

Payment Policy Change for Screening and Diagnostic Mammography Performed on Same Day

As of Jan. 1, 2002, radiologists may submit a claim for a screening mammogram (76092) and a diagnostic mammogram (76090 or 76091) performed on the same patient on the same day. Modifier -GG must be attached to the diagnostic mammography procedure code for tracking and data collection purposes. Medicare will reimburse for both the screening mammography and diagnostic mammography procedures (reference section 4601.2 (I) of the *Medicare Carriers Manual* - Transmittal #1724).

Before Jan. 1, 2002, when a radiologist's interpretation resulted in additional films obtained on the same day as the screening mammogram, the provider was able to convert the screening mammogram to a diagnostic mammogram and Medicare would approve payment. Only the diagnostic mammogram (76090 or 76091) was billed with a -GH modifier. This modifier alerted Medicare that a screening study had been converted to a diagnostic study based on the findings of the screening study. Medicare collected statistical data from the claims filed with a -GH modifier.

Screening mammography, which can be performed without the direct supervision of a radiologist and interpreted by the radiologist at a separate time from the actual study, is ordinarily limited to craniocaudal and mediolateral oblique views of each breast. On occasion, additional views may be required to completely or optimally visualize the entire breast. These additional views are considered part of the screening study and are not separately coded. A diagnostic mammogram is performed when pathology is suspected and specialized views of the breast are obtained. These views might include spot compression, spot compression with magnification, tangential views or other special views. As of Jan. 1, 2002, a diagnostic mammogram performed on the same patient on the same day as a screening mammogram may be coded as a diagnostic mammogram in addition to the screening mammogram (76092). After a screening mammogram, if additional views are performed (for suspected pathology, not just to visualize breast tissue) on one breast, a unilateral diagnostic mammogram (76090-GG) is coded. A bilateral diagnostic mammogram (76091-GG) is coded only when additional views of both breasts are performed after the screening mammogram.

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. In this scenario, no -GG modifier would be required.

According to the ACR's Breast Imaging Reporting and Data Systems (BI-RADS®) Committee, when a screening mammogram and a diagnostic mammogram are performed on the same patient on the same day, the radiologist should generate two separate reports, each with a final assessment category (Mammography Quality Standards Act or BI-RADS®). The initial screening report could be short, recommending that a diagnostic mammogram be done due to the findings (with explanation of the findings). Radiologists

should continue to collect data separately for screening and diagnostic procedures. The outcomes audit on screening mammogram vs. diagnostic mammogram data provides the physician with different information and should be performed separately.

Any ACR member with questions concerning this article can submit them to the economics and health policy department by fax at (703) 391-1757, or can call (800) 227-5463, ext. 4584.