogram on the same day and is used by the Health Care Financing Administration (HCFA) for tracking purposes. CPT code 76092, screening mammogram, should not be coded in addition to the diagnostic mammogram when a screening mammogram is changed to a diagnostic mammogram at the time of service. These special billing instructions are detailed in the Medicare Carriers Manual (Transmittal #1625).

It is important to note that this policy does not apply to the standard situation in which an asymptomatic patient comes in for a screening mammogram and is later called back for a diagnostic mammogram. In this situation a screening mammogram (76092) and a diagnostic mammogram (76090 or 76091) would be billed for this patient with each code reflecting a separate service on a different date.

The ACR approved a coding guideline policy for mammography in 1994, which supports HCFA's current coding guidelines. This ACR policy states "If at the time of a screening mammogram of a Medicare or any other patient, additional history is disclosed that renders the patient ineligible for a screening examination, or a mammographic abnormality is identified on the screening examination by a qualified interpreting physician that requires additional views, it is acceptable to change the coding from a screening to a diagnostic mammogram if done on the same date of service."

In addition, the Oct. 31, 1997 *Federal Register* details the ordering of a diagnostic test rule as it relates to changing a screening mammogram to a diagnostic mammogram. The "Ordering of Diagnostic Tests" instructions (Oct. 31, 1997, *Federal Register*, Vol. 62, No. 211, p. 59057) specify that "... a physician who meets the qualification requirements for an interpreting physician ... may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the beneficiary."

Definitions of Screening and Diagnostic Mammography

HCFA published definitions for screening and diagnostic mammography Sept. 30, 1994, with an update to these definitions published Dec. 8, 1995 (both in the *Federal Register*). These definitions are based on those developed by the ACR and the Agency for Healthcare Research and Quality (AHRQ). The following are HCFA's definitions for screening and diagnostic mammography as published.

"The term 'screening mammography' is defined as mammography performed on an asymptomatic patient to detect the presence of breast cancer at an early stage. In screening mammography the patient typically has not manifested any clinical signs, symptoms, or physical findings of breast cancer. The screening mammogram is performed to detect the presence of a breast abnormality in its incipient stage and to serve as a baseline film to which future screening or diagnostic mammograms may be compared."

Further clarification was added to read “screening mammography means a radiological procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer, and includes a physician’s interpretation of the results of the procedure.” Under HCFA’s Dec. 8, 1995, ruling, a personal history of breast disease is an indication for either a diagnostic or a screening mammogram. The physician and patient will have the flexibility to choose which test is appropriate.

“The term ‘diagnostic mammography’ is being defined as mammography performed on a patient with clinical signs, symptoms, or physical findings suggestive of breast cancer; an abnormal or questionable screening mammogram; a history of breast cancer with breast conservation surgery regardless of absence of clinical breast signs, symptoms, or physical findings; or augmented breasts regardless of absence of clinical breast signs, symptoms, or physical findings.” The definition of diagnostic mammography has been expanded to include “asymptomatic men or women who have a personal history of breast cancer or a personal history of biopsy-proven benign breast disease.”

The *Federal Register* goes on to clarify: “Diagnostic mammography is also called problem-solving mammography or consultative mammography. A diagnostic mammogram is performed because there is a reasonable articulable suspicion that an abnormality may exist in the breast. The diagnostic mammogram may confirm or deny the presence of an abnormality and, if confirmed, may assist in determining the nature of the problem.”

HCFA issued a Program Memorandum (Transmittal AB-01-20) on Feb. 1, describing the payment rates and codes to be used for mammography procedures performed with the new digital technology. These rates and codes will be covered in next month’s *ACR Bulletin*. For a copy of the HCFA notification, call the ACR economics and health policy department at (800) 227-5463, ext. 4584.

Although HCFA’s definitions are consistent with those from the ACR, the ACR’s definitions of screening and diagnostic mammography offer additional insight into what may be included in these procedures. The following are ACR’s definitions as stated in the ACR Standards for Performance of Screening Mammography and Diagnostic Mammography and Problem-Solving Breast Evaluation:

“Screening mammography is a radiological examination to detect unsuspected breast cancer at an early stage in asymptomatic women. The intent is to separate women into groups of low and high probability of breast cancer. This examination may be performed without a physician in attendance. The results may assure most women that no significant abnormalities are detected, while others will be informed that an abnormality exists, requiring further investigation.

“The examination should ordinarily be limited to craniocaudal and mediolateral oblique views of each breast. On occasion, supplementary views may be required to visualize breast tissue optimally, but such views should not be done routinely. Where pathology is suspected, a recommendation for additional imaging studies, diagnostic mammography, or biopsy may be warranted.

“If a breast physical examination is not available at the screening site, women should be informed that physical examination is a complementary and necessary procedure.

“The request for problem-solving breast evaluation is a consultation that will result in a comprehensive imaging examination. In addition to the standard craniocaudal (CC) and mediolateral oblique (MLO) views, a diagnostic mammogram may include additional views and may be supplemented by other procedures, such as sonography, ductography, fine-needle aspiration, large core needle biopsy, or MRI, to complete the diagnostic assessment. Diagnostic

breast evaluation is performed under the direct, on-site supervision of an interpreting physician qualified in mammography.

“The patient history; symptoms and signs, such as breast mass, nipple discharge, pain, or dimpling of the skin; findings on physical examination; and results of prior screening mammography, if performed, will focus the diagnostic breast evaluation.”

These two sets of definitions are similar in many ways but also bear some differences. For example, although both definitions of a diagnostic mammogram include a personal history of breast cancer, the ACR’s standard for diagnostic mammography also includes a family history of breast cancer. When billing for a Medicare patient who has had a mammogram, one must be cautious to follow HCFA’s definition. One should consult the local Medicare carrier to determine how to code for some of the questionable scenarios. Also note that non-Medicare third-party payers may handle coverage of screening and diagnostic mammograms differently.

If a member has any questions regarding this article please contact the ACR economics and health policy department at (800) 227-5463, ext. 4584.